NEW YORK STATE | Office of Mental Health

Review of NYCRR Part 524 and Reportability Requirements

Office of Quality Improvement

AUGUST 29, 2024

Overview

This training will cover the following:

- The Principles of Incident Management
- Portions of the Part 524 regulations
- The OMH NIMRS Definitions for Incident Types and Reportability guide and how to utilize it

Below are the links for the Part 524 Regulations and the NIMRS definitions for incident types reportability guide.

https://www.omh.ny.gov/omhweb/policy_and_regulations/adoption/part-501.pdf

https://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/regulations/omh_nimrs_reportability_card.pdf

Part 524 *Purpose*

- To ensure that providers develop, implement and monitor an incident management system designed to protect the health and safety of patients and enhance quality of care.

- Effective Incident Management programs encompass:
  - Timely incident reporting
  - Investigations commensurate with the seriousness of the event
  - Investigation of all incidents
  - Tracking and trending of incidents
  - Effective corrective action to protect individuals from future harm.
  - Being Proactive

Part 524.3 *Applicability*

Applies to all mental health providers operated or licensed by OMH, with two exceptions:

1) Secure treatment facilities and,
2) Programs operated by OMH that are located in correctional institutions.

These facilities and programs will continue to report incidents to OMH in accordance with OMH Policy.

CORE, Adult BH HCBS, and CFTSS programs have specific reporting requirements.

Part 524.3 *Applicability for Staff in Unlicensed Programs*

Although unlicensed, funded providers (such as supported housing, health homes, peer support, and case management) are **not** subject to the Justice Center's jurisdiction and thus are not subject to most of the provisions of 14 NYCRR Part 524, there is one important aspect to note:

Staff of unlicensed, funded providers that are human service professionals are likely "mandated reporters" who are required to report reportable incidents involving vulnerable persons if they discover or learn of such events.

Part 524.3 *Applicability for Providers*

The process for reporting incidents depends on the incident type and the provider's program or services in which the person was a participant.

Providers remain responsible for notifying other agencies (such as any accrediting or regulatory agencies) as required by all governing rules or statutes, including federal requirements.

Providers should also be informing other providers of any reportable incidents involving a shared client, as applicable.

Part 524.4 *General Definitions*

(a) *Custodian* means:

(1) a director, operator, employee or volunteer of a mental health provider; or

(2) a contractor that performs services pursuant to a contract that permits regular and substantial contact with patients of a mental health provider.

Part 524.4 *General Definitions*

(i) Mandated Reporter means a certain person or professional, identified in subdivision (5) of Section 488 of the Social Services Law, not including a patient, who is required to report allegations of Reportable Incidents to the Vulnerable Persons' Central Register immediately upon discovery, including:

(1) a custodian; or

(2) a human services professional,

Part 524.4 *General Definitions*

(d) *First aid* means one-time treatment, and any follow up, of minor scratches, cuts, burns, splinters, or other minor injuries which do not ordinarily require medical care.

(k) *Minor injury or harm* means: (1) physical pain or injury requiring no medical treatment or intervention, or no medical treatment or intervention beyond first aid; or (2) no apparent psychological harm, or psychological harm that does not require a significant change in psychotropic or psychotherapeutic intervention.

Part 524.4 *General Definitions*

(q) *Serious injury or harm* means:

(1) physical harm requiring medical treatment or intervention beyond first aid, (excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is provided);

(2) psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or psychotherapeutic intervention; or

(3) a risk for life threatening physical injury or for psychiatric emergency or trauma

Part 524.5 *Incident Category Definitions*

Section 524.5 provides the incident definitions for Abuse/Neglect categories and significant incidents.

Section 524.7 reviews the reporting requirements for these incidents.

The OMH NIMRS Definitions for Incident Types and Reportability card provides truncated definitions for incident types based on the regulations.

Incident Type – Sub Type		Definition	Required Reporting
Abuse and Neglect **Report to JC & OMH**	**Allegation of Abuse and Neglect:** Abuse and neglect involve an act (or failure to act) by an employee.		
	Physical Abuse	Intentional or reckless contact with a client which causes or has the likelihood of causing physical pain or harm.	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WIRW/#/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and submit the investigation via WSIR within 45 days.
	Psychological Abuse	Verbal or nonverbal conduct that intentionally or recklessly causes a patient emotional distress.	
	Sexual Abuse	Any sexual contact involving a custodian and a patient, or any legal sexual contact involving a patient that is encouraged or allowed by a custodian.	
	Neglect	Any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a patient.	
	Deliberate Inappropriate Use of Restraint	Use of restraint for any reason other than as an emergency safety intervention.	
	Obstruction of reports of Reportable Incidents	Conduct by a custodian intended to impede the reporting or investigation of a reportable incident.	
	Unlawful use/ administration of a controlled substance	Any illegal administration, use, or distribution by a custodian of a controlled substance (e.g. codeine, OxyContin, Ambien, cocaine) while in the workplace or on duty.	
	Aversive Conditioning	The use of unpleasant physical stimulus to modify behavior. ANY use of aversive conditioning is prohibited in facilities under the jurisdiction of OMH.	

OMH & JC Death Report to JC & OMH	OMH licensed or operated Inpatient Units, Residential Programs, or CPEP	Clients in OMH licensed or operated Inpatient Units, Residential Programs, or CPEP. Additionally, deaths of clients who had received services from such programs in the 30 day period preceding death. These "Death of Client" incidents are reported to the Justice Center.	**Report to JC & OMH** 1. Call JC Death Reporting Line at 1-855-373-2124 to make initial report. The VPCR report will appear in your JC Import List in NIMRS. 2. Import the VPCR report into a NIMRS Incident, enter required information on each NIMRS screen and click "Email OMH". 3. Submit ***Report of Death to the Justice Center*** by clicking "Email JC" within 5 days of the initial report to the JC.
OMH Only Death Report to OMH	OMH licensed or operated OUTPATIENT programs	Death of patients receiving services only from an OMH licensed or operated OUTPATIENT program, must be reported to OMH via NIMRS. Additionally, deaths of clients who had received services from such programs in the 30 day period preceding death. These "Death of Client" incidents are entered directly into NIMRS using the "New Incident" button on the NIMRS Home Page.	**Report ONLY to OMH** 1. Log into NIMRS & select "New Incident" from the home screen. 2. Bypass the "pop-up" window by clicking on the "x" in the right corner. 3. Enter required information on each NIMRS screen and click "Email OMH".

Special Note on Requesting an Autopsy

New York Consolidated Laws, County Law - CNT § 677. Records; reports
Section 7

7. (a) Upon the written request of the commissioner of mental health, the commissioner of the office for persons with developmental disabilities, the director of the mental hygiene legal service, the executive director of the justice center for the protection of people with special needs or the director of a mental hygiene facility, as defined in subdivision two of section five hundred fifty of the executive law, at which the deceased was a patient or resident, the coroner, coroner's physician or medical examiner shall provide such person with a copy of all reports and records, including, but not limited to, autopsy reports and toxicological reports related to the deceased prepared by a person, partnership, corporation or governmental agency pursuant to any agreement or contract with the coroner or medical examiner with respect to the death of a patient or resident receiving services at such a mental hygiene facility.

Incident Type – Sub Type		Definition	Required Reporting
Significant Incident Regardless of Harm	**Significant Incident:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian:		
	Crime	An event which is or appears to be a crime under New York State or Federal law which 1) involves a patient as a victim, or 2) which affects or has the potential to affect the health or safety of one or more patients of the program or 3) has the potential to have a significant adverse impact on the property or operation of the program.	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WIRW/#/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Financial Exploitation	The use, appropriation, or misappropriation by a custodian of a patient's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources.	
	Fire Setting	Action by a patient, either deliberate or accidental, that results in fire on program premises.	
	Injury of Unknown Origin*	Any suspicious injury to a patient for which a cause cannot be immediately determined.	
	Missing patient (Inpatient/Residential)	A patient of an inpatient or residential program who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location, or who is known to have left the facility grounds without the permission of an employee, when such permission is otherwise required or a patient of an outpatient program who is under the age of 18, and whose whereabouts is not accounted for when expected to be present or under the supervision of an employee.	
	Mistreatment: – Unauthorized Restraint or Seclusion	Unauthorized use of restraint or seclusion that is inappropriate because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable state or federal regulations, but which does not rise to the level of abuse (i.e. physical abuse or Deliberate Inappropriate Use of Restraint.	
	– Inappropriate use of time out	Use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming	
	– Intentional Improper Administration of medication	Intentional administration to a patient of a prescription drug or over-the-counter medication which is not in substantial compliance with a prescription.	
	Sexual Assault	A sexual attack including but not limited to those that result in vaginal, anal, or oral penetration, i.e., rape or attempted rape and sodomy or attempted sodomy; and/or any sexual contact between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years of age or older and a person who is less than 17 years old, or which involves a patient who is deemed incapable of consent.	
	Sexual Contact Between Children	Vaginal, anal, or oral penetration by patients under age 18 that occurs in a setting where the patient receives around-the-clock care or on the premises of an outpatient program.	
	Suicide Attempt	An act committed by a patient of a mental health provider in an effort to cause his or her own death.	
	Wrongful Conduct	Actions or inactions on the part of the custodian that are contrary to sound judgment or training and which are related to the provision of services, the safeguarding of patient health, safety or welfare, or patient rights, but which do not meet the definition of abuse or neglect.	

Incident Type – Sub Type		Definition	Required Reporting
Significant Incidents Only with Serious Injury or Harm	**Significant Incident Only with Serious Injury or Harm:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian with **serious injury or harm involved**:		
	Adverse Drug Reaction**	Unintended, unexpected, or excessive response to a medication given at normal doses, which results in transfer to ER or serious injury or harm.	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WIRW/#/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Assault**	A violent or forceful physical attack by a person other than a custodian, in which a patient is either the victim or aggressor, and which results in serious injury or harm.	
	Falls by Patients**	Events where patients trip, slip or otherwise fall in an inpatient or residential setting, resulting in serious injury or harm	
	Fights**	A physical altercation between two or more patients, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm	
	Medication Error**	An error in prescribing, dispensing, or administering a drug which results in serious injury or harm.	
	Other Incident**	An event, other than those identified above, which has or creates a risk of, an adverse effect on the life, health, or safety of a patient.	
	Self-Abuse**	Self-inflicted injury not intended to result in death that results in serious injury or harm.	
	Verbal Aggression by Patients**	A sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious injury or harm.	

OMH Only Incidents **Report Only to OMH**	**OMH INCIDENTS: The following off-site incidents are reportable ONLY to OMH**		**Report ONLY to OMH** 1. Log into NIMRS & select "New Incident" from the home screen. 2. A "pop-up" with info on the reporting process will be displayed. Click "x" to bypass. 3. Enter required information on each NIMRS screen and click "Email OMH".
	Crime in the Community	**An event which is, or appears to be, a crime under New York State or Federal law, and which is perceived to be a significant danger to the community or which involves a patient whose behavior poses an imminent concern to the community.**	
	Missing Subject of AOT Court Order	**A client who is subject to an AOT court order who fails to keep a scheduled appointment and/or who cannot be located within a 24 hour period (Outpatient Only) Inpatient and residential programs should report missing AOT persons under "Missing Client".**	
	Suicide Attempt, Off-site	**An act committed by a patient of a mental health provider in an effort to cause his or her own death that occurs off program premises or when the patient was not under the actual or intended supervision of a custodian.**	

****Serious Injury or Harm:** physical harm requiring medical treatment or intervention beyond first aid (excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is provided); psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or therapeutic intervention; or a risk for life threatening physical injury or for psychiatric emergency or trauma.

Please email NIMRSHelp@omh.ny.gov for NIMRS issues or for questions regarding incident reportability, call 518-474-3619.

* In some cases, definitions are abbreviated. The revised 14 NYCRR Part 524 contains full incident definitions.
** Meets definition of Significant Incident reportable to JC and OMH only when resulting in serious injury or harm.

Updated on 04/21/2023

Part 524.8 *Incident Reporting Procedures*

Reporting to the Justice Center: Mandated reporters must immediately report what appears to be a reportable incident to the VPCR.

- The report to the Register shall include the name, title, and contact information of every person known to the Mandated Reporter to have the same information
- If the incident is a death and there is any reason to believe that abuse or neglect may be involved, the Reporter must immediately contact the VPCR.
- Reporter must immediately notify the director of the mental health provider, or his//her designee, that a report has been made.
- An initial incident report in the form and format specified by the Justice Center shall be completed within 24 hours of discovery.
- The JC has statutory authority to investigate allegation of Abuse/neglect or significant incidents. Providers and employees are required to cooperate with such investigations.

Part 524.8 *Incident Reporting Procedures*

Reporting to OMH: Mental health providers are responsible for immediately notifying the Office of Reportable Incidents within 24 hours of occurrence or discovery, whichever occurs first.

- Such notification shall be in a form or format specified by the Office and shall include such information as is known at the time the form is completed. **Notification is made by importing an incident into NIMRS, completing the 1st four tabs, and pressing the "Email OMH" button.**
- OMH has statutory authority to investigate all incidents. Providers and employees are required to cooperate fully with OMH regarding such investigations.

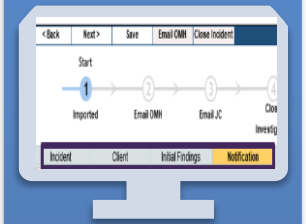
Behind the Scenes Workflow for JC Incidents

General Workflow for JC Reportable Incidents

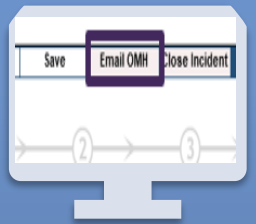
PROVIDER RECEIVES INCIDENT EMAIL ALERT NOTIFICATION

LOGIN TO NIMRS

ACCESS JUSTICE CENTER IMPORT QUEUE



COMPLETE REQUIRED FIELDS ON THE: INCIDENT, CLIENT, INITIAL FINDINGS, NOTIFICATION TABS AND SUBTABS



CLICK EMAIL OMH BUTTON TO MEET 24 HOUR REGULATORY REQUIREMENT

PROVIDERS HAS 45 DAYS TO COMPLETE THE INVESTIGATION

INVESTIGATION SUBMITTED BACK TO OMH/JC AND CLOSED

General Workflow for JC Reportable Incidents

Significant Incidents

Allegation of Abuse and Neglect – Investigations & CAPs

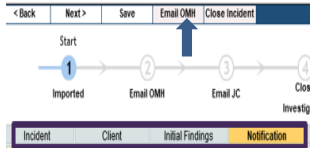
Death Incidents

OMH ONLY Reportable Incident Workflow

Create Incident Directly in NIMRS

Step 1

EMAIL OMH within 24 Hours

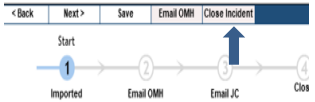


Step 2

Close Investigation & Confirm IRC within 45 days from Incident Creation

Step 3

Close NIMRS Incident Record



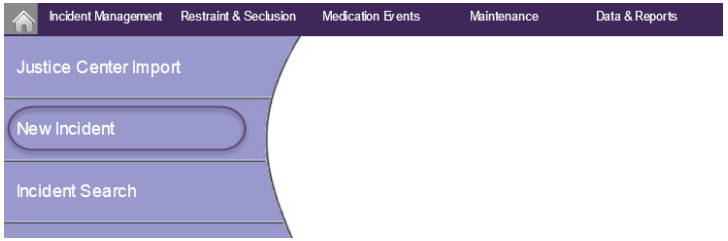
Step 4

Incident Reporting

Incident Reporting

Direct Entry

Facilities can enter OMH-only reportable incidents, outpatient deaths, and non-reportable incidents directly into NIMRS



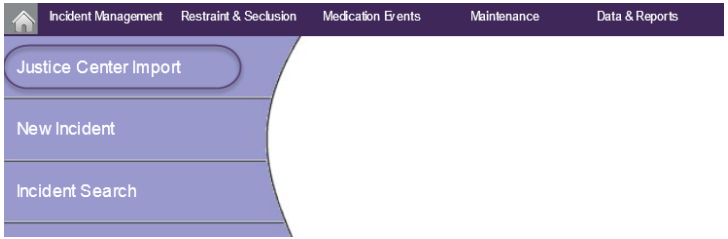
JC incident report received electronically from the VPCR to NIMRS

Within 24 hours of receipt facilities must:

1. Import incident

2. Link to a pre-existing incident report, when applicable

3. Create incident and click "Email to OMH" button.



Part 524.8 *Incident Reporting Procedures*

- Reasonable Cause to Suspect: In circumstances where a patient reports an allegation of abuse or neglect to a provider which appears to be impossible or incredible, the provider shall promptly review the matter and must determine, within 24 hours of such report, whether there is reasonable cause to believe a reportable incident has occurred. Discovery of the incident shall be deemed to be when the provider determined that such reasonable cause exists. If it is determined that reasonable cause does not exist and a report is not made to the Justice Center, such decision shall be documented.

Part 524.8 *Incident Reporting Procedures*

- Multiple Reporting: In cases where multiple mandated reporters have direct knowledge of the same reportable incident or have reasonable cause to suspect such incident has occurred, each mandated reporter is required to report such incident, unless he or she knows that the report has already been made by another mandated reporter and that he or she has been named in that report as a person with knowledge of such incident.
- 3BDR (Business Day Review): assists providers in appropriately and therapeutically responding in circumstances where: patients have a demonstrated pattern of frequently reporting allegations of abuse or neglect that are not reasonably reliable.

Part 524.8 *Incident Reporting Procedures*

- If during the course of an investigation, facts are discovered that suggest an incident should be reclassified all reports applicable to the revised incident type must be made.
- Providers must report to law enforcement or District Attorney when it appears that a crime **may** have been committed against a person receiving services.
- The regulation does not prohibit a reporter from contacting law enforcement or EMS before or after reporting to the VPCR.
- Nothing shall preclude a provider from identifying a non-reportable incident, investigating, monitoring and analyzing it pursuant to internal quality management procedures.

Part 524.12 *Other Required Notifications*

(a) Child Abuse (by Family of Caretaker)
Section 413 of Social Services Law

(b) Notification to Patients, Family or Personal Representatives

(1) Outcome of the incident involving them if clinically appropriate.

(2) the patient's next of kin or other persons identified in the patient's plan of care as a person involved in his or her care, shall be notified immediately of allegations of abuse or neglect, missing patients or incidents involving patient death or injury.

(3) Qualified persons – MHL 33.23 requires telephone notice to a qualified person of a patient of a Reportable Incident involving such patient and identified as injury, death, medication error, missing person, or allegation of abuse or neglect within 24 hours of the initial report of the incident.

Part 524.9 *Incident Investigation, Corrective Action & Records Maintenance*

- Safety of a Patient involved in an Incident: Providers shall make available to OMH a contact that is available 24 hours per day, 7 days a week to ensure that:
  - There has been separation of the subject and victim,
  - Appropriate medical/psychological treatment has been provided,
  - Appropriate corrective actions are taken to address systems and personnel issues that may pose a continued risk to individuals in care.

Part *524.9 Incident Investigation, Corrective Action & Records Maintenance*

(4) Commencing the investigation

- Immediately after reporting.

(5) Process

(i) Preservation of Evidence

(ii) Interviewing Witnesses

(iii) Analysis of Evidence

Part 524.14 *Special Investigations*

The following incident types require a Special Investigation be completed by the provider, if the Justice Center is not conducting the investigation:

(1) Inpatient homicides;
(2) Inpatient suicides;
(3) All inpatient deaths except natural deaths;
(4) Homicide and suicide attempts by inpatients;
(5) Allegations of abuse/neglect;
(6) Inpatient assaults resulting in serious injury to any person, including sexual assaults;
(7) Missing patients of inpatient programs;
(8) Wrongful conduct.

Part 524.9 *Incident Investigation, Corrective Action & Records Maintenance*

(c) Investigation Process

- All incidents shall be investigated in a timely manner by staff trained to conduct investigations.
- No one may conduct an investigation of an incident in which they are involved in, that has their testimony incorporated, or involves a spouse, partner or family member.
- No party in the line of supervision of staff who were directly involved in a Reportable Incident may conduct the investigation, provided, however, the director of the mental health provider may conduct the investigation if he or she is not an immediate supervisor of any staff who were directly involved in such incident.

Part 524.9 *Incident Investigation, Corrective Action and Records Maintenance*

(d) Final Reports

- A/N and Significant Incident Investigations are to be submitted within 45 calendar days of the incident acceptance by the VPCR.
- A/N Cases are to be submitted through the Web Submission of an Investigative Report (WSIR) portal and NIMRS. The investigation must include information pertaining to the victim, subject, personal representative, Executive Director, witness statements, the investigative report and any supporting evidence collected.
- Significant incident investigations whether reportable to the JC and/or OMH should be entered in NIMRS.

(e) Confidentiality

Part 524.9 *Incident Investigation, Corrective Action & Records Maintenance*

(b) Documentation:

- Incident Management programs shall have procedures for documenting incidents, examinations, investigation and reviews.
- Incident related documents are a confidential quality assurance documents that must be maintained separately from clinical records. Description of clinical impact may be included in the record.

Part 524.13 *Analysis, Review and Monitoring of Incidents*

Providers are responsible to compile and analyze incident data for the purpose of identifying trends and patterns and to determine the timeliness, thoroughness and appropriateness of the provider's reporting.

At a minimum, incident data shall be analyzed according to incident type, patient involvement, location, date, and time, and employee involvement.

If areas of improvement have been identified, and, if deemed necessary, plans of correction/prevention have been developed, implemented, and monitored must be documented in accordance with guidelines of OMH.

Part 524.13 *Incident Review Committees*

Each mental health provider shall appoint a standing IRC to assure that all incidents are reviewed and monitored, that all incidents that may adversely affect the care and safety of patients are appropriately addressed, and that preventive and corrective measures are identified, as appropriate.

- IRC's have responsibilities other than those related to incident management. They must have free and open exchange of information, maintain documentation attesting the committee membership includes:
  - Members of the governing body,
  - Direct support staff involved in direct care,
  - Licensed Health Care Practitioners,
  - Service recipients
  - Representatives of family, consumer or advocacy organizations

Part 524.13 *Incident Review Committees*

- The director of the mental health provider shall not be a member of the Incident Review Committee. (CEO/ED)
- The Committee must include a physician on a regular membership or ad hoc basis, to participate in review of all medically-related incidents
- The Incident Committee must review each Significant Incident and Allegation of Abuse and Neglect before it can be closed. Therefore, IRC meetings must occur within 45 days of the incident and/or quarterly at minimum per regulations.
- Written minutes of all meetings shall be maintained.

Investigation Due Dates & Actions Required

Abuse and Neglect Investigative IRC Confirmation:

Within 45 days from the date the incident is assigned to your NIMRS "JC Import queue", all data fields including corrective action (if applicable), need to be documented and submitted in NIMRS.

Abuse and Neglect Corrective Action Plans (CAPs):

Within 45 days from receipt of the JC determination letter, all CAPs must be finalized and submitted in NIMRS.

Significant Incidents:

Within 45 days from the date the incident is assigned to your NIMRS "JC Import queue", all data fields including corrective action (if applicable), need to be documented and submitted in NIMRS.

JC Reportable Deaths:

Within 5 days from the date the incident is assigned to your NIMRS "JC Import queue" the JC Report of Death must be emailed, via NIMRS.

Note: All death incident reports must be emailed to OMH within 24 hours of incident assignment.

OMH Only Reportable:

Within 45 days from the date the incident is created in NIMRS or assigned to your "Incident Pending Action" queue, all data fields including corrective action (if applicable), need to be documented and submitted in NIMRS.

Part 524.15 *Code of Conduct & Training*

Directors of Mental Health must ensure that each employee receives a copy of the Code of Conduct pursuant to Section 554 of the Executive Law.

(1) Persons hired on or after June 30, 2013 shall be provided with the Code upon hire.
(2) Written confirmation of receipt shall be maintained in each employees personnel file and renewed annually.
(3) Distribution can be manual or electronic.

Part 524.15 *Code of Conduct & Training*

Mandated Reporters shall receive training in the following areas on at least an annual basis:

(i) abuse prevention, identification, reporting, and processing of allegations of abuse;
(ii) laws, regulations and policies/procedures governing protection from abuse; and
(iii) incident reporting and processing

Training must be documented and records current.

Special Note: Mandated Reporter Training

1. The Mandated Reporter training required per this Part is not the same training required for Child Abuse Mandated Reporters. That is a completely separate training. The Justice Center provides this Mandated Reporter training via their website.

2. While the Justice Center Training meets the minimum requirement for incident reporting across state oversight agencies, the training required for OMH staff must include OMH specific incident types, as well as your agency's internal process for reporting incidents.

Clinical Risk Management Contacts

Office of Quality Improvement

Phone: 518-474-3619

Email: DQM@omh.ny.gov

Clinical Risk Manager (CRM) Regional Assignments:

Western NY- James Steed

Central NY- Deborah Feldman

Hudson River Region- Jessica Caldwell

Long Island and Staten Island- Christina Moran

NYC Brooklyn and Bronx- Silvia Diaz-Ferrero

NYC Manhattan and Queens-Abbey Hoffman

Questions?