IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH AND DISABILITY SERVICES

90 DAY FOLLOW UP INSPECTION TO DENIAL

PROGRAM:	*Elevate CCBHC* *604 Lafayette Street* Waterloo, Iowa 50703
LICENSED SERVICES:	This program provides Adult and Juvenile Levels 1, 2.1, and 2.5 Substance Use Disorder Treatment Services
DEPARTMENT SURVEYORS:	Lori Hancock-Muck and Amanda McCurley, Division of Behavioral Health
INITIAL NOTICE OF DENIAL FROM COMMITTEE:	March 9, 2022
CORRECTIVE ACTION APPROVAL:	March 15, 2022
90 DAY FOLLOW UP INSPECTION REPORT:	October 26, 2022

SUMMARY OF FOLLOW UP INSPECTION FINDINGS:

Corrective Action Plan Compliance Summary:

OVERALL COMPLIANCE –

- ***15 of 20 licensure standards are now in compliance.***
- ***3 of 20 licensure standards are now in partial compliance.***
- ***2 of 20 licensure standards remain in non-compliance.***

Compliance:

1. ***641—155.21(8)d. Personnel***
2. ***641—155.21(10)a. Patient Records***
3. ***641—155.21(10)f. Patient Records***
4. ***641—155.21(11)a. Assessment and Admission***
5. ***641—155.21(11)b. Assessment and Admission***
6. ***641—155.21(11)c. Assessment and Admission***
7. ***641—155.21(11)e. Assessment and Admission***

8. ***641—155.21(12)a. Treatment Plans***
9. ***641—155.21(12)b. Treatment Plans***
10. ***641—155.21(12)d. Treatment Plans***
11. ***641—155.21(13)c. Progress Notes***
12. ***641—155.21(14)a. Patient Record Contents***
13. ***641—155.21(14)b. Patient Record Contents***
14. ***641—155.21(19) Management of Care and Discharge Planning***
15. ***641—155.21(19)d. Management of Care and Discharge Planning.***

Partial Compliance:

1. ***641—155.21(11)d. Assessment and Admission***
2. ***641—155.21(12)c. Treatment Plans***
3. ***641—155.21(19)b. Management of Care and Discharge Planning.***

Non-Compliance:

1. ***641—155.21(19)c. Management of Care and Discharge Planning***
2. ***641—155.38(3)a. Baseline TB Screening Procedures for Facilities***

SUMMARY OF DENIAL:

On January 26 and 31, 2022, the Iowa Department of Public Health (Department) surveyors conducted a virtual licensure inspection of Elevate CCBHC (Elevate). As a result, it was determined Elevate had failed to achieve the minimum licensure weighting report rating (70%) required for a license pursuant to rule 641– 155.10(1)(b). Specifically, the program received a 54.8% score in the Clinical Standards section.

On September 8, 2021, the Substance Abuse/Problem Gambling Program Licensure Committee (Committee) proposed to deny Elevate's application for a program license due to the program's failure to achieve the minimum licensure weighting report rating.

In accordance with IAC 641—155.11(2), Elevate submitted a written corrective action plan addressing the 20 areas of non-compliance. The corrective action was approved by the Department on March 15, 2022. Pursuant to IAC 641—155.11(2)a., Elevate had 90 days to show compliance with the plan. From March 15, 2022 to June 13, 2022, Elevate was to demonstrate compliance with the following rules:

- ***641—155.21(8)d. Personnel***
  Personnel was in non-compliance because not all personnel records contained documentation of review and agreement to adhere to confidentiality laws and regulations prior to the staff person's assumption of duties.

- ***641—155.21(10)a. Patient Records***
  Patient records were in non-compliance because the content and format of the patient records were not uniform.

- ***641—155.21(10)f. Patient Records***
  Patient records were in non-compliance because releases of information were not in accordance with 42 CFR Part 2.

- ***641—155.21(11)a. Assessment and Admission***

Assessment and admission was in non-compliance because the assessment was not documented in the patient record in an organized manner that supported development of a treatment plan

- ***641—155.21(11)b. Assessment and Admission***
  Assessment and admission was in non-compliance because the program did not implement a uniform assessment process for the information to be gathered.

- ***641—155.21(11)c. Assessment and Admission***
  Assessment and admission was in non-compliance because the patient assessment was not updated on an on-going basis within the periods of time specified for outpatient level of care.

- ***641—155.21(11)d. Assessment and Admission***
  Assessment and admission was in non-compliance because the patient record did not contain documentation the assessment results were explained to the patient.

- ***641—155.21(11)e. Assessment and Admission***
  Assessment and admission was in non-compliance because patient records did not contain documentation that patients had been informed of the general nature and goals of the program, the rules governing patient conduct and infractions that can lead to disciplinary action or discharge from the program, the hours during which services are available, the costs to be borne by the patient, confidentiality laws, rules and regulations, or the safety and emergency procedures.

- ***641—155.21(12)a. Treatment Plans***
  Treatment plans were in non-compliance because the treatment plan was not developed within the time periods specified for each level of care.

- ***641—155.21(12)b. Treatment Plans***
  Treatment plans were in non-compliance because the treatment plan did not include a summary of assessment findings; patient short-term goals; and the type and frequency of planned treatment activities.

- ***641—155.21(12)c. Treatment Plans***
  Treatment plans were in non-compliance because there was no documentation that patients were provided a copy of the treatment plan.

- ***641—155.21(12)d. Treatment Plans***
  Treatment plans were in non-compliance because treatment plan reviews were not documented in the patient record.

- ***641—155.21(13)c. Progress Notes***
  Progress notes were in non-compliance because some patient records did not contain a weekly summary of group counseling sessions, as recreational activities were documented as such.

- ***641—155.21(14)a. Patient Record Contents***
  Patient record contents were in non-compliance because some patient records did not contain screenings; assessments; releases of information or authorization to disclose, or reports from a referring source or outside resource.

- ***641—155.21(14)b. Patient Record Contents***
  Patient record contents were in non-compliance because some patient records did not contain treatment plans, management of care reviews, progress notes, or discharge summaries documented within 30 days of discharge.

- ***641—155.21(19) Management of Care and Discharge Planning***
  Management of care and discharge planning was in non-compliance because patient records did not demonstrate proper use of The ASAM Criteria.

- ***641—155.21(19)b. Management of Care and Discharge Planning***
  Management of care and discharge planning was in non-compliance because management-of-care activities were not documented within the time frames appropriate to the patient's ASAM level of care (every 30 days for outpatient level of care).

- ***641—155.21(19)c. Management of Care and Discharge Planning***
  Management of care and discharge planning was in non-compliance because the patient record did not contain documentation the program is coordinating patient care with other programs.

- ***641—155.21(19)d. Management of Care and Discharge Planning***
  Management of care and discharge planning was in non-compliance because patient discharge planning is not started at the time of admission and does not include ongoing post-discharge patient needs.

- ***641—155.38(3)a. Baseline TB Screening Procedures for Facilities***
  Baseline TB screening procedures for facilities was in non-compliance because staff did not receive baseline TB screening upon hire.

RESULTS OF 90 DAY FOLLOW UP INSPECTION:
Due to COVID-19, the Department conducted a desk audit in lieu of the on-site inspection. On July 6, 2022, the surveyor contacted Elevate's Executive Director, Bob Lincoln, to request documents to determine compliance with the corrective action plan. The following is a summary of current adherence for each of the 20 licensure standards that were found to be in non-compliance from the January 26 and 31, 2022 inspection:

- ***641—155.21(8)d. Personnel***

Personnel was in non-compliance because not all personnel records contained documentation of review and agreement to adhere to confidentiality laws and regulations prior to the staff person's assumption of duties. Elevate's corrective action plan noted the program would ensure the confidentiality form was signed by all employees and that signing the confidentiality form would be added to the orientation checklist by February 1, 2022. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program responded that the confidentiality acknowledgement and agreement form has now been added to the Employer Handbook which is reviewed at the start of hire and collected on the first date of employment. It was further noted that it was also added to the personnel file checklist which is reviewed on the first date of employment and signed by staff and the HR department. The surveyor reviewed six personnel records that had been previously reviewed during the license renewal inspection. The surveyor found that all six records contained signed confidentiality forms, and it was determined that the program

completed the corrective measure within the timeframe stated. The Department finds the program to be in compliance with the corrective action plan as all files now have confidentiality agreements, and new staff have signed before assuming responsibilities.
COMPLIANCE: Compliant

- ***641—155.21(10)a. Patient Records***

Patient records were in non-compliance because the content and format of the patient records are not uniform. Elevate's corrective action plan noted patient records are standardized in the electronic medical record and that an Intake Checklist would be kept current and used to provide a standard process for intake and building the client's record. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. The program reported "all clients will have a substance use screen and social history completed upon intake." It was further noted that the "ASAM section of the assessment will be completed by the counselor at the first assessment and the information is also on a uniform intake checklist that is used for all intakes." The surveyor reviewed nine patient records. The surveyor found all nine records contained assessment and screening tools that were consistently documented in records. Assessments contained thorough drug use histories along with detailed reviews of the ASAM dimensions. The Department finds the program to be in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(10)f. Patient Records***

Patient records were in non-compliance because releases of information were not in accordance with 42 CFR Part 2. Elevate's corrective action plan noted the program would train all staff on January 30, 2022 instructing staff on how to correctly complete a release of information; that a consent would be obtained from minors prior to disclosing substance use disorder information to parents; a consent would be obtained prior to disclosing information to other service providers; and the Director of Operations would conduct QA on the intake process to ensure effective implementation of the changes. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported releases of information are now obtained for clients who are enrolled in programs other than the substance use disorder program and that this is checked during random file reviews by the clinical director and the quality assurance team. The surveyor requested verification of training as the program did not initially include that information with the requested documents. A staff sign-in sheet was then provided to the surveyor showing evidence that staff attended a training on January 31, 2022, and an accompanying training document was provided with the description of the topic. The surveyor also reviewed nine patient records to determine adherence with 42 CFR Part 2. Most records contained a quality assurance review form that included verification that appropriate releases of information were included in records. Several records included a written patient authorization to disclose information to other programs within the organization which is a noted improvement; although one record did not include the amount or kind information to be released. This was isolated to only one record. This would not be considered a valid entity for a disclosure. The Department provided technical assistance and additional resources to assist the program with 42 CFR Part 2 adherence. The Department finds the program to be in overall compliance with the corrective action plan as patient records contain releases of information to be in compliance with 42 CFR Part 2, and the required training was provided to staff within the required 90-day

implementation time frame.
COMPLIANCE: Compliant

- ***641—155.21(11)a. Assessment and Admission***

Assessment and admission was in non-compliance because the assessment was not documented in the patient record in an organized manner that supported development of a treatment plan. Elevate's corrective action plan noted the SBIRT screening tool would be used for adults and the CRAFFT screening tool would be used for youth. It was noted that if the screening was positive, a uniform drug use history would be assessed for amounts, frequency, and duration of alcohol and drug use. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported the assessment and admission process for services is more streamlined. The surveyor reviewed nine patient records. One of the patient records only included screening tools. The program clarified that the patient was seen by an intake coordinator for the initial screening, and the patient did not return to be assessed by the addictive disorder professional. As a result, the surveyor did not include this record in the review. For the nine records reviewed, all nine contained appropriate screening tools along with a thorough drug use history. The assessments were organized in a manner that supported development of specific goals. The Department finds the program is in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(11)b. Assessment and Admission***

Assessment and admission was in non-compliance because the program did not implement a uniform assessment process for the information to be gathered. Elevate's corrective action plan noted the program had standardized the intake process and hired a dedicated intake coordinator to ensure uniform intakes, screenings, assessment and information gathering. For the 90 day follow up, the Department requested Elevate to provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported the assessment and admission process for services is more streamlined, and an assessment session note is completed where recommendations are noted. The surveyor reviewed nine patient records. All nine records contained uniform assessment and screening tools. As the surveyor found assessments to be uniform in the information being gathered for the assessment, the Department finds the program is in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(11)c. Assessment and Admission***

Assessment and admission was in non-compliance because the patient assessment was not updated on an on-going basis within the periods of time specified for outpatient level of care. Elevate's corrective action plan noted a process was being developed to review the assessment every seven days for intensive outpatient service and every 30 days for outpatient services. It was further noted that the Quality Assurance Therapist on the clinical team would review records monthly to ensure compliance. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported that for required updates, the program was using the ASAM transition and update assessment, where the counselor can provide any changes and continued recommendations for treatment. It was further reported that this is maintained in the electronic record as well, and there are weekly

updates for intensive outpatient and monthly updates for outpatient services. The surveyor reviewed nine patient records. Of the nine records, five would have required updated assessments. The surveyor found all five records contained updated assessments documented. Although there were a few reviews considered untimely, the reviews were documented within a few days of the required timeframe. As a result, the Department found overall compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(11)d. Assessment and Admission***

Assessment and admission was in non-compliance because the patient record did not contain documentation the assessment results were explained to the patient. Elevate's corrective action plan noted the counselor would document the client's understanding of the relation of the assessment to the treatment plan. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported an assessment session note is completed where recommendations are noted, however the "program is still working on getting the counselor to provide an overall assessment of findings and recommendations or noting that it was reviewed with the patient and their response." The surveyor reviewed nine patient records. Evidence of the results being explained to the patient was inconsistently documented in records. There was overall documentation that options were discussed with patients and overall patient agreement with recommendations, however it was not clearly documented in records that the results of the assessment were explained to patients. Records contained inconsistent documentation to show evidence that the results of the assessment were explained to the patient. The Department finds the program is in partial compliance with the corrective action plan as it is not clearly documented in patient records that the results of the assessment were explained to the patient.
COMPLIANCE: Partial Compliance

- ***641—155.21(11)e. Assessment and Admission***

Assessment and admission was in non-compliance because patient records did not contain documentation that patients had been informed of the general nature and goals of the program, the rules governing patient conduct and infractions that can lead to disciplinary action or discharge from the program, the hours during which services are available, the costs to be borne by the patient, confidentiality laws, rules and regulations, or the safety and emergency procedures. Elevate's corrective action plan noted new patient paperwork would be developed and would include the required licensure elements. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported "we enhanced the Consent to Treat (document) and now give clients the Scope of Services document that notes the hours of services, days and times, fees, criteria for entry and discharge". The surveyor reviewed nine patient records. All nine records contained a "consent to treat" document that included all required elements. The Department finds the program is in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(12)a. Treatment Plans***

Treatment plans were in non-compliance because the treatment plan was not developed within the time periods specified for each level of care. Elevate's corrective action plan noted

the program's treatment plans have been standardized across the mental health and substance use disorder programs. It was further noted that the counselor had completed all treatment plans for intensive outpatient participants and will have all treatment plans completed and updated in files. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported treatment plans for intensive outpatient clients are completed within the first 7 days and updated again every 7 days. It was further reported that clients in outpatient care have a treatment plan completed within 30 days and updated again in 30 days. The surveyor reviewed nine patient records. Of the nine records, six would have required a treatment plan to be developed. All six records contained treatment plans that were developed within the required timeframes for intensive outpatient and outpatient levels of care. The Department finds the program is in compliance with the corrective action plan.

COMPLIANCE: Compliant

- ***641—155.21(12)b. Treatment Plans***

Treatment plans were in non-compliance because the treatment plan did not include a summary of assessment findings; patient short-term goals; and the type and frequency of planned treatment activities. Elevate's corrective action plan noted treatment plans have been updated to include summary assessment findings, short-term goals (objectives) and type and frequency of planned treatment activities. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program noted "areas we find that still need improvement are making sure objective, interventions are measurable, and having both short- and long-term goals." It was further noted that treatment plans are part of the file review and counselors come into the quality assurance office or to supervisors often to have staff review plans or help with plans. The surveyor reviewed nine patient records. Of the nine records, six would have required a treatment plan. All six records contained treatment plans that included assessment findings. The surveyor also reviewed the program's internal quality assurance review documents, and there was good clinical oversight guidance provided in records. Records contained guidance on improving treatment plan goals so that objectives are included with measurable action steps. The Department finds the program is in compliance with the corrective action plan.

COMPLIANCE: Compliant

- ***641—155.21(12)c. Treatment Plans***

Treatment plans were in non-compliance because there was no documentation that patients were provided a copy of the treatment plan. Elevate's corrective action plan indicated the client will be provided a copy of the treatment plan and clients have access to their treatment plan in the medical record portal. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, no specific summary on progress was noted by the program. The surveyor reviewed nine patient records. Of the nine records, six would have required a treatment plan. The surveyor was not able to find specific documentation in the patient record that a copy of the treatment plan was provided to the patient. The program did respond that all patients have the option to enroll in the patient portal to view a copy of their treatment plan, otherwise each patient is to receive a printed copy of the plan. It was further reported to the surveyor that a checkbox was to be included in the patient record evidencing that this copy was provided to the patient but this was not found in the records. Although it is reported that patients can access their treatment plans through

the portal, the patient record did not include documentation that the patient is provided a copy through accessing this portal. The Department finds the program is in partial compliance with the corrective action plan as it is not documented in patient records that a copy of the treatment plan is provided to the patient.
COMPLIANCE: Partial Compliance

- ***641—155.21(12)d. Treatment Plans***

Treatment plans were in non-compliance because treatment plan reviews were not documented in the patient record. Elevate's corrective action plan indicated treatment plans would be reviewed and modified based on the periodic review of the assessment every 7 days for intensive outpatient and 30 days for outpatient. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program noted the treatment plan is reviewed by the counselor and client and entered into the Treatment Plan Summary section of the treatment plan. The surveyor reviewed nine patient records. Of the nine records, six would have required a treatment plan. There was evidence in all six records that treatment plan reviews were being conducted. The Department finds the program is in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(13)c. Progress Notes***

Progress notes were in non-compliance because some patient records did not contain a weekly summary of group counseling sessions, as recreational activities were documented as such. Elevate's corrective action plan indicated the progress notes would contain more information on how the group content applies to the individual goals and progress, and the content of the notes, and activities will be reviewed regularly by the Quality Assurance Therapist and Clinical Director to ensure that it is an appropriately delivered service. It was also noted that the program would modify the billing for any incorrectly billed services to accurately reflect peer support services under the CCBHC expansion grant. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, it was reported that training and meetings on documentation expectations have occurred along with file reviews for compliance. It was further noted that areas of focus for intensive outpatient and groups were given to counselors along with ideas for how to break up the 3 hours to include educational, self-reflection, having speakers, etc. The surveyor reviewed nine patient records. Of the nine records, six would have required progress notes. The surveyor's review of progress notes, showed documented group therapy counseling sessions. The surveyor found no further incidents where recreational activities were documented as group counseling sessions. The Department had also made a referral to Iowa Medicaid – Provider Integrity regarding potential submission of claims to Medicaid found from the initial inspection conducted on January 26 and 31, 2022. It has since been reported by Iowa Medicaid that a review was conducted with "no exposures" and as a result, the "referral was closed out with no further investigation." The Department finds the program is in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(14)a. Patient Record Contents***

Patient record contents were in non-compliance because some patient records did not contain screenings; assessments; releases of information or authorization to disclose, or

reports from a referring source or outside resource. Elevate's corrective action plan indicated screenings will be conducted for all patients along with assessments, authorizations to disclose, and reports from referring or outside resources. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. Elevate responded that patients receive an SBIRT or CRAFFT screening and all new patient files are given to the operations director for review to ensure all documents have been signed and consents are completed accurately. The surveyor reviewed nine patient records. All records contained appropriate screenings, assessments, releases of information, and applicable reports from referring sources. The Department finds the program to be in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(14)b. Patient Record Contents***

Patient record contents were in non-compliance because some patient records did not contain treatment plans, management of care reviews, progress notes, or discharge summaries documented within 30 days of discharge. Elevate's corrective action plan indicated the program would maintain discharge summaries for inactive patients, and discharge planning would be part of the treatment planning process. It was further noted that management of care reviews would be conducted and documented in the patient record. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. Elevate responded that quality assurance record reviews are being conducted to ensure counselors include treatment plans, management of care reviews, progress notes, and discharge summaries in patient records within the required timeframe. It was further reported that counselors now document and monitor patient appointments and document collateral notes for missed appointments. The surveyor reviewed nine patient records. Of those nine records, six would have required the patient record contents for this specific standard. All six records contained evidence of treatment plans, management of care reviews, progress notes, and discharge summaries within the required timeframes. The Department finds the program to be in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(19) Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because patient records did not demonstrate proper use of The ASAM Criteria. Elevate's corrective action plan indicated the program replaced the ASAM Checklist tool that was not divided by dimensions and implemented a standardized ASAM tool used by other agencies accessed through their electronic health record. It was also noted that two extensive trainings and a review of the tools were conducted with counselors, QA Therapist, and Clinical Director. The program noted implementation of the ASAM tool would be reviewed monthly to ensure that it reflects the client's level of care and treatment plan and follow-ups will be conducted at the weekly clinical team meeting. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. The program responded that they are now using the ASAM Transition and Update assessment for patients. The surveyor reviewed nine patient records. All nine records contained the appropriate use of The ASAM Criteria. Each record contained an assessment that documented a thorough review of the 6 ASAM dimensions and each dimension contained a severity risk rating that was consistent with the recommended levels of care. Two were untimely by a day or two. The program also provided documentation that showed training and

clinical oversight had been conducted for the appropriate use of The ASAM Criteria. The Department finds the program is in compliance with the corrective action plan.
COMPLIANCE: Compliant

- ***641—155.21(19)b. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because management-of-care activities were not documented within the time frames appropriate to the patient's ASAM level of care (every 30 days for outpatient level of care). Elevate's corrective action plan indicated the program counselor was now conducting ASAM reviews and treatment plan updates every week for intensive outpatient services and monthly for outpatient services. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. The program responded that the assessment is completed for both intensive outpatient level of care (every 7 days) and outpatient level (every 30 days). It was further noted that those who have not returned for services will have that documented in the assessment. The surveyor reviewed nine patient records. Of those nine records, six would have required management of care activities. All six records included documented continued stay reviews however most records contained at least one untimely review. Overall the surveyor found significant improvement with the program's documentation of management of care activities and continued clinical oversight would be needed to ensure the continued stay review are being conducted within the required timeframes. The Department finds the program is in partial compliance with the corrective action plan as management of care activities are now being conducted however are not always conducted within the required timeframes.
COMPLIANCE: Partial Compliance

- ***641—155.21(19)c. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because the patient record did not contain documentation the program is coordinating patient care with other programs. Elevate's corrective action plan indicated that all external program coordination would be documented in the Contact Log with the appropriate release of information on file. It was further noted that coordination across programs within Elevate would be documented in the treatment plan and progress notes with the appropriate release of information on file. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. The program responded that the counselor often identifies patients who would benefit from mental health therapy or medications and will talk to the health services director or clinical director. The program further noted that "some area of improvement needed is documenting these conversations and that with it being in the same building, sometimes it is hard to remember those things that need to be documented for continued care." The surveyor reviewed nine patient records. Of those nine records, six would have required care coordination activities. Although releases of information were in the records, there was no evidence that coordination of care activities were conducted. As a result, the Department finds the program is in non-compliance with the corrective action plan.
COMPLIANCE: Non-Compliant

- ***641—155.21(19)d. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because patient discharge planning is not started at the time of admission and does not include ongoing post-discharge patient needs. Elevate's corrective action plan indicated that the electronic

health record was modified for the discharge planning to be included in the treatment plan. . For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. The program responded that discharge planning is initiated at the start of admission. The surveyor reviewed nine patient records. Of those nine records, six would have required documented discharge planning. All six records included discharge planning documentation, which was found in patient treatment plans. The Department finds the program is in compliance with the corrective action plan.

COMPLIANCE: Compliant

- ***641—155.38(3)a. Baseline TB Screening Procedures for Facilities***

Baseline TB screening procedures for facilities were in non-compliance because staff did not receive baseline TB screening upon hire. Elevate's corrective action plan indicated any staff who has involvement with the SUD programming, will obtain a TB test at the same time as their background checks are completed which will be conducted before hire. It was also noted that the process is now included on the personnel file checklist. For the 90 day follow up, the Department requested Elevate provide a summary response addressing the program's adherence to previous items of non-compliance. For this particular item, the program reported upon issuance of an initial license, the program was unaware of the need for the TB test being conducted upon hire so "initially we were catching up with staff" that still needed to be tested. The program further noted their Outreach and Engagement Coordinator requests a TB screening of any new applicant once the background checks clears. If the applicant has not already had one in the past twelve months, arrangements are made through the program for the administering of the test. The surveyor reviewed five personnel records. The surveyor was unable to find a baseline TB screen for one employee. The surveyor followed up with the program to see if it had been completed, and the program responded they were unable to locate the TB screen for that staff member. As a result, the Department finds the program is in non-compliance with the corrective action plan.

COMPLIANCE: Non-Compliant

Attached to this report is Elevate's program response to the areas that were found to be in non-compliance for the 90 day follow up inspection. In this response, it is noted that several of the corrective action plan measures were not able to be implemented within the 90-day required time frame due to staffing changes and the onboarding of a new electronic health record platform.

RECOMMENDATIONS:

The Department determined, of the 20 areas of noncompliance, the program demonstrated the following compliance at the 90 day follow up inspection:

- ***15 of 20 licensure standards are now in compliance.***
- ***3 of 20 licensure standards are now in partial compliance.***
- *2* ***of 20 licensure standards remain in non-compliance.***

As the Department finds Elevate to be in compliance/partial compliance with 18 of the 20 corrective action plan measures, the Department recommends the Committee not proceed with the denial and recommends a one-year license be issued with effective dates from November 7, 2021 to November 7, 2022, contingent upon the program's adherence with the following:

- Submission of a corrective action plan addressing the two areas of non-compliance and three areas of partial compliance within 30 days of the Committee's approval of the

recommendations.

- Following submission of the corrective action plan, the Department will review to determine if the plan is acceptable. Once the plan is approved by the Department, Elevate will have 60 days to show compliance with the plan. The Department may inspect the license to review the implement corrective measures and report back the findings to the Committee.
- Upon receipt of the next re-application materials, the Department shall inspect the program to verify application information and determine compliance with all law, rules, and regulations.

Failure to adhere with any of the above recommendations will be grounds for denial of a license pursuant to rule 641–155.10(1)(d)(16) and will result in the Committee reconvening to determine to deny, suspend, or revoke the program's license pursuant to rule 641–155.11(3). If the Committee determines, at that time, to deny, suspend, or revoke the program's license, the program shall be given written notice by restricted certified mail and may request a contested case hearing on the determination.

Summary of Corrective Action -JOV

Please find the following summary for each area of non-compliance from the JOV and how our corrective action plan and steps have brought the areas into compliance.

1. **155.21 (8) Personnel**
   The confidentiality acknowledgement and agreement form has now been added to the Employee handbook which is reviewed at start of hire and collected on 1st date of employment. It was also added to the personnel file checklist which is reviewed on the first date of employment and signed by staff and the HR department.

2. **155.21 (10) Patient Records**

   We currently have set assessments for all clients entering or being evaluated for the substance use disorder program. They will all have the substance use screen and a social history completed upon intake. Anyone conducting the intake can do the substance use screen except for the ASAM Section, which will be completed by the counselor at the first assessment. This information is also on a uniform intake checklist that is used for all intakes. The client will be entered as an active referral until they see the counselor for the evaluation.

   We did not have ROIs for clients in the SUD program who also were receiving services with other areas of Elevate. We ran a list of clients who were in additional programs and had them completed. This is now specified on the intake checklist in the ROI section, that if they are enrolling in SUD and another program, this ROI must be completed. This area is also checked during the random file reviews by the clinical director and QA team.

3. **155.21 (11) Assessment and Admission**
   We have finally gotten to a point where the assessment and admission process for services is more identified, streamlined and set for what is needed. Each client for walk in services is given the CRAFFT and SBIRT, which is scanned and uploaded into the chart. For those clients identifying they are here for substance use issues, will have the social history and the substance use screen completed in the chart. This substance use screen captures information on use of a variety of substances, including alcohol, and has the ASAM in that screening tool. The substance use screen also has the SNAPS included which helps drive the treatment plan as well. All clients are entered in as an active referral until they are seen by the counselor and at that time they are put in as an active patient. When they have their initial evaluation with the counselor, an assessment session note is completed where recommendations are noted, however still working on getting the counselor to provide an overall assessment of findings and recommendations or noting that it was reviewed with patient and their response.

   For the required updates, we now use the ASAM transition and update assessment, where the counselor can provide any changes and continued recommendations for treatment.

This is in the electronic record as well. IOP is updated every week and Outpatient is updated monthly.

We enhanced the consent to treat and now give clients the Scope of Services for Intensive outpatient and outpatient treatment. This document notes the hours of services, days and times, fees, criteria for entry and discharge. This is given to them after their first meeting with the counselor, signed and uploaded into EHR.

4. **155.21 (21) Treatment Plans**
   The current substance use screen has the SNAPs section which helps provide information for guiding the treatment plan. Treatment plans for IOP clients are completed within the first 7 days and again updated every 7 days. Clients enrolling in outpatient, have a treatment plan completed in 30 days and updated again in 30 days. This is reviewed by counselor and client and entered the Treatment Plan Summary section of the Tx Plan. The clients will also sign or give verbal consent once the plan has been reviewed with them, that they agree with the goals.

   Areas we find that still need improvement are making sure objectives, interventions are measurable, having clients sign off on plan while in session, having both short- and long-term goals. Treatment plans are part of the file review. Counselor comes into QA office or to his supervisor often to have them review plans or help him with a plan.

5. **155.21 (13) Progress Notes**
   Trainings and meetings on documentation expectations have occurred along with file reviews for compliance. Areas of focus for IOP and groups was given to counselor and ideas for how to break up each of the 3 hours such as educational, self-reflection, having speakers etc. Monthly file reviews are conducted for notes. While the recreational activities have been addressed for being group activities, the content or amount of content for group notes still needs some improvement. Each Monday they review the weekend, and at the end of the week the do review the overall week, goals for the weekend, its just not identified as a weekly summary.

6. **155.21 (14) Patient Record Contents**
   With implementing the open access, client intake checklist and streamlined assessments for clients coming in for substance use treatment, all clients have the SBIRT or CRAFFT, all clients have a social history and if they are being evaluated for the SUD program, will have the substance use screening. All new client files are given to the operations director, Nicole Russell, for review to ensure all documents have been signed and ROI's are completed accurately.

   QA file reviews are completed by the clinical director as well as director of operations. Director of operations will run reports for those without assessments, treatment plans, late notes etc. Counselor documents and monitors patient appointments and will document if

they have not attended groups in the treatment plan summary or in a collateral contact note if they are in jail, etc and note when the discharge will be completed. The counselor has been doing 60 days for discharge as we have had clients come back shortly after the 30 days, and most clients if they do relapse or find themselves arrested, do reach back out. Potential discharges are discussed at clinical meetings as well.

7. **155.21 (19) Management of Care and Discharge Planning**
   We now use the ASAM Transition and Update assessment for clients in the substance use programming for management of care and discharge planning. Discharge planning still begins at the time of admission, so they can identify what they need to work on in order to have a successful discharge, but the ASAM transition and update reviews all the dimensions and then a rating to go with it. These ratings of severity and progress or lack of progress documented in that assessment is what the counselor uses to provide recommendations for continued treatment or discharge.

   This assessment is completed for both IOP level of care (every 7 days) and outpatient level (every 30 days). Those who have not returned for group or sessions will have that documented in the assessment.

   Counselor has been having clients identify goals or areas of focus in the assessment session. Counselor often identifies those who would benefit from mental health therapy or medications and will talk to the health services director or clinical director. One area of improvement needed is documenting these conversations. With it being in the same building, sometimes it is hard to remember those things need to be documented for continued care even though we are in the same building/office/agency.

8. **155.38 (3) Baseline TB Screening Procedures**
   When we began at Elevate, we were unaware of the need of the TB test being upon hire, so initially we were catching up with staff who had been employed and needing the screen for the program. We have now implemented that when our Outreach and Engagement Coordinator sends confirms that the background check for an applicant is clear, we ask the applicant to send results of a recent TB screen (within the year) or have them set up a time to come into the clinic and have it administered by our RN. This is also captured on our personnel file checklist which is reviewed upon first day of employment.

   Technical Assistance areas
   Some areas in the technical assistance given have been addressed in the above areas (confidentiality agreements, ROI's needed for clients in other programming within Elevate, uniform assessments, unform patient records, sufficient information in assessments, updates for treatment plans, assessments, group note documentation information, discharge information, TB risk assessment).

One area of technical assistance given (although not area of non-compliance) is regarding assessments for those following and OWI arrest. Elevate is not licensed for the OWI classes, and therefore anyone who comes in for OWI assessment or treatment is referred to Pathways for that component.

Another area for technical assistance given, although not an area of noncompliance was regarding the annual TB Risk assessment form. We were given the IDPH form with instructions for the annual submission of TB Risk.

Technical assistance was provided to us regarding the limited availability of residential beds for clients who are recommended for inpatient treatment. It was shared that we can notify department staff if needed and were given a list of statewide programs. To date, those that have been referred to residential or recommended for such services, have been able to get a bed. Our counselor has been able to get clients into facilities in Mason City, Dubuque and Decorah.

Areas in need of continued improvement

Areas that have been identified through QA file reviews are focused around documentation content and ensuring that communication and collaboration is documented in the contact log. We constantly review notes and plans to ensure content is appropriate and related to the goals, demonstrates why clients are here, how they were helped, how they responded and a plan to move forward. Treatment plans continue to be an area to always improve on to ensure we are capturing the best way the client can learn the skills to make progress and really meet them at their current level of care to best serve them with the resources and skills we can provide. We have a routine QA system now and continue to work with the counselor on ways to better arrange group content, sessions, scheduling, and review caseloads.