Deschutes County Health Services
RIGHTS AND RESPONSIBILITIES

Our Mission: To promote and protect the health and safety of our community.

When you contact us about services we begin a two way relationship with you as the consumer and us as the treatment provider. We want this relationship to be productive. We want the best care for you or your family. We will work together toward the best possible result for you and your situation.

We also know you will expect things from us. We expect certain things of you as well. Your "Rights" are the things that you can count on getting from us. Your "Responsibilities" are things we need from you. With everyone doing their part and trying their best to work together, we will promote and protect your health and safety and the health and safety of your family and our community.

YOUR RIGHTS

RESPECT

1. You will be treated with dignity and respect by DCBH staff;

ACCESS TO SERVICES

1. To give informed consent in writing prior to the start of services (except in a medical emergency or otherwise permitted by law);
2. To seek outpatient services on your own if you are age 14 or older, emancipated or under age 18 and legally married;
3. To seek services for a minor if you are the legal guardian;
4. Be treated in the same manner as any other individual seeking behavioral health services;
5. You do not need a referral from a doctor to get our services;
6. You will get care that is right for your condition;
7. You will get care that is approved for your condition;
8. You will get behavioral health services in a timely manner equal to access available to any other individual seeking the same services;
9. You will be notified in a timely way if we have to cancel your appointment;
10. You can get help or "Protected Services" if you are being abused;
11. You can get crisis care 24 hours a day, 7 days a week;
12. You have access to Peer Delivered Services

INFORMATION

1. You will be given information about your rights and responsibilities;
2. You will be given information about services;
3. You will be given information about behavioral health services covered or not covered by your health care plan;
4. You can choose the service options covered by your health care plan that works for you;
5. You can have services explained, including expected outcomes and possible risks;
6. You can have free written materials in a form you can understand;
7. You can have us explain written materials to you;
8. You can have a free interpreter if you are hearing impaired or if your primary language is not English.
9. You can have information about "The Declaration for Mental Health Treatment" and "Advance Directive" for health care decisions and what is involved in those processes;
10. You will get a written notice and hearing request information when your services are denied or changed;

11. You will be informed before you receive a service not covered by your health care plan;
12. You will get information about fees before you receive a service;
13. You will receive prior notice of transfer, unless in circumstances necessitating transfer pose a threat to health and safety;

DIRECT YOUR CARE

1. We will give you our best effort to understand your condition;
2. We will give you details about your condition;
3. We will try our best to set up services that most closely meet your needs;
4. You can accept or decline services offered to you (except those required by court order);
5. We will inform you of how your decision to accept or not accept a service could affect your health;
6. We will not use the practice of "restraint" or "isolation" to punish you;
7. We will not "restrain" or "isolate" you to make you do something you don't want to do;
8. You can get a second opinion about your diagnosis and treatment;
9. You can receive medication specific to your diagnosed clinical needs, including medications used to treat opioid dependence
10. You may be referred to another provider if you need covered specialty care we do not provide;
11. You will be actively involved in making your plan for treatment;
12. You will be involved in making your child's plan for treatment, if you are a parent or guardian;
13. You can have a friend, family member, or advocate with you at appointments;
14. You will be involved in decisions about your care;
15. You can change your provider or treatment agency, with a good reason;
16. You can choose whether or not you wish to take part in any new forms of treatment offered;

CONFIDENTIALITY

1. Your personal information will be kept private;
2. What you say to your provider will be kept confidential unless required by law;
3. You will have a record kept with information about your condition, services you received, and referrals that were made for you;
4. Your record will be kept private and confidential according to the law;
5. You can get a copy of your record unless it is restricted by law;
6. You can ask to change or correct the information in your record;
7. You can ask us to give information from your record to another provider;
8. No research information gathered will identify your personal information;
9. You can withdraw a release at any time;

EXERCISE YOUR RIGHTS

1. You have religious freedom, freedom from seclusion and restraint;
2. You will be given information about our complaint process;
3. You will not be punished in any way for making a complaint;
4. You will not be punished for exercising your rights;
5. You will not be discriminated against or restricted from services based on race, age, gender, ethnic or national origin, language spoken, disability, sexual orientation, political or religious beliefs, or marital status;
6. You can make a complaint about DCBH, and will get a timely answer;
7. You can record a "Complaint" or "Appeal";
8. You can request a regular or speedy Department of Human Services Administrative Hearing;
9. You can ask for services to continue until a decision about an Appeal has been made;
10. You will be informed you may be responsible for paying for services that were continued if the Appeal decision is not in your favor.

Deschutes County Health Services
RIGHTS AND RESPONSIBILITIES

YOUR RESPONSIBILITIES

RESPECT

1. Treat your provider and treatment agency staff with respect;

INVOLVEMENT

1. Be actively involved in creating your plan of care;
2. Ask questions about anything you don't understand;
3. Use information you have received to decide about your care before care is given;
4. Follow plans of care you have agreed to;
5. If three (3) scheduled appointments are missed (no show or late cancel) within a three-month period, or there is a pattern of missed appointments with no cancellation, your chart may be closed;

COMMUNICATION AND INFORMATION

1. Keep appointments with your provider;
2. Be on time for your appointments, If you arrive more than 15 minutes late your appointment may be cancelled;
3. Call ahead when you are going to be late or can't keep the appointment, we ask you call 24 hours ahead if possible;
4. Give your provider correct information about your behavioral health situation;
5. Give accurate information for your record;
6. Help your provider get previous behavioral health records;
7. Keep your address, phone number and insurance information up to date

HONORING GUIDELINES

1. Use services from your assigned provider except in an emergency;
2. Use urgent and emergency services appropriately;

PAYMENT

1. Show your insurance card to your treatment agency before your receive services.
2. Pay all fees when they are due;
3. Sign papers to confirm you have been informed of how much any services not covered by your insurance will cost, should you choose to use them;
4. Provide proof of income documents if requested;
5. Sign forms to verify you have been informed who is responsible for paying for services if you choose to get services that are not covered by your insurance.

You can get this document in a larger print size or in a different format. You can also get this document in some languages other than English. Contact the office listed below to ask for this.	
Deschutes County Behavioral Health 2577 NE Courtney Drive Bend, OR 97701	Phone: 541-322-7500 TTY: 541-322-7610 Fax: 541-322-7565

NOTICE OF PRIVACY PRACTICES FOR DESCHUTES COUNTY HEALTH SERVICES (DCHS)

What is protected? Protected Health Information (PHI), which consists of any medical information containing your name or containing other publicly available information from which your identity can be determined.

Your PHI:

- Is kept in written charts, or stored electronically (i.e., in a computer system.)
- Includes records of evaluations, treatments, tests, visits, counseling sessions, and any other health care services you have received.

Protecting your privacy:

- By law, we must keep your PHI confidential, except in certain situations.
- We must give you a copy of this Notice.
- All Deschutes County Employees and Volunteers must follow applicable privacy rules.
- If there is a privacy breach that involves your PHI we will notify you.

The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw your consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

IN MANY CASES, WE NEED YOUR WRITTEN AUTHORIZATION BEFORE WE CAN SHARE YOUR PHI WITH ANY PERSON. However, we can share PHI without your written authorization in certain circumstances, such as:

- Providing you with medical treatment or assisting another healthcare provider to treat you.
- Running our organization.
- Billing or obtaining payment for services.
- Helping with public health and safety issues.
- Conducting research.
- As part of an organized healthcare arrangement (see "OCHIN," on next column).
- As part of a community health information exchange (see "RELIANCE", on next column).
- Complying with the law.
- Responding to lawsuits and legal actions.
- For law enforcement purposes.
- Working with a medical examiner or funeral director.
- Worker's compensation purposes.
- Scheduling an interpreter for you.
- In the event of a disaster.
- Preventing or controlling outbreaks of disease.
- Reporting births or deaths.
- In the event of a healthcare emergency.
- In the event of an eminent threat to self or others.
- Complying with court or administrative orders, or in response to a subpoena.
- Reporting suspected abuse, neglect or domestic violence.
- Responding to an investigation or audit conducted by a health oversight agency.
- To correctional facilities as necessary for your care.
- For national security or to protect the President.

Your privacy rights

- You can ask us to limit how we use or share your information. You must ask in writing. We can agree if law allows.
- You can ask us to contact you in a certain way or in a certain place. We will follow any realistic request.
- In most cases, you can look at or get copies of your records. You must ask in writing. You may have to pay for the copies. Please contact us for the form.
- You can ask to amend health information in your medical or billing records. This must be in writing. We may not agree to these changes in certain situations.
- You can usually revoke your written authorization if you ask us in writing. However, we can't take back any PHI or other information we have already shared.

- You can ask for a list of those with whom we have shared your PHI in the past 6 years. You must ask in writing. This list will not include disclosures of PHI made for treatment, payment, or health care operations, or those that were made pursuant to your written authorization.
- Your PHI will not be sold.
- Genetic information cannot be disclosed to health plans to determine eligibility.
- We will not disclose information to your health plan if you pay for services out of pocket.
- You can ask for a paper copy of this Notice at any time.
- You can choose to designate someone as your authorized representative for purposes of deciding whether your PHI should be shared. Any such designation must be in writing and otherwise legally valid.

Your Choices

You have some choices in the way we use and share your PHI in the following circumstances:

- To tell family or friends about your condition.
- To provide disaster relief.
- To market our services or sell your information.
- To include you in a mental health or hospital directory.
- To raise funds.

If you have a preference as to how we share PHI in any of these circumstances, please tell us and we will follow your instructions to the extent we are legally able to do so.

OCHIN: DCHS is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of DCHS, OCHIN supplies information technology and related services to DCHS and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by DCHS with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

RELIANCE: RELIANCE Health Information Exchange is a business associate of DCHS. RELIANCE provides secure, electronic exchange of health information among authorized members in the health care community – such as health care providers and public health agencies – to drive timely, efficient and patient-centered care. DCHS may share your PHI with RELIANCE for the purposes of facilitating the exchange of health information among authorized RELIANCE members for treatment, payment or healthcare operations purposes. A current list of Reliance members is available at http://reliancehie.org/frequently-asked-questions/.

We care about your concerns! If you do not agree with how we used or disclosed health information about you, you may file a complaint. You will not be punished and your care will not be affected.

TO FILE A PRIVACY COMPLAINT, PLEASE CONTACT ONE OF THE FOLLOWING:

Deschutes County Health Services
Attn: Division Privacy Officer
2577 NE Courtney Drive, Bend, OR 97701
Phone: (541) 322-7607
Fax: (541) 322-7567

Office for Civil Rights
U.S. Dept of Health and Human Services, Region 10 HHS
2201 6th Avenue, Seattle, WA 98121-1831
Phone: (206) 615-2290
FAX: (206) 615-2297 | TDD (206) 615-2296

Deschutes County Health Services

Client Grievance and Complaint Process Notice

If you, your family, or authorized representative(s) have an issue with access, service, clinical care, contact with staff, quality or care, or your rights, please let us know. You shall not be subject to retaliation for making a report or being interviewed about a grievance. You are immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

Grievances may be filed verbally (in-person or by telephone), in writing, or via email. If you would like assistance filling out a grievance form, please ask front desk staff or your service provider.

Your clinician, their supervisor, or a Quality Improvement Analyst will contact you regarding your complaint/grievance. One of these individual will work with you to resolve your concerns. An investigation of any grievance shall be completed within thirty (**30**) calendar days.

You, your family, or authorized representative(s) have the right to appeal a grievance decision. Grievance appeals must be made to the Health Systems Division of the Oregon Health Authority within ten (**10**) business days of notification of the grievance decision. If not satisfied with the appeal decision, you may file a second appeal in writing within ten (**10**) working days. If requested, staff shall be available to assist you.

In circumstances where the matter of the grievance is likely to cause harm to you or another before the grievance process as outlined above will be completed, you may request an expedited grievance review. Expedited grievances will be reviewed by the appropriate Program Manager within **48** hours of receipt of the grievance.

You also have the option file a complaint with:

Disability Rights Oregon
Call: (503) 243-2081 or 1-800-452-1694
welcome@droregon.org

State of Oregon Governor's Advocacy Office
Call: (503) 945-6904 or 1-800 -442-5238
ohso.info@dhsoha.state.or.us

Oregon Health Authority, Health Systems Division
Call: (503) 945-5763 or 1-800-527-5772
https://www.oregon.gov/oha/HSD/AMH/Pages/AMH-Complaint.aspx)

Your Coordinated Care Organization (i.e. PacificSource, Cascade Health Alliance, Health Share of Oregon)

For Additional Questions or Concerns:

Channing Casey, RN, Quality Improvement Analyst
Channing.Casey@deschutes.org
(541) 330-4600

Deschutes County Health Services (DCHS)
Grievance Form

If you, your family, or authorized representative(s) have an issue with access, service, clinical care, contact with staff, quality of care, or your rights, please let us know. You shall not be subject to retaliation for filing a grievance or complaint.

Date of Grievance:

Name: **Phone #:**

Address:

Date of Birth:

DCHS Program: ACCESS

Staff Involved:

Describe the Grievance (provide details about concerns**):**

Signature of Person Completing Form: **Date:**

Return to one of the following: Your clinician, a supervisor, a manager, front desk staff, or to a quality improvement analyst. This form may be mailed to: Attention: CQA, 2577 NE Courtney Drive, Bend OR 97701. This form may be emailed to: healthservices@deschutes.org. Your clinician, their supervisor, or a Quality Improvement Analyst will contact you regarding your complaint/grievance. One of these individual will work with you to resolve your concerns. An investigation of any grievance shall be completed within thirty (30) calendar days.

FOR OFFICE USE ONLY

DCHS Grievance Review

Instructions: If this is resolved at the supervisor and/or manager level, staff shall fill out the information below for CCO and state reporting purposes. Once completed, submit to the designated Quality Improvement Analyst.

Date of Review:

Supervisor and/or Manager Name:

Identification of Direct Care and/or System Concerns:

Determination of Response and/or Action Plan:

Resolution:

Signature: **Date:**

Compliance and Quality Assurance (CQA) Review

Date Received:

Additional Follow-Up Required: ☐ Yes ☐ No

Comments:

ACKNOWLEDGMENT AND CONSENT FOR TREATMENT

I am voluntarily applying for services at the Deschutes County Health Services (DCHS). I understand and agree that Deschutes County Health Services (DCHS) may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers, including other providers within DCHS, for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative, and business functions that support DCHS efforts to provide me with, and be reimbursed for, quality cost-effective health care; and
- Participate in the following as described in the Notice of Privacy Practices for Deschutes County Health Services;
    - Communicate with me through MyChart, an online secure patient portal.
    - As a member of the Reliance Community Health Information Exchange
    - Deschutes County Health Services is a member of an electronic health information exchange (HIE) called the OCHIN Collaborative. A purpose of this HIE is to allow health care providers to electronically share records regarding an individual. I understand and agree that DCHS may disclose any of my health information, including drug and alcohol treatment information protected by 42 CFR Part 2, to this HIE for the purpose of sharing the information with any individual or entity that has a treating provider relationship with me at the time he/she/it accesses the information. I understand that upon my written request, the HIE must provide me with a list of all entities to which my information has been disclosed within the past two years. The HIE would be responsible for responding to the request within 30 days.

I understand that my health information may include information both created and received by DCHS, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand that the health information used or disclosed may include vocational rehabilitation, alcohol and drug records, HIV/AIDS records, genetics information, and mental health or developmental disability records held by publicly funded providers.

I understand that the Notice of Privacy Practices for Deschutes County Health Services may be revised from time to time and that I am entitled to receive a copy of any revised version. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices for Deschutes County Health Services in effect will be posted in the waiting / reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices for Deschutes County Health Services, and I understand that DCHS is not required by law to agree to such requests.

By signing below, I agree that I am requesting services from DCHS, have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices for Deschutes County Health Services.

Printed Client's Name:_____ **Date:** _____

Signed By: _____ ***Patient or Patient's Authorized Personal Representative***