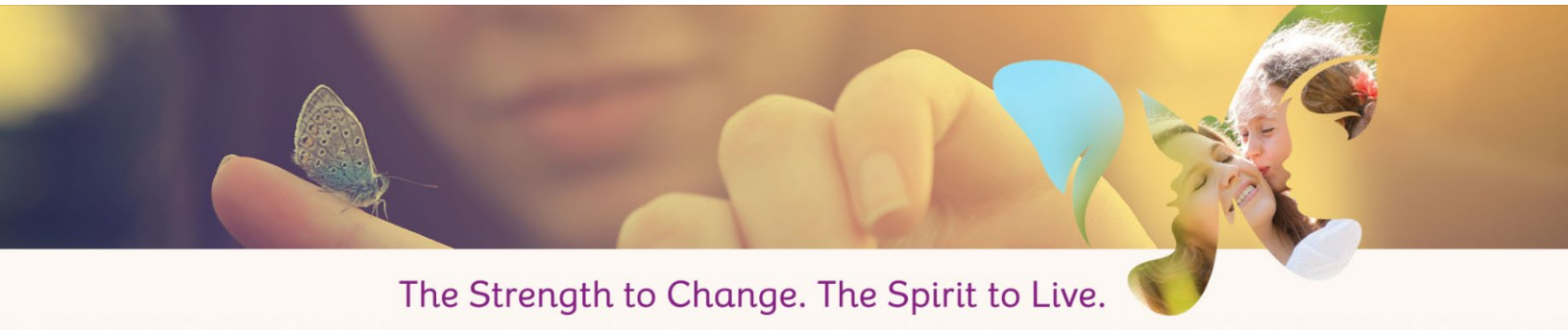

Recovering Hope Treatment Center

Outpatient Client Handbook

2031 Rowland Road

Mora, MN 55051

Phone: 844-314-HOPE

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www.recoveringhope.life

Revised 4/11/22 AT

WELCOME!

We know this was a big decision for you. Recovering Hope Treatment Center is a place that prides itself on helping individuals and families meet their goals. This handbook is for the clients, family members and other concerned persons and it is intended to serve as a guide for you as you move through the treatment process. As a substance use and mental health outpatient facility, we offer a safe space to address substance use disorders and/or mental health concerns.

You are not a number.

You are an individual and **your treatment will reflect your individual needs.** Your future is truly important to our caring professionals and we want help you achieve the goals you have set for yourself. Our treatment program is designed to individualize your treatment plan and recovery needs. We believe in helping you learn and practice lasting coping skills so that you achieve confidence and success. While at Recovering Hope, you will be able to identify and explore issues related to your substance use and mental health.

Mission and Program Philosophy

We Restore Hope.

Recovering Hope is dedicated to helping people improve their quality of life and overall well-being through industry-leading substance use disorder treatment and mental health therapy. We believe each client has unique needs and we are committed to helping them design a treatment plan that helps them achieve their individual goals.

Outpatient Program Goals and Objectives

The program is designed to assist individuals to develop the knowledge, skills, and attitudes for long-term recovery. Recovering Hope utilizes various evidenced based practices including cognitive behavioral therapy and motivational interviewing to assist individuals in identifying where they are in the change process, their personal concept of recovery, creation of goals, and to improve overall quality of life. Recovering Hope believes individuals have the best opportunity for long-term recovery when they have the services and education provided in a safe and supportive environment.

OUTPATIENT SERVICES OFFERED

Comprehensive Assessments

Recovering Hope Outpatient Services provides confidential and professional Comprehensive Assessments (also known as Substance Use Assessments) to help identify the appropriate level of care for individuals struggling with addiction. Recovering Hope Outpatient Service staff use diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders - V (DSM-5) and American Society of Addiction Medicine (ASAM).

Co-occurring Intensive Outpatient Substance Use Disorder Treatment Services

Recovering Hope provides integrated, individualized, and intensive co-occurring outpatient substance use services for all genders ages 18 and older. Recovering Hope offers programming throughout various times of the day to accommodate scheduling needs. Additionally, programming is offered both in-person and via telehealth to assist clients in accessing services regardless of where they live or ability to obtain transportation.

Intensive Outpatient Substance Use Disorder Treatment Services – Jail Program

Recovering Hope provides intensive outpatient substance use treatment services for adult males in Pine County Jail and Kanabec County Jail. Programing is offered onsite at Pine County and Kanabec County clients participate via telehealth.

Outpatient Mental Health Services

Recovering Hope offers a variety of outpatient mental health services that clients may participate in. These include:

- Diagnostic Assessments
- Individual Therapy
- Group Therapy
- Couples and Family Therapy
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)

OVERVIEW OF OUTPATIENT SUBSTANCE USE TREATMENT PROGRAMS

Co-occurring Intensive Outpatient Substance Use Disorder Treatment Services

A client's treatment consists of a comprehensive assessment, diagnostic assessment, individual appointments, individualized treatment plan, groups, and independent skill development and practice. The client attends 9-12 hours of group programming each week for an average of 16 weeks. Additionally, there is 1 hour of individual counseling each week to review goals, progress, and receive individualized counseling. Depending on each client's clinical needs and legal requirements, the length of treatment may be modified.

Program Options:

- IOP Mornings – In Person: Monday, Tuesday and Thursday from 9:00a – 12:00p
- IOP Mornings – Telehealth: Monday, Tuesday, Thursday, and Friday 9:00a – 12:00p
- IOP Afternoons – Telehealth: Monday, Tuesday, Wednesday, Thursday 1:00p – 4:00p

Programming is not currently offered on holidays.

Individual Counseling Sessions

In your first individual counseling session, you will work with your counselor to complete an Individual Treatment Plan (ITP). This will be your template for your

treatment goals and participation in services.

It is required that you engage in weekly individual counseling sessions with your assigned counselor. You must sign up for your one-on-one session every week. If you have an appointment that conflicts with your 1:1 time, you must advise Recovering Hope staff 24 hours prior to the appointment.

Group Outline and Topics:
Group is comprised of psychoeducation and processing. Each group begins with a check-in, process time, and psychoeducation is incorporated based on needs of the group. Curriculum from *The Matrix Model* is used to guide psychoeducation and topics covered include: relapse prevention, the disease model of addiction, trauma, co-occurring disorders, relationships, early recovery, cross addiction, skills-based interventions, and more.

Mental Health Diagnostic Assessments:
Recovering Hope Treatment Center is a co-occurring facility, which means that we provide both substance use and mental health services. As such, it is our policy to provide Mental Health Diagnostic Assessments upon intake of every client. If you have completed a Diagnostic Assessment within the past six (6) months, please complete a Release of Information (ROI) for Recovering Hope to obtain this document. If you do not wish to complete a ROI or would like a new Mental Health Diagnostic Assessment completed, you will be scheduled with a mental health provider. Following your Mental Health Diagnostic Assessment, you will be provided with recommendations, which may include individual mental health therapy or group therapy.

While we highly recommend participating in the assessment process, you have the right to decline this service.

<u>Intensive Outpatient Substance Use Disorder Treatment Services – Jail Program</u>
A client's treatment consists of a comprehensive assessment, individualized treatment plan, weekly individual appointments, groups, and independent skill development and practice. The client attends 9 hours of group programming each week. Length of program involvement is determined by each client's clinical needs, legal requirements, and length of stay in jail.

Program Options:

- IOP Jail (Hybrid In Person/Telehealth Group) – Wednesday, Thursday, Friday 8:15a – 11:15a
-

Programming is not currently offered on holidays.

Individual Counseling Sessions

In your first individual counseling session, you will work with your counselor to complete an Individual Treatment Plan (ITP). This will be your template for your treatment goals and participation in services.

It is required that you engage in weekly individual counseling sessions with your assigned counselor. You must sign up for your one-on-one session every week. If you have an appointment that conflicts with your 1:1 time, you must advise Recovering Hope staff 24 hours prior to the appointment.

Group Outline and Topics:
Group is comprised of psychoeducation and processing. Each group begins with a check-in, process time, and psychoeducation is incorporated based on needs of the group. Curriculum from *Criminal and Addictive Thinking* is used to guide psychoeducation topics.

RULES AND EXPECTATIONS FOR OUTPATIENT SUBSTANCE USE TREATMENT PROGRAMS

Substance Use Disorder Treatment Attendance

It is important for your treatment and for the group dynamics to have consistent attendance in groups. If you are going to be late or absent from group, you must contact your primary counselor. If you are absent from group for a medical reason, please bring with a note from your doctor for your absence to be considered excused. If you have three or more unexcused absences, you will be re-assessed to determine your current goals and motivation to continue with treatment. This could include an attendance contract, supportive persons meeting, transfer to a program you are more motivated to attend, or other interventions that may be appropriate to help you achieve your goals.

Excused Absences: medical emergencies; medical appointments that cannot be rescheduled (with documentation); funeral/bereavement

*** Please talk with your primary counselor if you know you will not be in group, and whether this absence would be considered excused or unexcused.*

Telehealth

If you are engaging in telehealth services through Recovering Hope Treatment Center, please Appendix C for the Telehealth Group Norms.

Types of Discharges

Individuals can end their involvement in treatment at Recovering Hope in one of four (4) ways: With Staff Approval (WSA), Against Staff Advise (ASA), At Staff Request (ASR), or be Therapeutically Transferred (TT). Below are general guidelines of how an individual complete the program in one of these ways but can be modified based on the individual client's needs. The appropriate type of discharge will be determined through consultation with the Outpatient Treatment Team.

With Staff Approval (WSA)/Completion of Goals

1. The client has successfully met majority of the goals in their individual treatment plan
2. The client has worked with the counseling to team develop a viable and supportive Continuing Care plan to Include specific appointments with specific providers within 30 days following discharge
3. The client has maintained their sobriety goals for most of the time they have been in the program.
4. The Treatment Team will collaborate with the client to identify expectations in the individual treatment plan which the client must achieve to complete the program With Staff Approval.
5. Consultation is required by three members of the clinical
6. The client is able to demonstrate they are involved in meaningful activity outside of the treatment program
7. The client is able to articulate how their symptoms progress, what to do in the event of recurrence of use, what the disease of addiction is, and general insight into their cycle of the disease.
8. The client has shown active engagement in the majority of their treatment for between 10-18 weeks.

Against Staff Advice (ASA)

1. The client contacts the counseling team to state they will no longer be participating in the program or they “no show” with no contact (3) three consecutive times, and do not respond to contact from staff, and do not follow plan to return; they have not met the majority of goals in their treatment plan and do not have a viable and supportive continuing care plan.
2. If the Treatment Director, Counselor and/or Mental Health Professional believe the client is at risk to harm self or others, they will follow the Emergency Behavioral Plan.
3. Clients will be provided with an opportunity to meet with staff to assess the needs of care and other resources.
4. If the client denies the opportunity to meet with staff, resources may be mailed to client at the last known address.

At Staff Request (ASR)

1. Clients who cannot, or will not, abide by program expectations regarding program participation even after an attempt to implement treatment interventions for behavioral modification or improved motivation to participate happens.
2. The client may be discharged from Outpatient Services if they are disruptive to others’ treatment process, and interventions to address the disruptive behaviors are not effective.
3. Clients who demonstrate aggressive behavior towards children, peers or

staff. Any client who threatens to assault anyone at Recovering Hope, physically assaults another client or staff, damages property, or is persistently verbally aggressive may be discharged and the Kanabec County Sheriff will be notified.

4. Recovering Hope staff confers with other interested person to review the issues involved in the decision is warranted.
5. Recovering Hope will document reasons for the discharge and alternatives considered and/ or attempted prior to discharge.
6. Recovering Hope staff will assist the client in finding appropriate referrals for recovery, including alternative treatment settings.
7. Clients who have behaviors that are consistently interfering with others' ability to receive treatment services.
8. Clients who are not agreeable to a therapeutic transfer to another facility, if it has been determined by the Clinical Team that they need a higher level of care, different services than Recovering Hope provides, or different type of care.
9. Clients refuses to take necessary precautions to protect themselves from danger or whose presence might pose a danger to other clients.
10. Consultation is required by three members of the clinical team for decisions about discharging a client at staff request.

Therapeutic Transfer

1. Clients may be Therapeutically Transferred to another program for stabilization and/or additional treatment for the following reasons:
2. They express suicidal ideation and/or intent. Clients may be re-admitted following stabilization.
3. They cannot maintain sobriety (client goal) while in the program. In this event, it may be RHTC is not the most effective program for you, and we want you to try a program you might have better success in. This decision is made on a case-by-case basis in consultation with the Treatment Director and the Mental Health Professional.
4. The client is in need of medical treatment which is beyond the scope of practice of Recovering Hope. The client will be referred to a medical facility capable of admitting the client. Clients may be re-admitted following stabilization.
5. The Treatment Director, Counselor and/or Mental Health Professional will meet with the client, whenever possible, to develop a plan for transfer.

<u>Tobacco</u>

You are not allowed to smoke cigarettes, use electronic cigarettes or pipe, or chew tobacco inside the building at any time. Client smoking area is located to the West of the Outpatient entrance. Do not smoke in front of the Outpatient Entrance. Please use proper receptacles to dispose of your cigarette butts.

<u>Drug and Alcohol Policy</u>

Abstinence from all mood altering, non-prescription chemicals is a recommended goal of everyone attending group and individual program sessions or other activities. Should any person continue to use mood altering chemicals while in the program, they may work with their primary counselor on harm reduction strategies and/or be referred to a higher level of care. Possession and/or use of alcohol or other drugs (including over-the-counter medications and non-alcoholic beverages such as near beer) or drug paraphernalia is not permitted on grounds.

If you appear under the influence of drugs and/or alcohol, a conversation with your provider will occur. Upon the discretion of your provider and/or the clinical team, you may be asked to leave the facility. You will be expected to find transportation and will not be allowed to drive yourself while under the influence. If you chose to drive your vehicle while under the influence, we will notify law enforcement.

Urinalysis and/or breathalyzers are valuable tools to provide evidence of your ongoing sobriety and commitment to programming at RHTC. Clients participating in outpatient programming at RHTC will be required to submit samples for urinalysis and/or breathalyzers throughout their treatment stay. Upon each arrival to programming, clients will be expected to check in at the front desk and inquire whether they have been selected for a urine screen. Clients will be expected to provide samples for urinalysis on breaks and not during programming hours. Staff reserve the right to request a urine sample if concerns arise. Refusal to provide a sample or inability to provide a sample will be considered a positive urinalysis.

For clients participating via telehealth, urine screening will be determined based on proximity to the facility, transportation, and third-party involvement prior to admission into the outpatient program. Clients participating in programming via telehealth will have 48 hours to provide a sample in the facility for urinalysis. Clients residing more than 60 miles from the facility will be admitted to the program contingent on their ability to work with third parties (e.g. CPS, probation, health care professionals, etc.) to provide results of urine screens completed regularly.

Child Care

If you have children, you will be expected to find appropriate childcare during your scheduled group and individual sessions. Typically, children are not allowed in the group setting. If you are unable to find childcare, please discuss with your primary counselor about an appropriate plan.

Boundaries with other Group Members

Clients are encouraged to develop lasting and healthy connections with other members of the group in order to grow their sober support network. In order to keep a strong sober support network, clients are encouraged to practice good boundaries and keep the nature of the relationship with one another as sober support. Therefore, clients are encouraged not to engage in romantic or sexual relationships with other

group members.

Group members who are in relationships (familial, employment, romantic, sexual) should disclose the nature of their relationship to the group facilitator, and the facilitator will schedule both clients into separate groups and different counselors as available.

Cell Phones

Please keep your cell phone turned off and put away during group and individual sessions. This is to preserve privacy of the group process and maintain the confidentiality of others in the group. Additionally, it promotes an environment of safety.

Photography

Any photographs, videotapes, digital images, or motion pictures of clients will be acquired through a release form for its use. Use will be limited to the purpose of enhancing therapy or staff supervision as a means of communication within the program. Upon intake, admission staff will take your photo to include in your medical record. There are also cameras throughout the facility and within groups rooms. Further information on this can be found in the informed consent section in the Client Intake Packet. Clients will always be informed when they are being taped or photographed. No unauthorized photos will be taken.

Clients are not allowed to take photos of each other for any reason and are not given permission to post photos of Recovering Hope or other clients on social media.

Pets

Pets are not allowed on RHTC property.

Violence or Threats of Violence

Verbal threats, physical assault, and weapons are not permitted and may be grounds for immediate discharge from the program, and law enforcement contact. We highly value the safety of our clients, their families/concerned persons, and our staff.

Illegal Activity

Engaging in illegal activities, including stealing from other clients, shoplifting, and damaging property may result in discharge from the program, and law enforcement contact. Committing a crime on the property or against personnel is an exception to client confidentiality, and a police report can be made.

Confidentiality

Recovering Hope seeks to abide strictly with all applicable confidentiality regulations, including Federal T.H. 42, Chapter 1, Part 2, “Confidentiality of Alcohol and Drug Abuse Patient Records” and any applicable sections of M.S. 15-1642, “Data Privacy Act”.
You have a right by law to privacy and anonymity during and after your time in the

program at Recovering Hope. We honor this right by not informing anyone before, during or after your program completion at Recovering Hope without your written consent, or exceptions permitted by law.

We also expect you to also honor the rights of your peers in the program to remain anonymous. This includes not communicating in any way "client identifying information" to people outside Recovering Hope. Please do not disclose anything that is said in group to anyone who is not in your group.

Recovering Hope is in a small community, you may see other clients or staff out in the community. Be mindful of confidentiality in the community and be aware that staff will not approach you unless you acknowledge them.

All staff are mandated reporters and by law are required to report potential of abuse of vulnerable adults and child abuse. If a mandated report is made, staff will inform you that a report was made.

Release of Information (ROI)

It is recommended that you complete a Release of Information (ROI) for any important persons involved in your treatment and/or mental health journey. These releases are often recommended for Probation Officers, County Workers, Emergency Contacts, and any other provider that are currently involved in your care. An ROI is the "written consent" that allows staff to communicate with someone various details about your treatment. You may elect to sign an ROI for someone so we could communicate, and the following are examples of reasons people often sign an ROI to be used for: communicate with Probation program participation, communication of urinalysis results, communication about progress in treatment plans, scheduling family sessions and education, referring a client for medical appointments, and transferring to a different care setting.

Clients Rights and Responsibilities

The Recovering Hope staff is committed to treating all clients and family members with respect. Please speak with your counselor or the treatment director if you have any questions or concerns about your treatment in this program. The attached document explains your right as a client at RHTC. Also, as a client in a chemical dependency treatment program in Minnesota, you have the following rights (Appendix A).

Grievance Procedure

Grievance forms (Appendix B) will be provided to you upon admission and can be requested at any time from a staff member. Any grievance from a client will be processed by the following procedure:

Grievance forms can be submitted to the Treatment Director who will respond to your grievance within three (3) business days after a staff member receives the grievance. You

are permitted to bring the grievance to the highest level of authority in the program if not resolved by other staff members. Any staff member can assist you in filling out the grievance form. Grievance procedure and necessary telephone numbers and the addresses of the Department of Human Services, Licensing Division of the Department of Health, Office of Health Facility Complaints will be posted and available to any client or former client.

This shall also be given to clients on admission. Staff shall be included to assist on the development and process of grievance.

Office of Health Facility Complaints P.O. Box 64970 St. Paul, MN 55164-0970 Tel: (651) 201-4201 (800) 369-7994		Minnesota Department of Human Services (DHS) Licensing Division 444 Lafayette Rd N, St. Paul, MN, 55155 Tel: (651) 431-6500
Minnesota Board of Behavioral Health and Therapy 335 Randolph Avenue, Suite 290 St. Paul, MN 55102 Tel: (651) 201-2756		Minnesota Board of Medical Practice 2829 University Ave. SE, Suite 400 Minneapolis, MN 55414-3246 Tel: (612) 617-2130 Fax: 612-617-2166

ADDITIONAL INFORMATION

Client Portal

Recovering Hope provides access to appointments and documents through our client portal. You can also view your scheduled appointments and any financial statements. If you would like information on how to setup and access your client portal, please speak with the front desk.

Transportation

Transportation services may be available to you via Recovering Hope Treatment Center, Timber Trails, or your insurance company. For additional information, please speak with a receptionist.

Insurance Information

If you have any questions about your insurance coverage for services provided at RHTC, please speak with reception.

Legal Involvement

If you are involved with the legal system, it is most helpful for you and all parties involved to have an open line of communication. Please make sure to have a valid Release of

Information to allow contact with any outside parties. This will ensure that we provide only the information that you want us to provide about your services at RHTC. It is important to know that there are limits to your confidentiality, including if your provider is subpoenaed to court. In this instance, there are legal obligations that your provider must uphold that supersedes your client confidentiality. Please talk with your provider if you believe this may apply to you.

Appendices

Appendix A

CLIENTS RIGHTS AND RESPONSIBILITIES

144.651(Except Sub. 28 and 29) HEALTH CARE BILL OF RIGHTS.

Subdivision 1. Legislative intent.

It is the intent of the legislature and the purpose of this section to promote the interests and well-being of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianship's and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Subd. 2.Definitions.

For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or Minnesota Rules, parts 9530.6510 to 9530.6590.

Subd. 3.Public policy declaration.

It is declared to be the public policy of this state that the interests of each patient and resident be protected by a declaration of a patients' bill of rights which shall include but not be limited to the rights specified in this section.

Subd. 4.Information about rights.

Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

Subd. 5.Courteous treatment.

Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

Subd. 6.Appropriate health care.

Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.

Subd. 7.Physician's identity.

Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Subd. 8.Relationship with other health services.

Patients and residents who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed, in writing, of any health care services which are provided to those residents by individuals, corporations, or organizations other than their facility. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Subd. 9.Information about treatment.

Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. Patients and residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's medical record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

Subd. 10.Participation in planning treatment; notification of family members.

(a) Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the patient or resident cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences. A chosen representative may include a doula of the patient's choice.

(b) If a patient or resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient or resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient or resident has an effective advance directive to the contrary or knows the patient or resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient or resident has executed an advance directive relative to the patient or resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the patient or resident;

(2) examining the medical records of the patient or resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the patient or resident has executed an advance directive and whether the patient or resident has a physician to whom the patient or resident normally goes for care; and

(4) inquiring of the physician to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient or resident and the medical records of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

Subd. 11.Continuity of care.

Patients and residents shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

Subd. 12.Right to refuse care.

Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's or resident's medical record.

Subd. 13.Experimental research.

Written, informed consent must be obtained prior to a patient's or resident's participation in experimental research. Patients and residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

Subd. 14.Freedom from maltreatment.

Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Subd. 15.Treatment privacy.

Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

Subd. 16.Confidentiality of records.

Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to

complaint investigations and inspections by the Department of Health, where required by third-party payment contracts, or where otherwise provided by law.

Subd. 17.Disclosure of services available.

Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.

Subd. 18.Responsive service.

Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.

Subd. 19.Personal privacy.

Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

Subd. 20.Grievances.

Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Subd. 21.Communication privacy.

Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician or advanced practice registered nurse in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician or advanced practice registered nurse in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Subd. 22.Personal property.

Patients and residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

Subd. 23.Services for the facility.

Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

Subd. 24.Choice of supplier.Residents may purchase or rent goods or services not included in the per diem rate from a supplier of their choice unless otherwise provided by law. The supplier shall ensure that these purchases are sufficient to meet the medical or treatment needs of the residents.

Subd. 25.Financial affairs.

Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

Subd. 26.Right to associate.

(a) Residents may meet with and receive visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes:

(1) the right to join with other individuals within and outside the facility to work for improvements in long-term care;

(2) the right to visitation by an individual the patient has appointed as the patient's health care agent under chapter 145C;

(3) the right to visitation and health care decision making by an individual designated by the patient under paragraph (c).

(b) Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

(c) Upon admission to a facility, the patient or resident, or the legal guardian or conservator of the patient or resident, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

Subd. 27.Advisory councils.

Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

Subd. 30.Protection and advocacy services.

Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

Subd. 31.Isolation and restraints.

A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible

and only for the shortest time necessary.

Subd. 32.Treatment plan.

A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to a written treatment plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and the minor patient's parents or guardian shall be involved in the development of the treatment and discharge plan.

Subd. 33.Restraints.

(a) Competent nursing home residents, family members of residents who are not competent, and legally appointed conservators, guardians, and health care agents as defined under section 145C.01, have the right to request and consent to the use of a physical restraint in order to treat the medical symptoms of the resident.

(b) Upon receiving a request for a physical restraint, a nursing home shall inform the resident, family member, or legal representative of alternatives to and the risks involved with physical restraint use. The nursing home shall provide a physical restraint to a resident only upon receipt of a signed consent form authorizing restraint use and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used.

(c) A nursing home providing a restraint under paragraph

(b) must:

(1) document that the procedures outlined in that paragraph have been followed;

(2) monitor the use of the restraint by the resident; and

(3) periodically, in consultation with the resident, the family, and the attending physician, reevaluate the resident's need for the restraint.

(d) A nursing home shall not be subject to fines, civil money penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a physical restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the commissioner from taking action to protect the health and safety of a resident if:

(1) the use of the restraint has jeopardized the health and safety of the resident; and

(2) the nursing home failed to take reasonable measures to protect the health and safety of the

resident. (e) For purposes of this subdivision, "medical symptoms" include:

(1) a concern for the physical safety of the resident; and

(2) physical or psychological needs expressed by a resident. A resident's fear of falling may be the basis of a medical symptom.

A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the physical restraint.

(f) When determining nursing facility compliance with state and federal standards for the use of physical restraints, the commissioner of health is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms. For purposes of this order, "medical symptoms" include the request by a competent resident, family member of a resident who is not competent, or legally appointed conservator, guardian, or health care agent as defined under section 145C.01, that the facility provide a physical restraint in order to enhance the physical safety of the resident.

148F.165 CLIENT WELFARE.

Subdivision 1.Explanation of procedures.

A client has the right to have, and a counselor has the responsibility to provide, a nontechnical explanation of the nature and purpose of the counseling procedures to be used and the results of tests administered to the client. The counselor shall establish procedures to be followed if the explanation is to be provided by another individual under the direction of the counselor.

Subd. 2.Client bill of rights.

The client bill of rights required by section 144.652 shall be prominently displayed on the premises of the professional practice or provided as a handout to each client. The document must state that consumers of alcohol and drug counseling services have the right to:

(1) expect that the provider meets the minimum qualifications of training and experience required by state law;

(2) examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;

(3) report complaints to the Board of Behavioral Health and Therapy;

(4) be informed of the cost of professional services before receiving the services;

(5) privacy as defined and limited by law and rule;

(6) be free from being the object of unlawful discrimination while receiving counseling services;

(7) have access to their records as provided in sections 144.92 and 148F.135, subdivision 1, except as otherwise provided by law;

(8) be free from exploitation for the benefit or advantage of the provider;

(9) terminate services at any time, except as otherwise provided by law or court order;

(10) know the intended recipients of assessment results;

(11) withdraw consent to release assessment results, unless the right is prohibited by law or court order or was waived by prior written agreement;

(12) a nontechnical description of assessment procedures; and

(13) a nontechnical explanation and interpretation of assessment results, unless this right is prohibited by law or court order or was waived by prior written agreement.

Subd. 3.Stereotyping.

The provider shall treat the client as an individual and not impose on the client any stereotypes of behavior, values, or roles related to human diversity.

Subd. 4.Misuse of client relationship.

The provider shall not misuse the relationship with a client due to a relationship with another individual or entity.

Subd. 5.Exploitation of client.

The provider shall not exploit the professional relationship with a client for the provider's emotional, financial, sexual, or personal advantage or benefit. This prohibition extends to former clients who are vulnerable or dependent on the provider.

Subd. 6.Sexual behavior with client.

A provider shall not engage in any sexual behavior with a client including:

(1) sexual contact, as defined in section 604.20, subdivision 7; or

(2) any physical, verbal, written, interactive, or electronic communication, conduct, or act that may be reasonably interpreted to be sexually seductive, demeaning, or harassing to the client.

Subd. 7.Sexual behavior with a former client.

A provider shall not engage in any sexual behavior as described in subdivision 6 within the two-year period following the date of the last counseling service to a former client. This prohibition applies whether or not the provider has formally terminated the professional relationship. This prohibition extends indefinitely for a former client who is vulnerable or dependent on the provider.

Subd. 8.Preferences and options for treatment.

A provider shall disclose to the client the provider's preferences for choice of treatment or outcome and shall present other options for the consideration or choice of the client.

Subd. 9.Referrals.

A provider shall make a prompt and appropriate referral of the client to another professional when requested to make a referral by the client.

253B.03 RIGHTS OF PATIENTS.

Subdivision 1.Restraints.

(a) A patient has the right to be free from restraints. Restraints shall not be applied to a patient in a treatment facility unless the head of the treatment facility, a member of the medical staff, or a licensed peace officer who has custody of the patient determines that they are necessary for the safety of the patient or others.

(b) Restraints shall not be applied to patients with developmental disabilities except as permitted under section 245.825 and rules of the commissioner of human services. Consent must be obtained from the person or person's guardian except for emergency procedures as permitted under rules of the commissioner adopted under section 245.825.

(c) Each use of a restraint and reason for it shall be made part of the clinical record of the patient under the signature of the head of the treatment facility.

Subd. 1a.

MS 2012 [Renumbered 253D.18]

Subd. 2.Correspondence.

A patient has the right to correspond freely without censorship. The head of the treatment facility may restrict correspondence if the patient's medical welfare requires this restriction. For patients in regional treatment centers, that determination may be reviewed by the commissioner. Any limitation imposed on the exercise of a patient's correspondence rights and the reason for it shall be made a part of the clinical record of the patient. Any communication which is not delivered to a patient shall be immediately returned to the sender.

Subd. 3.Visitors and phone calls.

Subject to the general rules of the treatment facility, a patient has the right to receive visitors and make phone calls. The head of the treatment facility may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

Subd. 4.Special visitation; religion.

A patient has the right to meet with or call a personal physician, spiritual advisor, and counsel at all reasonable times. The patient has the right to continue the practice of religion.

Subd. 4a.Disclosure of patient's admission.

Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

Subd. 5.Periodic assessment.

A patient has the right to periodic medical assessment, including assessment of the medical necessity of continuing care and, if the treatment facility declines to provide continuing care, the right to receive specific written reasons why continuing care is declined at the time of the assessment. The treatment facility shall assess the physical and mental condition of every patient as frequently as necessary, but not less often than annually. If the patient refuses to be examined, the facility shall document in the patient's chart its attempts to examine the patient. If a person is committed as developmentally disabled for an indeterminate period of time, the three-year judicial review must include the annual reviews for each year as outlined in Minnesota Rules, part 9525.0075, subpart 6.

Subd. 6.Consent for medical procedure.

A patient has the right to prior consent to any medical or surgical treatment, other than treatment for chemical dependency or nonintrusive treatment for mental illness.

The following procedures shall be used to obtain consent for any treatment necessary to preserve the life or health of any committed patient:

(a) The written, informed consent of a competent adult patient for the treatment is sufficient.

(b) If the patient is subject to guardianship which includes the provision of medical care, the written, informed consent of the guardian for the treatment is sufficient.

(c) If the head of the treatment facility determines that the patient is not competent to consent to the

treatment and the patient has not been adjudicated incompetent, written, informed consent for the surgery or medical treatment shall be obtained from the nearest proper relative. For this purpose, the following persons are proper relatives, in the order listed: the patient's spouse, parent, adult child, or adult sibling. If the nearest proper relatives cannot be located, refuse to consent to the procedure, or are unable to consent, the head of the treatment facility or an interested person may petition the committing court for approval for the treatment or may petition a court of competent jurisdiction for the appointment of a guardian. The determination that the patient is not competent, and the reasons for the determination, shall be documented in the patient's clinical record.

(d) Consent to treatment of any minor patient shall be secured in accordance with sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization, routine diagnostic evaluation, and emergency or short term acute care.

(e) In the case of an emergency when the persons ordinarily qualified to give consent cannot be located, the head of the treatment facility may give consent.

No person who consents to treatment pursuant to the provisions of this subdivision shall be civilly or criminally liable for the performance or the manner of performing the treatment. No person shall be liable for performing treatment without consent if written, informed consent was given pursuant to this subdivision. This provision shall not affect any other liability which may result from the manner in which the treatment is performed.

Subd. 6a.

MS 1990 [Renumbered subd 6c]

Subd. 6a.Consent for treatment for developmental disability.

A patient with a developmental disability, or the patient's guardian, has the right to give or withhold consent before:

(1) the implementation of any aversive or deprivation procedure except for emergency procedures permitted in rules of the commissioner adopted under section 245.825; or
(2) the administration of psychotropic medication.

Subd. 6b.Consent for mental health treatment.

A competent person admitted voluntarily to a treatment facility may be subjected to intrusive mental health treatment only with the person's written informed consent. For purposes of this section, "intrusive mental health treatment" means electroshock therapy and neuroleptic medication and does not include treatment for a developmental disability. An incompetent person who has prepared a directive under subdivision 6d regarding treatment with intrusive therapies must be treated in accordance with this section, except in cases of emergencies.

Subd. 6c.

[Repealed, 1997 c 217 art 1 s 118]

Subd. 6d. Adult mental health treatment.

(a) A competent adult may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments.

(b) A declaration may designate a proxy to make decisions about intrusive mental health treatment. A proxy designated to make decisions about intrusive mental health treatments and who agrees to serve as proxy may make decisions on behalf of a declarant consistent with any desires the declarant expresses in the declaration.

(c) A declaration is effective only if it is signed by the declarant and two witnesses. The witnesses must include a statement that they believe the declarant understands the nature and significance of the declaration. A declaration becomes operative when it is delivered to the declarant's physician or other mental health treatment provider. The physician or provider must comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The physician or provider shall continue to obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent. A treatment provider may not require a person to make a declaration under this subdivision as a condition of receiving services.

(d) The physician or other provider shall make the declaration a part of the declarant's medical record. If the physician or other provider is unwilling at any time to comply with the declaration, the physician or provider must promptly notify the declarant and document the notification in the declarant's medical record. If the declarant has been committed as a patient under this chapter, the physician or provider may subject a declarant to intrusive

treatment in a manner contrary to the declarant's expressed wishes, only upon order of the committing court. If the declarant is not a committed patient under this chapter, the physician or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as mentally ill or mentally ill and dangerous to the public and a court order authorizing the treatment has been issued.

(e) A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation. A revocation is effective when a competent declarant communicates the revocation to the attending physician or other provider. The attending physician or other provider shall note the revocation as part of the declarant's medical record.

(f) A provider who administers intrusive mental health treatment according to and in good faith reliance upon the validity of a declaration under this subdivision is held harmless from any liability resulting from a subsequent finding of invalidity.

(g) In addition to making a declaration under this subdivision, a competent adult may delegate parental powers under section 524.5-211 or may nominate a guardian under sections 524.5-101 to 524.5-502.

Subd. 7.Program plan.

A person receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary. The treatment facility shall devise a written program plan for each person which describes in behavioral terms the case problems, the precise goals, including the expected period of time for treatment, and the specific measures to be employed. Each plan shall be reviewed at least quarterly to determine progress toward the goals, and to modify the program plan as necessary. The program plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the program plan review. If the designated agency or the patient does not participate in the planning and review,
the clinical record shall include reasons for nonparticipation and the plans for future involvement. The commissioner shall monitor the program plan and review process for regional centers to insure compliance with the provisions of this subdivision.

Subd. 8.Medical records.

A patient has the right to access to personal medical records. Notwithstanding the provisions of section 144.292, every person subject to a proceeding or receiving services pursuant to this chapter and the patient's attorney shall have complete access to all medical records relevant to the person's commitment. A provider may require an attorney to provide evidence of representation of the patient or an authorization signed by the patient.

Subd. 9.

[Repealed, 1997 c 217 art 1 s 118]

Subd. 10.Notification.

All persons admitted or committed to a treatment facility shall be notified in writing of their rights regarding hospitalization and other treatment at the time of admission. This notification must include:

(1) patient rights specified in this section and section 144.651, including nursing home discharge

rights; (2) the right to obtain treatment and services voluntarily under this chapter;

(3) the right to voluntary admission and release under section 253B.04;

(4) rights in case of an emergency admission under section 253B.05, including the right to documentation in support of an emergency hold and the right to a summary hearing before a judge if the patient believes an emergency hold is improper;

(5) the right to request expedited review under section 62M.05 if additional days of inpatient stay are denied;

(6) the right to continuing benefits pending appeal and to an expedited administrative hearing under section 256.045 if the patient is a recipient of medical assistance or MinnesotaCare; and

(7) the right to an external appeal process under section 62Q.73, including the right to a second opinion.

Subd. 11.Proxy. A legally authorized health care proxy, agent, or guardian may exercise the patient's rights on the patient's behalf

Appendix B

Recovering Hope Client Grievance Form

Complete the top portion of this form and give to Treatment Director or appointed designee.

Client Name:	Date:
Describe the Complaint:	
Client Signature:	Date:
The Executive Director will respond your grievance within three business days after a staff member receives the grievance. You are permitted to bring the grievance to the highest level of authority in the program if not resolved by other staff members.	

***** Client Stop Here*****

Designee Interventions:
Follow-Up:
Designee Signature: Date:

Additional Comments:

This shall also be given to clients on admission. Staff shall be included to assist on the development and process of grievance.

Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
Phone: (651) 201-4200

Minnesota Board of Behavioral Health and Therapy
335 Randolph Avenue, Suite 290
St. Paul, MN 55102
Tel: (651) 201-2756

The Office of Ombudsman for Mental Health and Developmental Disabilities
121 7th Place East
Suite 420, Metro Square Building
Saint Paul, MN 55101- 2117
Phone: 651-757-1800 or 1-800-657-3506
Fax: 651-797-1950

Minnesota Department of Human Services (DHS) Licensing Division
444 Lafayette Rd N
St. Paul, MN, 55155
Phone: (651) 431-6500

Minnesota Board of Medical Practice
335 Randolph Avenue, Suite 140
St. Paul, MN 55102
Phone: 612- 617-2130
Fax: 612-617-2166

Minnesota Board of Nursing
1210 Northland Drive, Suite 120
Mendota Heights, MN 55120
Phone: 612-317-3000
Fax: 651-688-1841

Appendix C

Telehealth Group Norms

1. Join Zoom 5 minutes prior to group so group can start on time. If you are more than 10 minutes late, you will need to wait until the break to join group.

2. Provide the group facilitator with your location through the chat feature of Zoom at the start of group. If your location changes, please inform the facilitator.

3. To participate in group, you must have a private space without others present. We ask that your space be quiet with limited distractions and background noise.

4. Your camera must be on and you must be visible at all times with the exception of breaks.

5. Please be fully clothed.

6. Speak respectfully to one another and about others.

7. Avoid interrupting others and cross-talk.

8. Be mindful of nonverbal communication and body language.

9. Use "I" statements when providing feedback and share how you can relate.

10. Avoid giving others advice.

11. Cell phones must be on silent and put away. If you are expecting an urgent call, please let the group facilitator know at the start of group.

12. It is the expectation that group is the focus of your attention. You cannot work, shop, drive, text, check emails, watch tv/movies, etc. during group time.

13. Do not smoke, eat, or engage in distracting behaviors during group.

14. If you leave the group at any point after it has started, you may have to wait until the break to re-join.

15. **Confidentiality:** Do not discuss identifying information about peers or what peers have shared outside of group. Essentially, *what is said in group stays in group.*

Revised 4/11/22 AT

Recovering Hope Outpatient Programming Schedule

	Monday	Tuesday		Wednesday		Thursday			Friday	
8:00				Pine County Group 8:15 - 9:05		Pine County Group 8:15 -9:05			Pine County Group 8:15 -9:05	
8:30										
9:00	IOP Morning - Telehealth 9:00-9:50	IOP Morning - In Person 9:00-9:50	IOP Morning - Telehealth 9:00-9:50	Pine County Group 9:15 - 10:05	IOP Morning - In Person 9:00-9:50	Pine County Group 9:15 - 10:05	IOP Morning - In Person 9:00-9:50	IOP Morning - Telehealth 9:00-9:50	Pine County Group 9:15 - 10:05	IOP Morning - Telehealth 9:00-9:50
9:30										
10:00	IOP Morning - Telehealth 10:00 - 10:50	IOP Morning - In Person 10:00 - 10:50	IOP Morning - Telehealth 10:00 - 10:50	Pine County Group 10:15 - 11:05	IOP Morning - In Person 10:00 - 10:50	Pine County Group 10:15 - 11:05	IOP Morning - In Person 10:00 - 10:50	IOP Morning - Telehealth 10:00 - 10:50	Pine County Group 10:15 - 11:05	IOP Morning - Telehealth 10:00 - 10:50
10:30										
11:00	IOP Morning - Telehealth 11:00 - 11:50	IOP Morning - In Person 11:00 - 11:50	IOP Morning - Telehealth 11:00 - 11:50		IOP Morning - In Person 11:00 - 11:50		IOP Morning - In Person 11:00 - 11:50	IOP Morning - Telehealth 11:00 - 11:50		IOP Morning - Telehealth 11:00 - 11:50
11:30										
12:00										
12:30										
1:00	IOP Afternoon - Telehealth 1:00p - 1:50p	IOP Afternoon - Telehealth 1:00p - 1:50p		IOP Afternoon - Telehealth 1:00p - 1:50p		IOP Afternoon - Telehealth 1:00p - 1:50p				
1:30										
2:00	IOP Afternoon - Telehealth 2:00p - 2:50p	IOP Afternoon - Telehealth 2:00p - 2:50p		IOP Afternoon - Telehealth 2:00p - 2:50p		IOP Afternoon - Telehealth 2:00p - 2:50p				
2:30										
3:00	IOP Afternoon - Telehealth 3:00p - 3:50p	IOP Afternoon - Telehealth 3:00p - 3:50p		IOP Afternoon - Telehealth 3:00p - 3:50p		IOP Afternoon - Telehealth 3:00p - 3:50p				
3:30										