Statement of Purpose

As part of the ongoing accreditation process, University Psychological Center, Inc. – Recovery Network (UPCRN) annually analyzes the organizational effectiveness and efficiency of operations across programs. This analysis serves as an assessment of stakeholder input, corporate compliance, and continuous quality improvement. UPCRN has been operating as a behavioral health organization since 1979 in the Baltimore-Washington Metro area. Specializing in and Mental Health (MH), Addictive Behaviors, and Alcohol and Other Drug (AOD) treatment, UPCRN is in the second year of accreditation following a 2015 three-year accreditation approval status 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 regulations for the certification of treatment programs. Effective April 1, 2018, behavioral health programs will begin following the COMAR 10.63 revision for license-based accreditation of programs.

During the second year of accreditation, UPCRN continued to work towards strengthening program processes outlined by CARF conformance standards. The following areas were identified as established goals to be addressed in the next year of strategic planning:

1. Facilities Improvement and Expansion
2. Data Collection
3. Risk Management
4. Staff Development

The Executive Management, Leadership, and team of personnel continue to be tasked with maintaining CARF conformance standards, as well as consistently working to improve operations. This process involves seamless service delivery to a complex and underserved population, while concurrently and strategically fine-tuning operations for treatment. While plans of action for 2017 were addressed by UPCRN stakeholders, ongoing planning and enhancements will need to be addressed in 2018 for the purpose of continued analysis and performance improvement.

The standards and guiding principles have served as a roadmap to ongoing development and innovation in the field of behavioral health. The 2017 organizational analysis will act as annual summary and also a footprint for the next years strategic planning. All standards, policies and procedures are established through conformance to CARF, DHMH, COMAR, OHCQ, and regulatory entities governing treatment programs in Maryland.

Focus Areas for Improvement

Four areas for improvement were identified in 2017 by UPCRN Leadership and stakeholders. These areas were not a reflection of nonconformance to standards, but instead components of the organization that needed attention and enhancement. These focus areas include:

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

Risk Management
- Minimizing Critical Incidents
- Loss Exposures and Prevention
- Health and Safety
- Financial Planning & Billing

Staff Development
- Recruitment
- Clinical Skills Enhancement
- Workflow Analysis
- Middle Management and Leadership Support

Program Development
- Facilities Expansion and Upgrade
- Admissions and Access to Care
- Program Expansion & Realignment with New 10.63 COMAR Regulations
- Systematic Changes in Maryland
    - COMAR 10.63
    - IMD Waiver (1115) – Residential Transition from Grant to Fee-for-Service

Summary of Findings

2017 was a year of growth and expansion for UPC, Inc. – Recovery Network. Services increased significantly due to innovative processes and newly formed departments who worked relentlessly to improve workflows and access to care. One key change was the implementation of the UPCRN Admissions Department who streamlined the intake and referral process through ongoing collaboration and integrated care. This access to care increased the overall census as seen in the data collection outlined throughout this analysis.

This growing census also brought with it the challenges. Physical space and infrastructure was needed to support the increased volume of persons served. UPCRN expanded the square footage of the 25th St. Outpatient office through the Facilities Department's hard work and dedication to remodeling offices and increasing useable space. The organization also relocated from its Fulton Ave. location to a new property in Baltimore located at 707 St. Paul. This relocation occurred due to ongoing unresolved maintenance issues by the landlord as well as cost savings from the high expenditures incurred from that specific site. In addition to growth in space, UPCRN began using the 1208-10 James St. property solely as transitional housing effective July 2017. This change was made to meet the growing demand for a step-down supportive housing component following completion of clinical residential treatment.

UPCRN Psychiatric Rehabilitation Program & Community Integration (PRP) program also began expanding service delivery to the 25th St. location in 2017. In the previous year, off-site services from the Charles St. office were primarily rendered for those receiving services at the other outpatient and residential locations. Additional staff was added to the PRP team to meet the growing census and services offered. The PRP program has come to be an invaluable modality and compliment to the mental health and substance abuse integrated programs. PRP has improved coordination of care, somatic referral and follow-up, as well as building ADL's and other community supports such as housing, educational and occupational development.

The facilities were also impacted by a change in treatment teams in 2017. UPCRN recognized that with a growing census was a need for increased treatment team meetings for case consultation and coordination of care. Development of new teams in conjunction with the implementation of the Admissions Department, UPCRN reorganized the bed capacity of several III.1 residential programs. This adjustment was made to increase the number of treatment teams while maintaining an even distribution of interdisciplinary treatment team members for case consultations.

In July 2017, UPCRN increased the treatment teams twofold, with two team meetings at each location for special populations and programs. Clinical teams included: 25th St. Outpatient Team; 25th St. Residential Team; Charles St. Men's Residential and III.3 Team; and the Charles St. Women and Children's Team. All interdisciplinary teams were comprised of AOD counselors, MH therapists, PRP Direct Care, supervisors, nurses, psychiatrists or psychiatric nurse practitioners, and key management.

The added treatment teams led to more than doubling the number of case consultations (collaboration notes) in 2017. The following data was observed after implementation:

- 1/1/17 – 6/30/17: 258 Case Consultations
- 7/1/17 – 12/31/17: 523 Case Consultations

Despite the increased case consultations, it was expected that there were to be some attrition with the move of beds. The organization provided support and sensitivity to residential patients, but there were several patients who left treatment as a result of the move. Despite these isolated AMA discharges, UPCRN discharges against medical advice decreased 2% from 2016 to 2017. UPCRN did see a 4% decrease in successful discharges in the residential programs which was largely attributed to the residential changes made this year. UPCRN did see a 17% improvement in successful discharges from outpatient treatment as well as an increased number of transitions to other levels of care in 2017. These transitions in care are seen as positive interventions to step patients up or down to more appropriate levels of care to meet their individual treatment plan needs.

With the progression of service delivery comes the need for management of claims processing as UPCRN handles all billing and finances in-house. The organization identified billing and collections as a focus area as a shift in payers and revenue cycles was acknowledged as part of 2017 funding and 2018 systematic changes in Maryland. To address this issue, the organization began focusing on billing workflows and recruitment of billing specialists to assist in A/R management. The organization hired a Director of Revenue Cycles in October 2017 improve billing in a growing fee-for-service market. The approval of the Medicaid IMD Waiver 1115 in December 2016 will drastically change funding streams for residential treatment.

The previous IMD (Institution for Mental Diseases) Exclusion prohibited Maryland Medicaid reimbursement for adults between the ages of 21 and 64 receiving services provided in "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and treatment of individuals with mental diseases."

Because of this non-payment policy, many Medicaid enrollees with acute psychiatric and addiction treatment needs are referred to hospital emergency departments and general acute care inpatient units, rather than smaller, community-based specialized providers with expertise to care for these individuals. Historically, Baltimore City has been provided grant-based funds to support the much needed service of residential treatment.

The approval of the Maryland Medicaid Waiver will allow reimbursement to IMDs for the treatment of Medicaid enrollees aged 21-64 with acute psychiatric and substance-use-related needs through a fee-for-service payer model. Cost savings would be generated at both the state and federal levels by enabling the state to pay for appropriate care in appropriate settings, but will be a shift from grant to insurance-based reimbursement for the organization. This heightens the importance of having an efficient and effective revenue cycle in place.

To address this concern, UPCRN dedicated more attention to revenue cycles. Some actions taken included staff development, update of 835's, EOBs, and electronic fund transfers. Front end workflows related to admissions, intake, registration, eligibility checks and redetermination for patient insurances, revised hardship processes, as well as ongoing updates to patient information and profiles. On the back end, management of accounts receivables through reconciliations, patient outreach and collections, and financial reporting were addressed to improve systems. The organization continued to contract with CredibleBH for ongoing support and consultation to improve billing matrix's, reporting, and monthly closing of accounts.

Moving into 2018, UPCRN will need to play close attention to all billing workflows to ensure smooth transition from reimbursement systems. Fee for service billing for ASAM Level III.3 went into effect July 1, 2017, however UPCRN retained grant funding for the program by BHSB through December 31, 2017. All patients will be billed to Beacon Health, ASO for Maryland Medicaid, effective January 1, 2018. Three sample patients were billed to Beacon Health from November through the end of 2017 to test billing of two new residential CPT codes, clinical and room/board. Test claims proved to be effective with billing and collections.

Data Collection & Program Outcomes for 2017

Data collection and program outcomes were a focus area for improvement in the 2016 analysis and original QIP. In 2017, UPCRN worked to improve accuracy of data through reporting and analysis of open or closed programs. Workflows, assignment of responsibilities, and training to clinical and admin personnel were influential in improving overall data collection. While there is still room for improvement in data analysis, leadership and stakeholders have worked together in improving these outcomes. The data collection continues to involve assessing various stakeholder satisfaction, patient information and outcomes, and identify areas for improvement. UPCRN personnel have become savvier in EMR functionalities that were formerly seen as barriers to accurate data collection in past analyses.

Multiple forms of stakeholder feedback was collected in 2017, including: employee surveys, patient surveys, and stakeholder meetings without management present where employees could provide anonymous feedback to upper level management. These survey structure and forms are reviewed annually to meet the growing needs of stakeholders improve outcomes of data collected.

The 2017 employee satisfaction was sent out in October 2017 with thirty (31) responses focused on job training, support, work environment, benefits, compensation, and other areas for self-assessment. The outcome of the survey identified communication and benefits as areas for improvement. Staff also commented on the "Hectic and crazy" environment that can sometimes occur within the workplace and persons served. Additional training on de-escalation difficult patients and therapeutic environments will need to be reviewed with employees to increase confidence in skills and competencies. Leadership also continues to examine benefits on an annual basis to meet the growing socioeconomic needs of stakeholders employed through the organization.

Overall organizational and program development has increasingly relied on staff training and improved benefits as a focus in 2017. Leave time was identified in 2016 as unsatisfactory to some employee. Management increased paid time off (PTO) by one week in 2017 as well as adding two days of paid continuing education days to improve stakeholder satisfaction in leave benefits. Costs for insurance also decreased for staff in 2017 by up to 20%. Benefits will continue to be examined in 2018 to improve stakeholder satisfaction and output.

Patient surveys were also disseminated in 2017 to review satisfaction for all persons served in all 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. Survey outcomes were largely targeted at the poor condition of the 25th st. outpatient facility. The property was acquired by UPCRN in 2014 and has been identified by management as a project that needs to be improved. Since its acquisition, the facilities department have been quietly working to improve it piece by piece. Failing to collect external resources for capital improvement, the organization is budgeting personal assets for slow renovation of the facility. The management and facilities team have devised a plan to overhaul the infrastructure of the building in 2018 by overhauling electrical, plumbing, and cosmetic workings.

Clinical program outcomes are a summary of aggregate data collected through CredibleBH. This data was initially impacted by the transfer of record-keeping, but has improved since going electronic in 2015. Accuracy of data input and output continues to be a goal in the continuous quality improvement (CQI) process. The CQI members have reviewed data collection processes annually improve 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.

Admissions for ASAM Level 1.1 - Outpatient Substance Abuse Treatment:

- 355 patients (270 unduplicated)
    - 28% Increase in admissions from 2016

Discharges:

- 25% Completed Treatment Plan – No Additional Tx. Required
- 17% Completed Treatment Plan – Additional Tx. Required
- 9% Transitioned out of Outpatient to another Level of Care
- 27% Left Treatment Against Clinical Advice
- 6% Incomplete – Additional Tx. Required
- 12% Incomplete – Non-Compliance with Program
- 2% Incarcerated

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.

Admissions for Intensive Outpatient Treatment for Substance Abuse Treatment:

- 479 patients (385 unduplicated)
    - 64% Increase in admissions from 2016

Discharges:

- 4% Completed Treatment Plan – No Additional Tx. Required
- 3% Completed Treatment Plan – Additional Tx. Required
- 46% Transitioned out of Intensive Outpatient to another Level of Care
- 29% Left Treatment Against Clinical Advice
- 4% Incomplete – Additional Tx. Required
- 13% Incomplete – Non-Compliance with Program
- 1% Incarcerated

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.

<u>III.1 Low-Intensity Residential Outcomes:</u>

Admissions:

- Level 3.1 Low-Intensity Residential Program 301 patients (270 unduplicated)
    - 40% Increase in admissions since 2016

Discharges:

- 16% Completed Treatment Plan – No Additional Tx. Required
- 21% Completed Treatment Plan – Additional Tx. Required

- 4% Transitioned out of 3.1 Residential to another Level of Care
- 33% Left Treatment Against Clinical Advice
- 8% Incomplete – Additional Tx. Required
- 16% Incomplete – Non-Compliance with Program
- 2% 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.

<u>III.3 Medium Intensity Residential Outcomes</u>:

Admissions:

- Level 3.3 Medium-Intensity Residential Program 46 Patients (42 unduplicated)
    - 43% Increase in admissions since 2016

Discharges:

- 16% Completed Treatment Plan – No Additional Tx. Required
- 10% Completed Treatment Plan – Additional Tx. Required
- 58% Transitioned out of 3.3 Residential to another Level of Care
- 10% Left Treatment Against Clinical Advice
- 3% Incomplete – Non-Compliance with Program
- 3% Incarcerated

Goals for all substance abuse programs involve increasing referrals and marketing in the community. In addition to maintaining a census, the organization is working to improve clinical competencies for direct care staff through ongoing training and support, improved training manuals and schedules for onboarding, and improved coordination of care for positive treatment outcomes. In increasing positive outcomes, meeting patients where they are and constructing individualized strengths-based treatment plans will important in improving comprehensive care. UPCRN will continue to examine all levels of substance abuse treatment to ensure a continuum of care that promotes patient autonomy and growth.

Outpatient Mental Health Clinic (OMHC)

Outpatient mental health in collaboration with the substance abuse and PRP programs has served as an integrated platform to treat the growing needs of those served. UPCRN maintains the philosophy that many affected by addictive behaviors are exacerbated by co-occurring mental health disorders and therefore need to be treated holistically by a range of providers on a interdisciplinary team. Therefore disorders are treated through a joint treatment planning process. While not all persons served in the mental health program have co-occurring needs, UPCRN maintains a diverse mix of treated disorders.

Services that have proven to be quite effective in the mental health programs have been the innovation of Neurofeedback technologies offered in the Baltimore offices. These non-invasive and alternative treatment practice has been effectively offered by clinicians since 2014 as a supplement to an array of mental health services provided onsite.

Data for admissions into the mental health program remains complicated from merger of record-keeping in 2015. While over 2000 patients show being enrolled in 2017, this is not an accurate reflection of patients admitted into treatment. A total of 239 Psychiatric Evaluations by a psychiatrist or psychiatric nurse practitioner as well as 299 Behavioral Health Evaluations by a licensed mental health provider were completed in the outpatient programs. A range of mood and psychiatric disorders were treated through individual, group, and family counseling. Medication management, neurofeedback, and intensive psychiatric case management were also used as part of the treatment planning process.

Discharge types for 2017 include:

- 12% Completed Treatment Plan – No Additional Tx. Required
- 11% Completed Treatment Plan – Additional Tx. Required
- 1% Transitioned out of Outpatient Mental Health to another Level of Care
- 36% Left Treatment Against Clinical Advice
- 14% Incomplete – Additional Tx. Required
- 18% Incomplete – Non-Compliance with Program
- 2% Incarcerated

UPCRN continues to improve supervision and case-consultation as an effort to improve outcomes from the mental health program. In working with a transient and complex population, “No-Show” and drop-out rates continue to be a problem for the organization. While this challenge continues to be one of outreach and engagement, the program maintains a regularly full census of caseloads and persons served.

Community Integration/Psychiatric Rehabilitation Program (PRP)

PRP service delivery maintains its role as a supplemental program complimenting the outpatient mental health and substance abuse programs. The additional case management offered to a complex and priority population is undoubtedly a much warranted service for the impoverished basic needs seen in the ongoing assessment process. PRP direct care staff have been great additions to the interdisciplinary treatment teams. The PRP program was subject to submitting a Performance Improvement Plan (PIP) to DHMH due to a one month shortfall in staffing pattern requirements needed for the growing census of the program. The deficit was expeditiously resolved and the PIP approved by DHMH for ongoing operations.

Patients referred to the PRP services must meet priority population diagnoses for mental health disorders. Reasons for referral to the PRP program 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.

Admissions for PRP include:

- 273 Patients (243 unduplicated)
    - 31% increase in referrals and admissions since 2016

Discharges:

- 16% Completed Treatment Plan – No Additional Tx. Required
- 34% Completed Treatment Plan – Additional Tx. Required
- 12% Left Treatment Against Clinical Advice
- 34% Incomplete – Additional Tx. Required
- 2% Incomplete – Non-Compliance with Program
- 2% Incarcerated

Goals for the PRP program in 2018 will include improving patient outcomes in completing treatment throughout increasing care coordination and expanded services which began this past year. PRP will also utilize patient surveys to address feedback on improving off-sites, expanding services, and improving referrals to community resources. In 2017, the PRP program improved organization of referral databases by compiling a resource book for patients and staff to use in connecting patients to additional services and resources in the community.

Risk Management

UPCRN saw a 5% decrease of incidents in 2017 with a total of 376 documented. Of these incident reports, two were documented sentinel events involving a two separate patient overdoses, four medical emergencies, two utility failures and drills, and one live fire-drill due to a fire at the Charles St. location. No deaths occurred as a result of any of the above incidents as swift and appropriate action was taken by the leadership onsite and emergency services. UPCRN recognizes the importance of ongoing training and support for emergency preparedness to minimize loss exposure and risk management.

Of the 376 incidents documented in 2017, two overdoses were recorded as sentinel events. Both patients on separate occasions were hospitalized and returned to treatment where the team intervened to continue care and update 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. It has been noted by UPCRN Leadership that relapse and overdose rates continue to spike across the nation and specifically, Baltimore City. Considering the increase in overdoses, UPCRN has posted information and literature for patients on overdose prevention and data.
The majority of internal incidents continue to stem from the residential programs and patient behaviors such as: 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).

Infectious Disease Control continues to be an agenda item for the facilities department and all organization stakeholders. Entry/Exit protocols and infectious disease protocols have kept 2017 risks to a minimum. These precautionary measures helped the agency reduce infestations of bed-bugs and other communicable diseases in 2017. On the contrary. Pest-Control has been an ongoing need for minimizing rodents and other critters within the facilities. UPCRN has prioritized upgrading the facilities as part of the strategic plan for improvement in 2017 and 2018. The organization has completed a "purge" of the facility to remove clutter and unwanted belongings. In addition, the organization began improving the therapeutic environment through updating office space and rooms.

The review of UPCRN incidents also included three (3) emergency drills. Two drills involved a water utility outage lasting two days. Staff were relocated from the 25th St. Main Office to Charles St. where services were provided without delay. The third incident involved a fire in the bathroom of the Charles St. Office and all persons were evacuated safely. Minimal interruption of operations and service delivery were incurred, while also confirming the effectiveness of UPCRN emergency preparedness planning. No claims were submitted for these events as there were minimal losses or treatment service interruption.

As part of the organizations risk management analysis, it reviews its insurance and liability coverage for maximal protection of assets, programs, facilities, and personnel. Additionally, UPCRN continues to maintain the requirement for all direct care personnel to hold active individual malpractice insurance as part of their employment contract. HR reviews personnel coverage on an ongoing basis to ensure no lapse in insurance. UPCRN takes precautions regularly in the form of supervision, compliance and risk management audits, and internal and external reviews to minimize losses for the organization.

In 2017, UPCRN has continued to adhere to regular external audits by its funding stakeholder Behavioral Health Systems Baltimore (BHSB). These Quality Assurance reviews assess: facility health and safety; compliance for documentation and record-keeping; and other regulatory monitoring as an established by the Core Service Agency (CSA) BHSB. In addition to these quarterly audits, UPCRN conducted semi-annually and as-needed self-inspections of facilities to ensure conformance to regulations and standards, as well as reduce risks for the organization. The organization is also periodically reviewed by Maryland Department of Health and Hygiene, Maryland Medicaid, and its ASO Beacon Health Options for compliance reviews, The above audits have resulted in compliance and conformance to all licensing and accrediting bodies without retraction of services.

Staff Training and Program Development

UPCRN recognizes that ongoing staff training and development is a key aspect of providing quality and integrated service delivery and managing occupational triggers. Through ongoing assessment and review of staff needs, the organization has been sensitive to training needs and feedback from its stakeholders. It has been recognized by the organization that various levels of stakeholders needing additional training to fulfill job responsibilities and strengthen workflows.

In 2016 and 2017, UPCRN recognized that one area for improvement in the residential programs were skills development for the House Managers, who typically have been senior residents or alumni in the program and worked in Peer capacity commonly found in a Recovery Oriented Systems of Care (ROSC). While House Managers go through a one to two month training orientation and ongoing monthly trainings, UPCRN worked with community stakeholders in registering Peers for the Connecticut Community for Addition Recovery (CCAR) Training which provided one-week of intensive training on peer recovery coaching. UPCRN recognized that there were high levels of patients leaving treatment against medical advice (AMA) that potentially could have been de-escalated or intervened with earlier by house staff which could have changed discharge outcomes. The first CCAR training for Live-In House Managers took place in October 2017.

Recognizing the importance of middle-management and ongoing training for supervisors and managers was an important training agenda for 2017. Supervisors and managers received additional training in

2017 on their supervisee's responsibilities, as well as their own. Supervisors were also retrained on troubleshooting EMR issues, HR and Employee P&P, workflow responsibilities, and accountability.

Training of staff has been essential in the enhancement of all workflows and processes. UPCRN holds trainings monthly to meet the standards set forth by CARF addressing a multitude of business and behavioral health practices. In addition to these required conformance trainings, UPCRN also ensured additional trainings needed for EMR workflows, clinical competencies, administrative workflows, and billing cycles. UPCRN will continue to examine these needs through CQI, stakeholder meetings, and other observed shortfalls within the organization.

Recruiting coincided with staff development and enhancement as the growing census demanded a need for more direct care providers and administrative support. In 2017, UPCRN added a Full-Time Psychiatric Nurse Practitioner, Somatic Nurse Practitioner, Therapists, and Alcohol & Drug Counselors to the treatment team. This treatment team was complimented by an administrative team and newly formed admissions department. The department is comprised of an Admissions Director and Assessor, Licensed Clinical Social Worker (Clinical Coordinator), and Patient Service Coordinator.

The Admissions Department was implemented in July 2017 to expedite access to all services across UPCRN's continuum of Care. It was recognized in 2016 that wait times for placement in ancillary programs could take as long as 30-days before enrolling in additional programs. The goal for the admissions department is offer access to all programs in a smooth and expedited process tailored each individual patient within one week of admission. The admissions department has strengthened access to care and increased admissions significantly from 2016 to 2017.

Staff training and development will continue to be addressed in 2018 as part of the organizations growing needs of patients served. One outlying concern for development that will tentatively be addressed in 2018 is the changes to treatment service standards as Maryland moves from COMAR 10.47 certification regulations to the new accreditation-based licensure outlined in COMAR 10.63 which will go into effect April 1, 2018. Furthermore, many of the regulations that will be set forth for residential programs will not be released to providers until mid-year 2018. UPCRN will continue to play an active role in provider workgroups and communicating with state and local authorities to stay abreast of the changes to come.