IOWA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF BEHAVIORAL HEALTH

90 DAY FOLLOW UP INSPECTION TO DENIAL

PROGRAM:	*Palo Alto County Health System* 3201 1st Street Emmetsburg, Iowa 50536
LICENSED SERVICES:	This program provides Adult and Juvenile Levels 1 and 2.1 Substance Use Disorder Treatment Services
DEPARTMENT SURVEYORS:	Lori Hancock-Muck and Amanda McCurley, Division of Behavioral Health
INITIAL NOTICE OF DENIAL FROM COMMITTEE:	September 8, 2021
CORRECTIVE ACTION APPROVAL:	October 4, 2021
90 DAY FOLLOW UP INSPECTION REPORT:	March 24, 2022

SUMMARY OF FOLLOW UP INSPECTION FINDINGS:
Corrective Action Plan Compliance Summary:

OVERALL COMPLIANCE –

- ***5 of 17 licensure standards are now in compliance.***
- ***9 of 17 licensure standards are now in partial compliance.***
- ***3 of 17 licensure standards remain in non-compliance.***
- ***1 additional licensure standard was found to be in non-compliance from the 90 day follow up inspection.***

Compliance:

1. ***641—155.21(8)d. Personnel***
2. ***641—155.21(11)b. Assessment and Admission***
3. ***641—155.21(11)e. Assessment and Admission***
4. ***641—155.21(12)b. Treatment Plans***

5. ***641—155.21(12)d. Treatment Plans***

Partial Compliance:

1. ***641-—155.21(5)c. Staff Development and Training***
2. ***641—155.21(6) Data Reporting***
3. ***641—155.21(11)a. Assessment and Admission***
4. ***641—155.21(11)d. Assessment and Admission***
5. ***641—155.21(12)c. Treatment Plans***
6. ***641—155.21(14)a. Patient Record Contents***
7. ***641—155.21(14)b. Patient Record Contents***
8. ***641—155.21(19) Management of Care and Discharge Planning***
9. ***641—155.21(19)b. Management of Care and Discharge Planning***

Non Compliance:

1. ***641—155.21(10)f. Patient Records***
2. ***641—155.21(11)c. Assessment and Admission***
3. ***641—155.21(19)d. Management of Care and Discharge Planning***

New Areas of Non Compliance:

1. ***641—155.21(12) Treatment Plans***

SUMMARY OF DENIAL:

On June 2, 2021, Department surveyors conducted a virtual licensure inspection of Palo Alto County Health System (Palo Alto). As a result, it was determined Palo Alto 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 57.7% score in the Clinical Standards section.

On September 8, 2021, the Substance Abuse/Problem Gambling Program Licensure Committee (Committee) proposed to deny Palo Alto'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), Palo Alto submitted a written corrective action plan addressing the 17 areas of non-compliance. The corrective action was approved by the Department on October 4, 2021. Pursuant to IAC 641—155.11(2)a., Palo Alto had 90 days to show compliance with the plan. From October 4, 2021 to January 2, 2022, Palo Alto was to demonstrate compliance with the following rules:

- ***641—155.21(5)c. Staff Development and Training***

  Staff development and training was in non-compliance because there was no documentation staff completed orientation with the required elements.
- ***641—155.21(6) Data Reporting***

  Data reporting was in non-compliance because no data has been reported to the division in accordance with department requirements and processes.

- ***641—155.21(8)d. Personnel***

Personnel was in non-compliance because not all personnel records contained verification of experience, qualifications, and professional credentials.

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

Patient records was 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 there was no evidence that assessments were updated within the period of time specific for each level of care.

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

Assessment and admission was in non-compliance because the patient record did not show evidence that the results of the assessment had been explained to the patient.

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

Assessment and admission was in non-compliance because the patient record did not contain documentation that the patient had been informed of the costs to be borne by the patient or confidentiality laws, rules and regulations.

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

Treatment plans was in non-compliance because the treatment plan did not include a summary of assessment findings; patient short-term goals; or the type and frequency of planned treatment activities.

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

Treatment plans was in non-compliance because there was no evidence that the patient was provided a copy of the treatment plan.

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

Treatment plans was in non-compliance because treatment plans reviews were not documented in the patient record.

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

Patient record contents was in non-compliance because 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 was in non-compliance because patient records did not contain management of care reviews (ASAM reviews).

- ***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 of outpatient level of care).

- ***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.

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 January 10, 2022, the surveyor contacted Palo Alto's Executive Director, Jared Ball, to request documents to determine compliance with the corrective action plan. The following is a summary of current adherence for each of the 17 licensure standards that were found to be in non-compliance from the June 2, 2021 inspection:

- ***641-155.21(5)c. Staff Development and Training***

Staff development and training was in non-compliance because there was no documentation staff completed orientation with the required elements.

Palo Alto's corrective action plan noted program staff would complete required orientation with all the required elements. For the 90 day follow up, the surveyor reviewed five personnel records. A new orientation checklist had been developed yet community resources and HIV/Blood Borne Pathogens were not included on the checklist. The program was unable to provide a response as to why these items were not included on the checklist. The Department provided additional technical assistance for these missing elements and Palo Alto has since added community resources on their orientation checklist and has distributed resources to all program staff. Palo Alto was given technical assistance to make sure each required element of orientation is clearly stated on their orientation checklist. The Department finds the program to be in partial compliance with the corrective action plan as the program did not include all required elements in the staff orientation during the 90 day time frame.

COMPLIANCE: Partial Compliance

- ***641-155.21(6) Data Reporting***

Data reporting was in non-compliance because no data has been reported to the division in accordance with department requirements and processes.

Palo Alto's corrective action plan noted the program would continue communications with the Department to receive proper instructions for data reporting. For the 90 day follow up, the program reported a new employee was working to complete certification with the state data reporting system (IBHRS) to begin submitting required data. The surveyor confirmed that Palo Alto staff did have communications with Department staff in December 2020 and again in January 2021 regarding data reporting processes. The surveyor reviewed Palo Alto's data integrity reporting, and it was determined that the program had yet to become certified to report

data, and no data had been reported since July 1, 2021. The surveyor requested a detailed plan/timeline for reporting the data. The program responded that IBHRS has been difficult to navigate and the employee responsible for data reporting was new to the position. The program reported they had received Department approval to begin reporting the data in IBHRS on February 10, 2022 and would be reporting data by the end of February 2022. A follow up response from the program on March 3, 2022, reported the program had reported data on two patients with the goal of gathering additional patient information to enter into the system. The Department finds the program to be in partial compliance with the corrective action plan as some, but not all data, has been reported in the state data reporting system.
COMPLIANCE: Partial Compliance

- ***641-155.21(8)d. Personnel***

Personnel was in non-compliance because not all personnel records contained verification of experience, qualifications, and professional credentials.
Palo Alto's corrective action plan noted updated staff licenses and credentials would be maintained in applicable staff personnel records. For the 90 day follow up, the program reported their human resource department maintains professional credentials in their electronic system. The surveyor reviewed five personnel records where two would have required verification of professional credentials. Both personnel records contained up to date professional credentials. 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 was in non-compliance because releases of information were not in accordance with 42 CFR Part 2.
Palo Alto's corrective action plan noted the program would utilize Department approved releases of information that are compliant with 42 CFR Part 2. It was further noted that staff would receive training on understanding the difference between HIPAA and 42 CFR Part 2. For the 90 day follow up, the surveyor requested verification of training as the program did not include that information with the initially requested documents. A response from the program noted, Jared Ball, Behavioral Health Director provided an in person "Supervision Meeting" focusing on 42 CFR Part 2 on February 9, 2022. A link to the YouTube training video was provided along with a sign in sheet showing staff attendance of this training. It should be noted that the training was provided outside the 90 day implementation time frame, following the surveyors request for verification of the training. The surveyor also reviewed four patient records to determine adherence with 42 CFR Part 2. One of the four records did not contain a disclosure consent to the insurance company. In at least one record, an additional patient consent would have been required as the record contained documentation that patient information was disclosed to court. The surveyor also found the consent form was not uniform in records as one patient record contained different disclosure consent formats. One of the consent forms was not in compliance with 42 CFR Part 2 as specific substance use disorder information was not included on the consent. In another record, the surveyor found a release

of information to "MA". It was not clear in this record who or what that entity was. The surveyor provided the program an opportunity to respond to the deficiencies found with the patient record review and the program responded that the hospital utilizes multiple releases depending on the disclosures. The program also confirmed that the record that would have required a disclosure consent to the court did not include the consent. The program also noted that the consent, which included "MA" as an entity for information to be disclosed to, was an acronym for "medical assistance". 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 is not in compliance with the corrective action plan as patient records did not contain releases of information to be in compliance with 42 CFR Part 2, and the required training was not provided to staff within the required 90 day implementation time frame.

COMPLIANCE: Non 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.

Palo Alto's corrective action plan noted they would be transitioning to a hospital electronic health record (EHR). It was noted that this would include assessment and admission documents that would support the development of a treatment plan and would adequately assess and admit according to requirements. For the 90 day follow up, the surveyor reviewed four patient records. All but one record contained a thorough assessment that was organized in a manner that supported development of a treatment plan. The surveyor was unable to find a documented substance use disorder assessment in one record. The record contained a summary letter addressed to "To Whom It May Concern" that appeared to summarize the assessment results, but a documented assessment was not found in the submitted record. As a result, the Department finds the program is in partial compliance with the corrective action plan.

COMPLIANCE: Partial Compliance

- ***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.

Palo Alto's corrective action plan noted a uniform assessment process would be implemented with sufficient information to be collected at each visit. For the 90 day follow up, the surveyor reviewed four patient records. One of the patient records did not include a documented assessment. For the three records that contained assessments, there was a thoroughly documented review of each of the six ASAM dimensions that supported the recommended levels of care. All three records contained a thorough drug use history to include amounts, pattern of use, last use and an assessment of all substances. Although one record did not contain an assessment, the other three assessments were uniform in the information being gathered for

the assessment and therefore 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 there was no evidence that assessments were updated within the period of time specific for each level of care.
Palo Alto's corrective action plan noted a process was being developed to review the assessment every seven days and to make necessary changes. For the 90 day follow up, the program indicated they had incorporated a "reminder" pop up in the record to support the continued patient assessment for on-going treatment. The surveyor reviewed three patient records that contained assessments and found the assessments were not updated within the required time frame for the specified level of care (every 7 days for intensive outpatient and every 30 days for outpatient). The Department finds the program is in non-compliance with the corrective action plan.
COMPLIANCE: Non Compliant

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

Assessment and admission was in non-compliance because the patient record did not show evidence that the results of the assessment had been explained to the patient.
Palo Alto's corrective action plan noted a checklist would be completed weekly to ensure the results of the assessment were discussed with each patient. For the 90 day follow up, the program provided a sample progress note to the Department that would show evidence that the results of the evaluation were explained to the patient. The surveyor reviewed four patient records to find evidence of this compliance however the surveyor was unable to find a note in any of the records documenting that the results of the evaluations were explained to the patients. The surveyor followed up with the program to request the specific progress note for each of the four records that contained evidence of this. The program was able to send additional progress notes that showed two of the four records contained evidence that the results of the assessment had been explained to the patients. The program responded that the other two records did not contain documentation due to the following reasons: "Statement is not in the progress note as the ASAM was completed by (patient's) primary counselor, who states that (patient) signature on the Full ASAM Assessment document indicates the results were explained, and client agrees" and "statement is not in the progress note as the ASAM was completed by (patient's) primary counselor with a referral to residential treatment. IOP was to be attended until (patient) could get to residential treatment." The Department finds the program is in partial compliance with the corrective action plan as two of the four records did not contain evidence 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 the patient record did not contain documentation that the patient had been informed of the costs to be borne by the patient or confidentiality laws, rules and regulations.

Palo Alto's corrective action plan noted new patient paperwork would be developed which would include costs, confidentiality laws, rules and regulations. For the 90 day follow up, the surveyor reviewed four patient records. All four records contained newly developed intake forms that included costs of services and information on confidentiality laws, rules, and regulations. The Department finds the program is in compliance with the corrective action plan.

COMPLIANCE: Compliant

It should be noted that during the review of the intake form, the surveyor found a reference instructing patients to report suspected abuse to either "DCF Substance Abuse & Mental Health office" or "Disability Rights". The phone numbers associated with these contact numbers were for state departments located in Florida. The form should be updated to reference the state of Iowa departments.

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

Treatment plans was in non-compliance because the treatment plan did not include a summary of assessment findings; patient short-term goals; or the type and frequency of planned treatment activities.

Palo Alto's corrective action plan noted the program would be transitioning to a hospital EHR. The EHR's treatment plan would include a summary of assessment findings, short-term goals; and the type and frequency of planned treatment activities. For the 90 day follow up, the surveyor reviewed four patient records. Of the four patient records, two treatment plans were documented in the records. The surveyor followed up with the program to request whether treatment plans were developed for the other two patients. The program submitted the two missing treatment plans. A review of the plans showed that although the treatment plans now contained the required elements, plans were not individualized. Each treatment plan contained the same summary of assessment finding, goals, objectives, and interventions. The program provided a response noting that "Participants in intensive outpatient services engage with the same evidence based program. Thus, goals and interventions are similar." The surveyor provided technical assistance to the program in regards to the requirement for developing individualized treatment goals based on assessed needs for each patient. Although the Department finds the program is in compliance with including all the elements required of a treatment plan, the treatment plans are not individualized and would not be in compliance with 641—155.21(12).

COMPLIANCE: Compliant with 641-155.21(12)b

Non compliant with 641-155-21(12) The policies and procedures for substance use disorder treatment programs, problem gambling treatment programs, and substance use disorder and problem gambling programs shall describe the programs uniform process for developing individualized treatment plans based on ongoing assessment and documentation of such plans in the patient record.

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

Treatment plans was in non-compliance because there was no evidence that the patient was provided a copy of the treatment plan.

Palo Alto's corrective action plan noted a patient signed copy of the treatment would be provided to the patient. For the 90 day follow up, the surveyor reviewed four patient records. The program provided the surveyor with a treatment plan template that included a statement that a copy of the treatment plan would be provided to the patient. None of the treatment plans included the statement from the template indicating the patient was provided a copy of the treatment plan. Two of the records did include a progress note documenting that the patient was provided a copy of the treatment plan. There was no evidence found in the other patient records that the patient was provided a copy of the treatment plan. As the surveyor found documentation noting two of the four patients were provided with a copy of the treatment plan, the Department finds the program is in partial compliance with the corrective action plan.

COMPLIANCE: Partial Compliance

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

Treatment plans was in non-compliance because treatment plans reviews were not documented in the patient record.

Palo Alto's corrective action plan indicated a process was being developed to ensure treatment plan reviews were to be documented in the patient record. For the 90 day follow up, the program reported a new "module" was started in December 2021 where the EHR populates an automatic reminder for staff to conduct a treatment plan review. The surveyor reviewed four patient records. The surveyor did not find treatment plan reviews documented in progress notes and requested the provider provide additional directions to where this could be located in the submitted records. The provider sent the surveyor additional documents which contained evidence of treatment plan reviews. As there was evidence that treatment plan reviews were documented in the progress notes, the Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

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

Patient record contents was in non-compliance because patient records did not contain screenings; assessments; releases of information or authorization to disclose; or reports from a referring source or outside resource.

Palo Alto's corrective action plan indicated the new EHR module would contain screenings, and new admission packets would contain necessary consents to facilitate referrals to and from outside agencies. For the 90 day follow up, the surveyor reviewed four patient records. All records contained screenings, releases of information and applicable reports from referring or outside resources. The surveyor was unable to find an assessment in one patient record. As a

result, the Department finds the program is in partial compliance with the corrective action plan.
COMPLIANCE: Partial Compliance

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

Patient record contents was in non-compliance because patient records did not contain management of care reviews (ASAM reviews).
Palo Alto's corrective action plan indicated a checklist would be developed and would be completed weekly containing line items to review the ASAM criteria once a week. For the 90 day follow up, the surveyor reviewed four patient records. The surveyor asked the program to specifically submit all documented ASAM reviews from the records as it was difficult for the surveyor to identify where these were located in records. The program was able to provide some, but not all required ASAM reviews. As the program has started to document ASAM reviews but is not documenting ASAM reviews within the required timeframes, the Department finds the program is in partial compliance with the corrective action plan.
COMPLIANCE: Partial Compliance

- ***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.
Palo Alto's corrective action plan indicated staff would receive additional training on The ASAM Criteria and how to use the ASAM forms by December 28, 2021. For the 90 day follow up, the surveyor asked for training verification for the training. The program responded that Jared Ball provided training to counselors on February 16, 2022 and "he utilized the SAMHSA website". The surveyor asked for the specific training and the program provided the surveyor with two links; a link to an ASAM pamphlet designed for patients and their families and a link to an ASAM web page titled "About the ASAM Criteria." In addition, the program sent a training sign in sheet that noted "Training for ASAM Criteria and Dimesons [sic} were covered in group and individual supervision on the following dates. January 27, 2021, February 10, 2021, March 3, 2021, June 16, 2021 and February 2, 2022." It should be noted that training was conducted during supervision and not provided during the 90 day implementation time frame. The surveyor also did not find evidence that staff received the reported February 16, 2022 training. As a result, the Department finds the program to be in partial compliance with the corrective action plan.
COMPLIANCE: Partial Compliance

- ***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 of outpatient level of care).
Palo Alto's corrective action plan indicated an ASAM form would be created and documented weekly, and that the patient's level of care would be assessed at admission, continued stay and discharge. It was further noted that staff would receive additional training on ASAM criteria

and how to use the form. For the 90 day follow up, the surveyor did not find that staff received training on how to use the created ASAM form. The surveyor reviewed four patient records. Two records would have required an ASAM review to be documented every seven days as the patients were admitted to intensive outpatient services. Although both records did have an ASAM review documented in progress notes, the ASAM was not documented every seven days as required. The additional two records would have required an ASAM review to be documented every 30 days as the patients were admitted to outpatient services. Although both records contained ASAM reviews, the reviews were not always documented every 30 days. None of the records contained an ASAM review at the time of discharge. As the program has started documenting ASAM reviews but not within the required timeframes, and there was no evidence of staff receiving training on how to use the ASAM form, the Department finds the program to be in partial compliance with the corrective action plan.
COMPLIANCE: Partial Compliance

- ***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.
Palo Alto's corrective action plan indicated the new EHR module would include treatment plans that would have discharge planning capabilities. For the 90 day follow up, the surveyor reviewed four patient records. The surveyor was unable to find discharge planning documented on the treatment plan or anywhere else in the patient record. The surveyor also was unable to find a discharge summary documented for the two patients that had been discharged. 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 Palo Alto'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 17 areas of noncompliance, the program demonstrated the following compliance at the 90 day follow up inspection:

- ***5 of 17 licensure standards are now in compliance.***
- ***9 of 17 licensure standards are now in partial compliance.***
- ***3 of 17 licensure standards remain in non-compliance.***
- ***1 additional licensure standard was found to be in non-compliance from the 90 day follow up inspection.***

As the Department finds Palo Alto to be in compliance/partial compliance with 14 of the 17 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 July 1, 2021 to July 1, 2022, contingent upon the program's adherence with the following:

- Submission of a corrective action plan addressing all current findings of non-compliance (4) and partial compliance (9) within 30 days of the Committee's approval of the recommendations.
- Following submission, the Department will review the corrective action plan to determine if the plan is acceptable. Once the plan is approved by the Department, Palo Alto 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.