

## **Statement of Purpose**

University Psychological Center, Inc. – Recovery Network (UPCRN) annually assesses the organizational effectiveness and efficiency across multiple dimensions for the purpose of surveying stakeholders, compliance, as well as advancement and enhancement of overall program operations. UPCRN has been operating as a behavioral health organization since 1979 in the Baltimore-Washington Metro area. Specializing in Mental Health (MH), Alcohol and Other Drug (AOD) treatment, UPCRN was accredited in December 2015 by the International Commission on Accreditation of Rehabilitation Facilities (CARF). UPCRN Programs and Services Accredited include:

1. Community Housing for Integrated AOD/MH for Adults
2. Community Integration for MH Adults
3. Outpatient MH for Children and Adolescents
4. Outpatient Integrated AOD/MH for Adults
5. Intensive Outpatient Treatment Integrated AOD/MH for Adults
6. Residential Treatment Integrated AOD/MH for adults.

UPCRN adheres to the standards outlined by the international accrediting organization CARF, as well as regulations set forth by Maryland Department of Health and Mental Hygiene's (DHMH) COMAR 10.47 for the certification of treatment programs.

Following the accreditation survey in December 2015, UPCRN worked towards strengthening program processes outlined in the CARF Quality Improvement Plan (QIP). While focus in the QIP identified areas for improvement, UPCRN has been dedicated to ongoing conformance of standards. Four themes (#1-4) were identified in the QIP by UPCRN leadership as well as two additional areas to note (#5-6):

1. Marketing
2. Data Collection
3. Risk Management
4. Staff Training and Development
5. Access to Services
6. Therapeutic Environments and Person-Centered Care

The Executive Management and Leadership Team agendas were tasked with strengthening CARF conformance standards, as well as rectifying areas outlined in the QIP. This process involved managing a complex and underserved population through daily service delivery, while concurrently and strategically building workforce development and program performance improvement. While plans of action for 2016 were addressed by UPCRN stakeholders, ongoing planning and enhancements will need to be addressed in 2017 for the purpose of continued analysis, planning, and development.

The CARF Accreditation process has been an educational and experiential milestone and accomplishment for the organization. The standards and guiding principles have served as a roadmap to ongoing development and innovation in the field of behavioral health. The 2016 organizational analysis will serve as an annual summary and footprint for the next years strategic planning and goal development. All standards, policies and procedures are established through conformance to CARF, DHMH, COMAR, OHCQ, and other local and state regulating bodies for treatment programs.

## **Focus Areas for Improvement**

The six focus areas identified in this analysis were a reflection of themes assessed by UPCRN Leadership as well as other stakeholders throughout the calendar year. These areas were not a reflection of nonconformance to standards, but rather a focus for strengthening program operations and outcomes. The focus areas identified include:

### **Marketing**

- Sharing Organizational Plans with Stakeholders
- Email Marketing and Website Development
- Promotional Materials and Literature

### **Data Collection**

- Patient Data and Clinical Outcomes
- Stakeholder Feedback
- EMR Data Input and Output
- Deliverables

### **Risk Management**

- Documentation and Analysis of Critical Incidents
- Evaluation and Assessment of Loss Exposures and Prevention
- Ongoing Health and Safety
- Financial Planning
- Corporate Compliance

### **Staff Training and Development**

- Program Enhancement
- Stakeholder Performance Evaluation and Assessment; Peer Reviews
- Human Resource Development
- Clinical Skills Development
- Workflow Analysis
- Leadership Support

### **Access to Services**

- Timely Referral and Placement for Ancillary Services
- Community Outreach and Engagement

### **Therapeutic Environments and Person-Centered Care**

- Treatment Planning
- Increased Strengths-Based Approaches

## **Summary of Findings**

UPCRN assessed four themes from the survey and QIP in 2016 which included the improvement of marketing, data collection, risk management, and staff training and development. While some of these goals will be ongoing in 2017, UPCRN has made strides of progress through ongoing dedication and commitment to performance improvement. The findings herein are a summary of conclusions made from the ongoing evaluation, assessment, and analyses conducted throughout 2016. The summary also includes recommendations to be considered in 2017 as goals towards overall improvement of the organization.

The targeted areas identified were not limited to the themes above, but were all encompassing of improving daily workflows throughout the year. In addition to the four areas identified in the QIP, UPCRN identified *Timely Access to Services* and *Improving Therapeutic Environments* at our 25<sup>th</sup> St. facility as other areas needing improvement as identified by stakeholders and persons served. It was identified that some patients were not receiving services timely from the antiquated evaluation and referral workflows previously in place. This challenge created brainstorming for development in 2016 and be a goal addressed in 2017 strategic planning for smoother access to care.

In addressing the goals outlined in the CARF QIP, it was recognized by UPCRN leadership that a significant barrier to resolving some goals was the conversion of an outdated method of record-keeping with paper-based charts to a streamlined electronic medical record (EMR) in August 2015. This evolution was a major accomplishment of the UPCRN team as it required a group of Credible *Super-Users* and invested Leadership to work rigorously towards a building the customized system and a smooth ‘Go-Live’ rollout for front-end users. While the initial ‘Go-Live’ was quite seamless for most, the implementation posed hurdles on back-end processing of data collection and billing processing.

The initial 2015 CARF survey took place only three (3) months after the ‘Go-Live’ date with Credible Behavioral Health (CredibleBH) EMR. This implementation was complicated by turnover in CredibleBH personnel and Project Managers resulting in a lack of support and setup during the initial building of the EMR. This complicated input and output of data; billing matrix setup; mapping of EMR basic functionalities; ongoing staff training and support; and incessant tweaks to the system to meet the growing needs of the organization.

The EMR issues identified largely effected data collection needed for financial reporting; however, additional measures were taken to maintain forms of accurate data needed for essential financial management. In addition, EMR functions continued to improve over the course of the year through the persistence of the *Super-User* team. Additional contract support from CredibleBH was also required. UPCRN Leadership will need to continue addressing data collection and improved EMR mapping in 2017 to improve all functionalities.

Clinical Services also expanded in 2016 in response to the rising and complex needs of persons served. Through continued partnerships with local agencies and community stakeholders, UPCRN has continued to deliver innovative services in an integrated and person-centered approach to a wide demographic. A new addition to the residential programs involved the partnership with *Real Food Farms, Civic Works* which began in 2016. The program offered cooking demonstrations to residential patients to promote healthy cooking, teach easy recipes, and revamp menus in the houses.

UPCRN expanded Outreach services in multiple neighborhoods as a supplement to all programs. Mobile services were also added to hone in on “Hot Spots” in the city where screening and intervention was needed. Peer Recovery Coaches provided outreach, case management, and referral to a continuum of care within UPCRN and other community organizations. Peers working on this project made over a thousand contacts in the city in an attempt to screen and intervene the most underserved and at-risk individuals on the streets. This project continues to be one that breaks barriers and increases access to care.

The treatment team also worked with multiple Maryland Hospital systems on the Overdose Survivor Outreach Program (OSOP). The OSOP worked with Bon Secours Hospital, University of Maryland Medical Center, Mercy Hospital, and Johns Hopkins Hospital in delivering streamlined access to treatment using an SBIRT model of care. Peer Support Services were offered in the hospital to those who overdosed and needed **S**creening, **B**rief **I**ntervention and **R**eferral to **T**reatment (SBIRT). UPCRN/s role was to provide Peer Support Services within the OSOP as well as serve as a point of referral for patients discharged from the hospital to step-down levels of care. Participation in this initiative also led to UPCRN involvement in the Overdose Response Program (ORP) in Baltimore City, providing outreach and opioid intervention services to at-risk users on the streets.

Maintaining various referral sources throughout 2016 and heading into 2017 is vital to the organizations stability in an ever changing funding world of behavioral health. The year in review reflected the organizations ability to meet service deliverables set forth by its funding organization Behavioral Health Systems Baltimore. The organization maintains a diverse referral base including Maryland Hospital’s; BHSB; Drug and Mental Health Courts; Parole and Probation; Department of Social Services; Family Reunification Program; among other treatment programs in the community. These agencies have continued to hold UPCRN in high regard as a model integrated program in Baltimore. These stakeholders will play a central role in UPCRN’s continued success in a growing competitive market.

Funding changes have also been identified beginning July 1, 2017 due to the passing of the Medicaid IMD Waiver 1115 in December 2016. This shift in reimbursement will be an adjustment from historical grant funded residential treatment to a fee-for-service model in the next fiscal year. UPCRN Leadership will ensure regular participation in stakeholder and community meetings about this transition as it will have a significant impact on revenue streams. Strategic and financial planning will be sure to reflect these areas in the year ahead.

## **Marketing Analysis**

Throughout 2016, UPCRN worked towards maintaining relationships and partners in the community, as well as establishing new working relationships directed at serving Maryland residents, particularly in Baltimore City. Existing partnerships included: Behavioral Health Systems Baltimore; Baltimore City Drug and Mental Health Courts; Maryland Hospitals – JHH, UMMC, Bon Secours, and Mercy; Family Preservation (FRP); Baltimore City Parole & Probation; Baltimore City Health Department’s Reproductive Health Initiative; Overdose Survivors Outreach Program (OSOP) and Overdose Response Program (ORP); and various provider workgroups. The UPCRN Outreach Program expansion has also been a growing resource for referrals as well.

To maintain referrals in the community, UPCRN continues to build on a growing email distribution list which is sent out weekly informing referring partners on capacity within the program for substance abuse and mental health services. This distribution list has been instrumental in communicating with our network of referrals. UPCRN has also added to the organizations website an online referral portal where individuals searching for treatment can apply online for admission into the program. This portal was set up in May 2016 and resulted in over 15 unsolicited referrals to treatment in the first 6-months of implementation.

In addition to these marketing expansions, UPCRN also revised the organizations promotional literature following the CARF accreditation process. Updates were made to pamphlets, signage, and other marketing materials to reflect the CARF accreditation accomplishment, but also to expand on the increasing services offered by the agency which were not all outlined in the previous material. Specific pamphlets were created for: Comprehensive Co-Occurring Treatment; Women and Children's Residential Program; Comprehensive Alcohol & Drug Treatment; and Comprehensive Mental Health Treatment. A specialized niche of services were added like Neurofeedback; Integrated Care; Medication-Assisted Treatment (MAT); and Outreach.

UPCRN believes in the importance of being visible and active in the community through professional conference sponsorships and grassroots support. In 2016, UPCRN sponsored the Annual Tuerk Conference, Baltimore City Recovery Walk, M.D. ASAM Conference, and other community health fairs. Organization personnel also attend local Neighborhood Community Association meetings with the focus on *How to be a Good Neighbor*. Facilities staff continue to vibrate in maintaining positive relationships around the facility surroundings.

Marketing Recommendations for 2017 will include continued improvement to online marketing and website development; strengthen relationships with current referral sources; and developing new relationships within the referral network of community treatment programs.

### **Data Collection & Programs**

Data collection continues to be an ongoing goal for the organization to assess stakeholder satisfaction, patient information and outcomes, and identify areas for improvement. UPCRN's primary barrier to data collection for 2015/2016 was the transition from paper record-keeping to electronic. During the transition, all patient paper files, both active and inactive, were entered into the new EMR. This posed limitations for obtaining true accurate information when running reports. Due to these issues, UPCRN contracted with CredibleBH for additional support hours to work towards resolve.

In addition to patient outcomes, the organization places value on surveying and gathering feedback from its various stakeholders. UPCRN began collecting staff and external stakeholder feedback in 2015 and continued to improve its processes in 2016 as part of its QIP. These reviews consisted of staff exit interviews, updated employee satisfaction surveys, counselor workgroup, and patient satisfaction surveys during treatment and upon completion. These surveys were used as a means to address organizational weaknesses and identify areas for improvement or other developments.

The 2016 employee satisfaction was sent out in May 2016 with thirty (30) responses focused on job training, support, work environment, benefits, compensation, and other areas for self-assessment. The outcome of the survey addressed a few areas for improvement: Medical Insurance and Benefits; Paid Time off (PTO); and Staff Training. In response to these areas, UPCRN reviewed its insurance benefits for staff and decreased the monthly cost to employees as well as provided Health Savings Account (HSA) monies towards coverage. The organization also increased staff trainings to review EMR functionalities, registration and discharge workflows, job responsibilities, and also a supervisor training directed at middle-management support. The organization has acknowledged the need to review employee leave policies in 2017. Overall, the organization received positive scores in the survey and emphasized the satisfaction with the organizations management and support to its employees. Over 50% of employees strongly recommended the organization to others and an additional 37% agreed in recommending the organization to others. Only 7% of employees were neutral in this question and no employees disagreed.

Patient surveys were also disseminated in 2016 to review satisfaction for those in the IOP, OP, and residential programs. The surveys assessed patient satisfaction with service delivery, facilities, staff, and patient participation in the program. The results of the surveys reflected a generally strong program with service delivery and assisting patients in meeting treatment goals. There were a minority of surveys addressing one counselor in particular and need for ongoing skills development. The surveys also recommended improvement to the 25<sup>th</sup> St. office space as well as ongoing training for residential house managers. These items will be addressed in 2017 strategic planning.

Outcomes for clinical programs are a summary of aggregate data collected through CredibleBH. This data was impacted by the transfer of charts and record-keeping, including active and inactive patients. The organization has identified improving accuracy of data as part of the continuous quality improvement process. The CQI members have reviewed discharge criteria options, admissions workflows, and other input/output processes in 2016 in an attempt to improve data collection for outcomes. Data collection for admissions, discharges types, and summaries of analysis are seen below.

### **ASAM Level 1.1 - Outpatient Program**

UPCRN's Outpatient Substance Abuse Program (OP) is a low intensity program designed to provide a variety of diagnostic and therapeutic treatment in a non-residential setting for persons suffering from substance abuse. The program is for patients whose physical and emotional status allows them to function in their usual environment. It also is offered as an adjunctive service to select patients who are concurrently receiving residential services. On the basis of an individual assessment and a treatment plan, the outpatient program offers a variety of services from the list of core services outlined above. Regularly scheduled sessions up to nine hours per week are provided in the form of individual, group, and/or family counseling. Services are designed to treat the individual's level of illness severity according to ASAM dimensions. The goals of treatment are aimed at modifying attitudinal, behavioral, and lifestyle issues that are maintaining the addictive disease cycle. When indicated, the treatment of any co-occurring disorder is also provided. Length of time in the program is ongoing and determined when treatment goals are reached.

Enrollments for the Substance Abuse Outpatient Program included 276 patients (256 unduplicated)

Discharges consisted of:

- 20% Completed Treatment Plan – No Additional Tx. Required
- 5% Completed Treatment Plan – Additional Tx. Required
- 25% Transitioned out of Outpatient to another Level of Care
- 34% Left Treatment Against Clinical Advice
- 4% Incomplete – Additional Tx. Required
- 11% Incomplete – Non-Compliance with Program
- 1% Incarcerated

The outpatient program tends to be directed at the higher functioning and stable individuals seeking treatment. UPCRN will need to extend treatment hours to include later hours for those who are working or engaged in other daily activities. The organization also needs to increase its census for operations.

UPCRN will increase the number of evening OP groups for those seeking evening hours. The organization will also increase marketing in the community, meet with probation and parole agencies, revision of the program flyer/pamphlet, updating the website, and development of a referral email list of existing referrals and partners to inform them of program updates.

Indicators for improvement will be an expanded base of referring agencies and referral partners, increased census for the outpatient program, utilizing consumer feedback to develop specialty groups and curriculums catered to patient needs.

### **ASAM Level II.1 - Intensive Outpatient Program**

UPCRN's Intensive Outpatient Program is a 9-week program (or longer depending on clinical needs) and delivered through structured treatment at a minimum of nine hours of clinical services per week. This service is structured for quick and seamless movement throughout the treatment process. Our clinical services include individual, group, and family counseling; case management services; addictive disease education; psychiatric consultation; psychological services for dual diagnosis; Self-Help Group/meeting required attendance; diet and nutritional counseling and education; and special groups for parenting, infectious diseases, anger management, co-dependency, criminal offenders, and trauma. IOP and OP programs may be delivered concurrently with III.1 residential treatment programs.

As part of the IOP and OP programs, additional evidenced-based curriculums were introduced and utilized in 2016. UPCRN utilized the *Hazeldon – Living in Balance* curriculum as part of the IOP and OP programming to standardize the information conveyed in the group. This curriculum supplemented the Matrix Model Curriculums, Relapse Prevention, and other psychoeducational materials already in place.

Admissions for the Level II.1 Intensive Outpatient included 159 patients (143 unduplicated) in 2016

- 6% Completed Treatment Plan – No Additional Tx. Required
- 9% Completed Treatment Plan – Additional Tx. Required
- 55% Transitioned out of Intensive Outpatient to another Level of Care
- 21% Left Treatment Against Clinical Advice
- 3% Incomplete – Additional Tx. Required
- 6% Incomplete – Non-Compliance with Program

A large basis of the outpatient program census stems from the residential patients. Our goal is to improve the outpatient-only census from additional community referrals through focused outreach to community programs, online marketing, increase patient satisfaction and patient referrals, and parole and probation for re-entry consumers leaving corrections based treatment programs. Indicators for improvement will be an expanded base of referring agencies and referral partners, increased census for the outpatient program, utilizing consumer feedback to develop specialty groups and curriculums catered to patient needs.

### **ASAM Level III.1 & III.3 - Residential Programs and Community Housing**

The Low Intensity (III.1) and Medium Intensity (III.3) Residential Programs within UPCRN are an intensive 6-9 month treatment program with a current capacity of approximately over one-hundred and twenty-five (125) beds spread throughout city in twelve residential facilities. These facilities are halfway houses of varying size and bed capacity and staffed 24 hours per day and seven days per week. Individuals placed in residential care are in need of a safe, structured, and stable environment that is conducive to their recovery process. Residential care affords the resident the opportunity to practice recovery skills while reintegrating back into the community. Services are provided both in the individual houses as well as UPCRN's main clinical office.

The program is based on the disease concept of chemical dependency and twelve-step recovery programs. The primary goal for each patient is re-entry back into the community. Each resident has a treatment program tailored to his personal situation and individual needs. Residential treatment includes an in-depth bio-psychosocial assessment and treatment planning; individual and group counseling; dual diagnosis evaluation and treatment; referrals for rehabilitation and educational training; coordination of aftercare treatment services; and assistance in utilization of community resources for employment, medical or legal issues.

UPCRN continues offer two levels of care based on ASAM placement criteria - **Level III.1** and **Level III.3**. In addition to these two levels of care, transitional housing (community housing) is also offered as a step-down from the residential clinical programs. The primary difference between these two levels of care is the intensity of the services offered as well as patients level of autonomy in the community. Patients in the III.1 program typically attend other outpatient services within the community while III.3 services tend to be centralized to the independent facility.



**Level III.1**, or *Low Intensity Clinically Managed Residential*, provides a structured living environment with low intensity professional addiction treatment services of at least five hours per week. Treatment is directed toward applying recovery skills, preventing relapse, promoting personal responsibility, and reintegrating the person onto the worlds of work, education, and family life. These services minimally include relapse prevention, life skills, case management, urinalysis and other forms of drug testing, and Self-Help Group attendance. While in the program, residents move through phases of treatment, from admission to discharge. Each resident has a treatment program tailored to his personal situation and individual needs.

### III.1 Low-Intensity Residential Outcomes:

Admissions for Level III.1 Low-Intensity Residential Program were 180 patients (168 unduplicated)

Discharges include:

- 35% Completed Treatment Plan – No Additional Tx. Required
- 6% Completed Treatment Plan – Additional Tx. Required
- 4% Transitioned out of 3.1 Residential to another Level of Care
- 35% Left Treatment Against Clinical Advice
- 6% Incomplete – Additional Tx. Required
- 12% Incomplete – Non-Compliance with Program
- 0% Incarcerated

**Level III.3**, or *Medium Intensity Clinically Managed Residential*, provides a structured living environment with medium intensity professional addiction treatment services of 9-20 hours per week. Individuals referred for Level III.3 services generally have severe deficits in interpersonal and emotional coping skills that prevent outpatient treatment from being effective. The pace of the clinical program at this level is slower, more repetitive, and more intense than Level III.1 services. Among the population of these residential patients are a higher percentage of biomedical problems and co-occurring mental health disorders. While treatment services are directed in a similar fashion as in our Level III.1 residential program, more of our **25 core services** are provided in Level III.3. Reintegration of Level III.3 residents is directed more toward community based programs and publically funded agencies supporting housing, vocational services, transportation assistance, financial assistance, and self-help groups.

### III.3 Medium-Intensity Residential Outcomes:

Admissions for Level III.3 Medium-Intensity Residential Program were 26 Patients (24 unduplicated).

- 20% Completed Treatment Plan – Additional Tx. Required
- 60% Transitioned successfully to a lower level of care within the agency (III.1 Residential)
- 20% Incomplete – Additional Tx. Required

Both the III.1 and III.3 programs remain one of the most difficult programs to manage due to the nature of residential treatment and range of motivation from patients enrolled. The residential programs have served as a step-down from higher institutions such as jails, hospitals, detox, and other intensive inpatient programs. It also serves as a safe-haven for many coming from the streets without many resources at all. This environment demands consistent needs assessments of persons served to ensure basic functions for living are met.

It has been identified through patient surveys, counselor feedback, and observation that the House-Managers working in the residential facilities need additional training and skills development to help mediate patients, de-escalate, and work towards reducing patients leaving against clinical advice. In addition, maintenance continues to be an ongoing area for improvement to keep up with multiple sites and housekeeping.

The organization will increase trainings for house managers as well as look into external modes of training to increase skills as peer support advocates. UPCRN will continue to financially plan for resources needed to upgrade facilities. The organization had attempted to use lobbying to raise capital for improvement but was unsuccessful in doing so. The organization has increased the number of staff needed in the facilities department to meet the growing demand for upkeep. Increased training schedule for house managers and enrollment in peer support trainings. Positive scores on health and safety audits. Receipt and observation of repairs to facilities.

### **Outpatient Mental Health Clinic (OMHC)**

The census enrolled for the Outpatient Mental Health Program was 2560 patients (2081 unduplicated) in 2016 according to CredibleBH reporting. This number however does not reflect an accurate representation of patients seen for the year due to the “data-dump” of active/inactive charts in late 2015 during the transition of record-keeping. In addition, discharge rates for leaving treatment against clinical advice may be inflated due to the discharges of some inactive charts from 2015 and previous years. This also includes data from office unaccredited in College Park that is a satellite group practice in individual providers. Discharge outcomes pulled from Credible at in January 2017 reflect the below data:

- 14% Completed Treatment Plan – No Additional Tx. Required
- 7% Completed Treatment Plan – Additional Tx. Required
- 1% Transitioned out of Outpatient Mental Health to another Level of Care
- 38% Left Treatment Against Clinical Advice
- 11% Incomplete – Additional Tx. Required
- 27% Incomplete – Non-Compliance with Program
- 1% Incarcerated

Outpatient mental health has continued to be a program stressed by the drop-out of patients unexpectedly during their treatment process. UPCRN’s policy of two consecutive “No-Show” appointments has generally led to the premature discharge of some patients. The organization continues to encourage therapists to use outreach to re-engage patients as they can. This process can be difficult at

times when working with a very transient population commonly seen within the organizations practice. Unstable living environments, addresses, and unreliable phone numbers create challenges in retaining attendance at times.

One support to the Outpatient Mental Health program is the PRP program. UPCRN is still in the early stages of operation and has only offered the service at one outpatient location. The organization plans to continue expansion of this program to the 25<sup>th</sup> St. office in 2017 to address the emerging needs of patients served. The barriers that coincide with a transient population will be addressed as part of the PRP treatment planning process to increase patient retention and positive outcomes for the overall mental health program.

### **Psychiatric Rehabilitation Program & Community Integration (PRP)**

The Psychiatric Rehabilitation Program admitted 187 Patients (162 unduplicated) in 2016 providing community integration and psychiatric case-management to priority population mental health adults. This program has been an instrumental addition to the management of complex patients needing an array of case-management services. The PRP program has proved to be one of the stronger programs within the organization due to its intensive case-management, holistic approaches, and person-centered care.

Reasons for referral included: Lack of self-care; Social skill building; Medication management; Needs to increase health promoting behaviors; Homelessness and housing assistance; Somatic referral and follow-up; Legal referrals and assistance; Linkage to community supports; Lack of employment skills and work history; Limited leisure skills; Poor time-management; Educational development; and benefits education.

The below outcomes were observed for the PRP program:

- 27% Completed Treatment Plan – No Additional Tx. Required
- 20% Completed Treatment Plan – Additional Tx. Required
- 4% Left Treatment Against Clinical Advice
- 33% Incomplete – Additional Tx. Required
- 11% Incomplete – Non-Compliance with Program
- 1% Incarcerated

Goals for the PRP program in the coming year will include expansion of service delivery to other outpatient offices in Baltimore and integration into the mental health and substance abuse programs. The added case-management services to the co-occurring population served will be a strength to outcomes systematically.

## **Risk Management**

In 2016, UPCRN identified the need to update the incident reporting form and processes as part of the QIP for CARF. Incident Report forms were updated in summer 2016 and retrained with staff for documentation of incidents occurring within the organization. The organization had a total of 397 incidents in 2016, largely related to the encouragement of staff to document all incidents. In review, most incidents reported were internal relating to patient behaviors or activities that were noteworthy.

Of the 397 incidents documented in 2016, only one (1) incident was a sentinel event which involved a patient overdose while on a travel pass in the community. The patient was hospitalized, then returned to treatment where the treatment team resumed care with adjustments to the treatment plan. The organization continues to place high value and importance on overdose prevention education in the orientation groups and treatment plans for all substance abuse patients.

The main themes identified in the internal incidents documented were: patient refusal of medication; patients being late for curfew or not checking in while out of the residential facilities; patient non-compliance with treatment schedule; contraband (food, pocket knives, cleaning products, OTC medications) found while conducting random room searches; or other non-compliance with program rules (refusal of GI, escorting issues, verbal disrespect). Additionally, relapses were documented as internal incidents and comprised a minority of incidents compared to behavioral incidents noted above.

Separate from behavioral incidents, two infectious disease control incidents occurred in 2016 in the residential programs. One incident involved multiple cases of Conjunctivitis, or pink eye, in the Women and Children residential facility located at Fulton Ave. A second incident occurred at the Calvert St. Women and Children facility where two children were diagnosed with Hand, Mouth, and Foot Disease (HMFD). Infectious Disease Control action was taken to GI the facility, seek medical attention, and quarantine those infected; which resulted in a low number of infections in the facility and quick recovery for those involved. UPCRN continues to stress the importance of ongoing infectious disease control measures and quality controls to minimize health and safety risks in the organization and its facilities.

The review of UPCRN incidents also included three (3) emergency drills. The first drill included evacuation from a residential facility due to smoke; however, there were no losses while all persons exited timely and safely. The second incident involved one utility failure resulting in relocation of patients from one residential facility to another for under 12-hours, operations continued as normal and no additional shelter in place was needed. The third incident was a medical emergency involving a staff member that had a mild stroke. Staff member was treated at a nearby hospital and returned to work after recovery. Two other incidents involved full loss of a company truck and a minor accident of the company van. The truck was replaced after the loss and the van incurred minimal damage. Proper claims were filed and staff were unharmed.

As part of the organizations liability protection, full insurance coverage is reviewed annually for maximal coverage of assets, programs, facilities, and personnel. The organization reviewed these claims and renewed insurance policies with no gaps in coverage. Furthermore, UPCRN continues to require all personnel to maintain individual insurance for malpractice, or other associated coverage by job description. UPCRN takes risk management precautions regularly in the form of audits, internal and

external reviews, and consulting as needed. The steps are taken to ensure minimal risks within the agency by using quality controls to assess risks within the organization.

As part of these quality controls, UPCRN is/was audited quarterly by its funding stakeholder Behavioral Health Systems Baltimore (BHSB) for quality assurance, which includes: review of facility health and safety; compliance for documentation and record-keeping; local and state regulatory monitoring as a Core Service Agency (CSA) for certification of treatment programs; and adherence for service deliverables as set forth by the funder. In addition to these quarterly audits, UPCRN conducted semi-annually and as-needed self-inspections to ensure conformance to regulations and standards, as well as reduce risks for the organization. The above audits resulted in compliance and conformance to all licensing and accrediting bodies. The organization will continue with ongoing staff training and risk-management assessments to minimize loss exposures or nonconformance to standards.

### **Staff Training and Development**

All staff, including administrative and clinical, receive some form of supervision and/or continuing education. Supervision is offered to direct care staff in the form of both individual and group supervision, as well as weekly case consultation and team meetings. All supervision is conducted on a weekly scheduled basis and in accordance with local and state regulations and requirements, particularly in maintaining compliance for health care licensing and certification. UPCRN staff are provided in-service training monthly and encouraged to seek continuing education and training to stay abreast of new and emerging treatment trends. UPCRN offers paid trainings both on and off-site to provide clinical and administrative staff with the appropriate continuing education opportunities to increase their skill set in their realm of practice. Supervisors and management are also provided with paid trainings to increase management and supervisory skills and technique. Clinical staff meets in supervision weekly to discuss cases, experiences, and challenges of integrating substance abuse and mental health treatment.

The following in-service topics are provided annually for all staff members:

- Emergency Preparedness/Fire Safety
- Therapeutic Environment
- Confidentiality and HIPAA/Patient Rights
- Reducing physical risk/Crisis Management
- Reporting Abuse
- Promoting Patient Wellness
- Harassment Prevention
- Boundaries and Dual Relationships
- Cultural Diversity/Consumer Relations
- Infection Control/Communicable Diseases
- Person Centered Practice/Unique needs of the patients
- Limited English Proficiency

The organizations team of providers has grown with the addition of a Part-Time prescriber and fully licensed mental health clinicians in 2016 with ongoing recruiting identified as a key component of organizational growth. Annual supervisor trainings have also been added for support of middle-management and trainings needed to perform their roles. Supervisor trainings reviewed Performance Evaluations and Assessments of Supervisee; Applicable P&P; HR; and other needed areas.

One major area for improvement identified through patient satisfaction surveys was training for house managers. While some received high marks for their support of patients in navigating the treatment process, some were noted to need training on de-escalation and peer support. Additional training needs will be assessed for peer support services within the next year. Assessing the efficacy of these training will be reflected through increased successful completion from treatment, increased utilization and retention of patients, and increased scores from patient satisfaction surveys.

### **Therapeutic Environments and Person-Centered Care**

Strengthening Treatment Planning was identified as an area for improvement in the CARF accreditation QIP. One of the initial barriers for treatment planning in 2015/2016 was the adjustment of moving from Microsoft Word-based treatment plans to using the new EMR and the functionalities within. This required additional training with staff and supervisors on the functionality and workflows for treatment planning. In addition, treatment plans were even more individualized as there were no templates or “drop-down” menus to use in the EMR. Multiple Counselor trainings were held in addition to the required CARF trainings to promote staff development and comfort in using the EMR.

Increasing Strengths-Based Approaches was also critical in maintaining a supportive and therapeutic environment. Staff has worked on many levels to individualize treatment plans, revise treatment schedules and services, or build off strengths to promote growth and positive behavioral change. Staff has also changed simple daily processes such as their use of vocabulary in every day practice, ceasing use of terms such as “Blackout”, “Dirty”, “Sanction”, or other negative connotations. SNAP has been integrated into the ongoing evaluation and treatment process for patients.

UPCRN has also identified need for increased space and updating of offices in the 25<sup>th</sup> St. location. In this regard, the organization began updating offices in 2016 and will be continuing to improve facilities in 2017. The need for increased staffing to tend to a growing patient census was recognized as a necessity to individualized care.