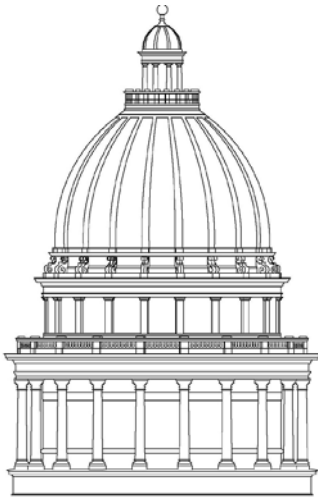
REPORT TO THE

UTAH LEGISLATURE

Number 2019-02



A Performance Audit of the University Neuropsychiatric Institute and Crisis Services

April 17, 2019

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH

Office of the Legislative Auditor General

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KADE R. MINCHEY, CIA, CFE
AUDITOR GENERAL

April 17, 2019

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of the University Neuropsychiatric Institute and Crisis Services** (Report #2019-02). A digest is found on the blue pages located at the front of the report. The audit scope and objectives are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE
Auditor General

Digest of
A Performance Audit of the University Neuropsychiatric Institute and Crisis Services

The University of Utah Neuropsychiatric Institute (UNI) offers mental and behavioral health services and patient-centered care to treat all aspects of the individual essential to achieving balance in mental health. UNI is part of an integrated healthcare system under the University of Utah Hospitals and Clinics (UUHC). UNI's finances are tracked, reported, and subject to an annual financial audit by UUHC. UNI has expanded crisis services over the past several years through state and local contracts. This audit addresses aspects of UNI's finances, the growth in crisis services, patient assessments, discharge planning, and quality assurance.

Chapter II
Responding to the Growing Demand for Crisis Services Is Challenging for UNI

UNI's Crisis Services Are Reliant on Multi-Agency Support. Crisis services provided by UNI rely on multiple funding streams for financial support. Six different funding sources covered 94 percent of the $20.6 million operational expenditure total for crisis services over the last three fiscal years (2016 – 2018). The remaining 6 percent of the $1.16 million crisis services operational expenditure total was covered collectively by UNI and UUHC. Although UUHC has invested significantly in crisis services, future funding concerns remain. UNI projects a $3.6 million deficit in fiscal year 2020. The projected loss pertains to the growth of the SafeUT app, Crisis Line (National Suicide Prevention Lifeline, Salt Lake County Crisis Line), Warm Line, Mobile Crisis Outreach Teams (MCOTs), and the Receiving Center.

Growth Contributes to Staffing Issues for Crisis Center Services. Workload for UNI's Crisis Center services (MCOT, SafeUT text line, Crisis Line, Warm Line) is increasing and will continue to increase significantly in the future. During 2016-2018, Crisis Center services have experienced the following increases in workload:

1. Crisis Line – 29 percent increase
2. MCOT – 26 percent increase
3. SafeUT – 1,081 percent increase
4. Warm Line – 54 percent increase

Expanding crisis services could affect UNI's Crisis Center's ability to adequately staff those services and have clinical social workers provide prompt and compassionate crisis service.

The Crisis Center has begun taking steps to mitigate the effects of rapid growth. UNI's Crisis Center should continue pursuing innovative practices for managing the effects of growth.

UNI and Mental Health Partners Are Addressing Growth. UNI has been working with a workforce management consultant to gather call data to help make staffing decisions. Management now requires staff to take work breaks and has hired additional staff to meet the demand for crisis services. UNI also collaborates with other crisis service providers. This appears to be an appropriate way to accommodate expanding services by sharing financial and operational responsibilities amongst multiple entities.

Chapter III
Most Patients Are Assessed Correctly but Documentation Can Improve

Most Medicaid and Uninsured Patients Are Assessed and Referred Appropriately. We were asked to determine if UNI assesses patients appropriately due to concerns that uninsured and Optum Medicaid members were not hospitalized when needed. Our review did not validate these concerns. We reviewed a statistical sample from two years of assessment data and found 90 percent of the time (in 142 out of 158 cases), UNI staff assessed the patient's need for treatment correctly.

Documentation of Assessments Can Improve. Documentation of client assessments conducted in the Clinical Assessment Center (CAC) should support the social worker's recommendation to admit a patient or refer them to the appropriate lower level of care. We reviewed the documentation for 184 assessments with the help of a consultant. The review found that 61 (33 percent) of the assessments had at least one documentation problem. Seven assessments did not have enough information to evaluate the outcome. Other assessments had enough information to evaluate the outcome, but were still lacking important documentation elements, such as a diagnosis or evidence of a safety plan.

Chapter IV
Discharge Planning Is Consistent but After-Care Options Are Limited

Review Shows Consistency in Referrals for Continued Treatment After Discharge. We reviewed one year of hospitalization data to examine concerns about discharge referrals after inpatient stays. Specifically, the concerns were that UNI directs patients referred by residential treatment centers to alternative residential treatment centers and that patients referred by other sources are inappropriately directed to two specific

centers over all others. Despite the concerns, our review of data for fiscal year 2018 found 96 percent (226 of 236) of patients referred by a residential treatment center for medical detox returned to their referring facility as expected after discharging from the UNI. Second, we found no evidence that UNI staff direct patients to certain facilities over others.

Appropriate Treatment Options in the Community Are Not Always Available. After hospitalization for detox or mental health, patients usually need to continue treatment at a lower level of care to support their recovery. Patients who were suicidal prior to admission are at particularly high risk after leaving inpatient care, which can be mitigated by appropriate ongoing treatment. Despite the robust discharge planning process, UNI has the opportunity to improve by implementing new guidelines from Utah's Division of Substance Abuse and Mental Health (DSAMH). However, cost, location of services, and Medicaid rules are barriers that prevent patients from connecting to appropriate treatment.

Chapter V
Quality Assurance for UNI's Crisis Line and Clinical Assessments Can Be Enhanced

Quality Assurance Process at the Crisis Center Can Be Strengthened. Organizations offering crisis intervention are responsible for making sure that trained crisis workers continue to practice effective crisis intervention techniques and for ensuring the integrity of their operations. The Crisis Center recently began a formalized process for measuring the quality of its services. The Crisis Center is currently meeting most of its quality assurance targets. However, we found that UNI can strengthen the quality assurance process for its Crisis Line service by implementing additional procedures that are present in other crisis call centers' quality assurance programs:

- Utilizing independent reviewers
- Adjusting the sampling methodology to consistently review all crisis workers
- Gathering caller feedback
- Conducting call monitoring

These practices will help to continuously improve and refine operations as the center continues to improve and refine operations.

CAC's Internal Document Review Should Be More Formalized. The CAC conducts two types of audits: a monthly chart audit and a quarterly internal document review. We believe the internal document review needs additional procedures and a more formalized process, similar to the current chart review process. The CAC should track the results of the document review and add an outcome measure. The CAC's document review should also include an independent reviewer who is not involved in assessment decisions.

REPORT TO THE
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Report No. 2019-02

A Performance Audit of the University Neuropsychiatric Institute and Crisis Services

April 17, 2019

Audit Performed By:

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Chapter I
Introduction

The University of Utah Neuropsychiatric Institute (UNI) offers mental and behavioral health services and patient-centered care to treat all aspects of the individual essential to achieving balance in mental health. Mental and behavioral health services at UNI target adults, youth, and children. UNI is part of an integrated healthcare system under the University of Utah Hospitals and Clinics (UUHC). UNI's finances are tracked and reported centrally by UUHC. UNI has expanded crisis services over the past several years through state and local contracts. This audit addresses aspects of UNI's finances, the growth in crisis services, patient assessments, discharge planning, and quality assurance.

UNI Provides a Continuum of Mental Health Services for Adults, Youth, and Children

UNI is a 162-bed, full-service, psychiatric hospital that is generally at, or over, capacity. UNI provides inpatient, partial hospitalization, intensive outpatient, and outpatient services for children, adolescents, and adults. UNI has nine inpatient programs and one intensive outpatient program, as well as specialty clinics, two partial hospitalization/day treatment programs, and outpatient services.

UNI is a 162-bed, psychiatric hospital that provides mental and behavioral health inpatient and outpatient services.

In 2012, UNI began providing crisis services for Salt Lake County. UNI defines a crisis as "a time of intense difficulty, trouble, or even danger when someone is unable to use effective coping and problem-solving skills." UNI's crisis services include the Salt Lake County Crisis Line, Mobile Crisis Outreach Teams (MCOTs), the SafeUT smart phone application, a Receiving Center, and the National Suicide Prevention Lifeline (Lifeline). Crisis services have evolved over time to meet increasing demands.

UNI also provides crisis services including crisis lines, outreach teams, a Receiving Center, and the SafeUT smart phone application.

UNI Is Financially Supported by the University of Utah Hospitals and Clinics

UUHC is a single healthcare service delivery enterprise with several hospitals, clinics, and services that operate as large and small

business units. Because UNI is a business unit within UUHC, the centralized financial system has helped UNI cover costs. UNI's costs for shared centralized services such as information technology (IT), human resources (HR), and other financial services have exceeded UNI's ability to pay by $22.3 million over the last three fiscal years (2016-18).[1] UUHC absorbed the $22.3 million loss centrally through the consolidation of all its other business units. In addition to covering the $22.3 million loss, UUHC covers the debt service costs of two bonds issued in 2009 used to fund a 72-bed expansion of UNI's facility.

UUHC Uses a Centralized Financial System

UNI is part of an integrated healthcare system under University of Utah Hospital and Clinics (UUHC).

UNI is part of an integrated healthcare system under UUHC. For management purposes, the entity has been divided into six business units; however, UUHC centrally manages finances for all its business units. Additionally, all expenses for UUHC and its six business units are paid from one centralized cash account. Figure 1.1 shows UUHC's six business units, including UNI.

All expenses for UUHC and its six business units are paid from one centralized cash account.

Figure 1.1 UUHC Has Six Business Units for Management Purposes. As one of the six business units, UNI's operating costs totaled $99.3 million for fiscal year 2018.

Source: UNI

Centralized financial targets are collectively set for each of UUHC's six business units, and individual business units are expected

[1] As crisis services have consistently expanded, including the recent addition of the SafeUT smartphone application, financial data for the last three fiscal years was collected and used to best capture the expansion.

to manage operations in a way that meets the centralized financial targets.

Because of centralization, financial practices tend to be a collaborative process between central administrative staff and individual business units. The structure of a centralized financial system allows for some financial flexibility. For example, if a business unit is not able to meet centralized budget expectations or other financial targets, the loss is absorbed centrally by the system (UUHC). Systematic business adjustments and management decisions are made at the central level to compensate for these losses. Administrative staff at UUHC refer to the mental and behavioral health services provided by UNI as an investment in the community.

Because of centralization, financial practices tend to be a collaborative process between central administrative staff and the business units.

Furthermore, UUHC makes the principal payments on a revenue bond that was issued in 2009. Two hospital revenue bonds were issued in 2009 to fund a 72-bed expansion for UNI that was completed in 2014. The bonds issued to the University of Utah totaled $50,920,000. The first bond was issued for a total of $9,135,000 and matured in 2016; therefore, this bond currently has a zero balance. The second bond was issued for $41,785,000 and will reach maturity in 2030. As of today, about $37 million remains outstanding. Principal bond payments for UNI's expansion are made centrally by UUHC and totaled about $2.3 million in fiscal year 2018. UNI manages its finances in a way that contributes toward the interest payments made on the bond. The interest payment for the bond totaled about $1.6 million in fiscal year 2018.

A Centralized Financial System Helps UNI Cover Costs

UNI's operational costs in fiscal year 2016 totaled $81.7 million. By the end of fiscal year 2018, operational costs had increased 22 percent to $99.3 million. Part of this increase was due to the growth of crisis services, which will be discussed in Chapter II. Rising operational costs have resulted in UUHC covering a higher percentage of UNI's costs for shared centralized services. UNI is only able to cover a small portion of the costs for shared services.

UNI's operational costs have increased 18 percent since 2016. Operational costs were $99.3 million in 2018.

UUHC's six business units have access to shared centralized services such as IT, HR, malpractice insurance, and financial services. Further support comes from related entities, including marketing, internal audit, compliance, and public affairs. The costs for use of the

UUHC's six business units, including UNI, have access to shared centralized services such as IT and HR.

centralized services are allocated and shared by each of the six business units based on varying methodologies including net revenue, number of full-time employees (FTEs), number of beds, and related expenses. The total amount of shared institutional costs allocated among the six business units was $232.7 million at the end of fiscal year 2018.

Figure 1.2 shows the total amount of UNI's shared centralized costs, the centralized costs covered by UUHC, and the amount of centralized costs covered by UNI.

Figure 1.2 UUHC Paid 88 Percent of UNI's Shared Centralized Costs. Over a three-year period, UNI was allocated $25.4 million in centralized costs, and $22.3 million was covered centrally. UNI paid $3.1 million.

Fiscal Year	UNI's Total Allocated Costs	Costs Covered by UUHC	Costs Covered by UNI	Percentage of Costs Covered by UNI
2016	$ 6,225,700	$ 5,000,000	$ 1,225,700	20%
2017	8,486,400	7,304,400	1,182,000	14
2018	10,715,900	9,993,400	722,600	7
Totals	**$ 25,428,000**	**$ 22,297,800**	**$ 3,130,300**	**12%**

Source: UUHC

The percent of centralized costs covered by UNI have decreased over the past three years.

Figure 1.2 shows the benefit of a centralized business model, as most of UNI's centralized costs have been covered by UUHC. Centralized costs covered by UNI have decreased over the past three years. Conversely, UNI's operational costs have increased $17.6 million over the past three years.

Beginning in fiscal year 2019, UUCH staff decided to increase transparency and show all costs for centralized services for each of the business units.

Beginning fiscal year 2019, UUHC staff decided internally to increase transparency and show the entire share of costs for centralized services for UNI and the other business units. Because UNI does not generate enough revenue to cover its portion of the centralized costs allocations, UNI's income statement will show a loss. Likewise, other business units that cannot cover the costs of centralized services will also show losses. However, since UUHC is a single financial entity, all losses will be included in the financial statements that represent UUHC in its entirety.

UUHC is a non-profit clinical enterprise operating within the University of Utah. As with all non-profits, UUHC maintains a Statement of Net position. At the end of fiscal year 2018, the net financial position of UUHC was $904 million. On average, UUHC's net position has increased $116.6 million over the last three fiscal

years (2016-18). UUHC also maintains a financial report reflecting operating revenues and operating expenses; the difference of the two results in operating margin. UUHC's operating margin has averaged $148 million over the last three fiscal years and is net of the UNI losses. Even though UNI cannot independently cover all its costs, as part of a centralized system, UUHC is able to help cover UNI's deficit.

In addition to UNI's increasing centralized costs and operational costs, UNI's costs for crisis services have also increased due to growth and expansion (discussed in Chapter II). The next section of this chapter provides a brief history of the expansion of UNI's crisis services.

State and Local Contracts with UNI Expanded Crisis Services

According to the Division of Substance Abuse and Mental Health's Suicide Prevention Plan, "Utah's suicide rate has been consistently higher than the national rate for more than a decade." From 2005-14, Utah's rate rose from 17.1 suicides to 22.9 suicides per 100,000 people (a 34 percent increase), while the national rate rose from 12.7 suicides to 15.4 suicides per 100,000 people (a 21 percent increase). To reduce Utah's suicide rate by 10 percent before 2026, the Utah Suicide Prevention Coalition[2] identified several goals, including the promotion and expansion of crisis services. Crisis service programs help people who are suffering with suicidal thoughts, depression, anxiety, stress, and addictions.

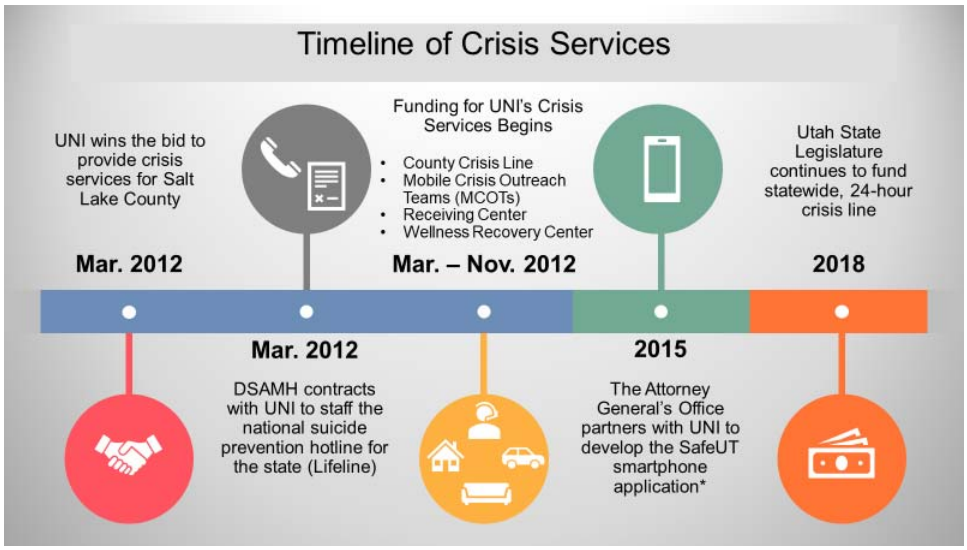
Utah's suicide rate has been consistently higher than the national average for more than a decade.

To make crisis services in Salt Lake County more available to Medicaid clientele, the county issued a request for proposals (RFP) in 2011 for the delivery of mental health and substance abuse services. In 2012, the procurement process to expand crisis services took place to meet the needs in the community. Figure 1.3 illustrates the evolution of crisis services and UNI's involvement in the expansion of crisis services over time.

To make crisis services in Salt Lake County more available to the Medicaid clientele, the county issued an RFP in 2011. Optum was selected.

[2] The Utah Suicide Prevention Coalition is a partnership of community members, suicide survivors, service providers, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah.

Figure 1.3 An Expansion of UNI's Crisis Services Began in 2012. Over the past six years, UNI has added six crisis services and a peer support line.



Source: UNI, Salt Lake County, and DSAMH
**The SafeUT smartphone application is discussed in detail on page 8.*

Many entities have contributed to help expand crisis services in Utah.

As Figure 1.3 shows, many different entities have contributed to the growth of crisis services, including Salt Lake County, the Division of Substance Abuse and Mental Health (DSAMH), the Attorney General's Office, the Utah State Legislature, UNI, Medicaid, and other community partners. The remainder of this section walks through each point of the timeline in greater detail.

Salt Lake County's Reorganization of Behavioral Health Led to the Expansion of Crisis Services

UNI was selected for five separate RFPs to provide crisis services for Salt Lake County.

In 2011, Salt Lake County Behavioral Health conducted a procurement process for mental health and substance abuse services provided to Medicaid clientele. Optum was selected and became the managed care organization (MCO) to hold the Medicaid contract for mental health and substance abuse services in Salt Lake County. In their proposal, Optum modeled their outline of crisis services after a program in Pierce County, Washington, where the crisis services listed below had been operating. Because the delivery of crisis services is outsourced by Optum, Optum has contracts with various qualified providers, including UNI. After five competitive RFPs, Optum selected UNI in March 2012 to provide the following five crisis services for Salt Lake County:

- A 24/7 county crisis line staffed by licensed clinical social workers (LCSWs).
- A county "warm" line staffed by peer specialists. The warm line functions more like a peer support line for those who are not in crisis but need support.
- MCOTs, which function as in-person community response teams to assess and stabilize individuals in crisis.
- A Receiving Center that provides up to 23 hours of observation for adults needing additional stabilization (since inpatient hospitalization occurs after 24 hours).
- A Wellness Recovery Center that serves adult Medicaid clients in need of residential treatment (no longer operating as of February 2018)[3]

UNI developed and rolled out a bulk of these crisis services during 2012.

DSAMH Has Two Contracts With UNI

DSAMH holds two contracts with UNI for the provision of crisis services. The first contract is a Zero Suicide project, and the second contract is for the operation of the National Suicide Prevention Lifeline. In early 2012, UNI became the only call center in Utah to host the National Suicide Prevention Lifeline. In addition to managing Lifeline, UNI has continued to enhance its local crisis services and adapt to increasing demand by adding resources to accommodate growth.

In addition to the Salt Lake County Crisis Line, UNI hosts the National Suicide Prevention Lifeline for the state.

DSAMH uses national surveys to assess the extent to which mental health needs are unmet in Utah. In 2016, DSAMH estimated that 74 percent of Utahns in need of mental health services did not receive them. As a result, DSAMH has encouraged the expansion of crisis services. The challenges associated with increased growth, along with the funding for crisis services, will be discussed in Chapter II. The next

[3] The Wellness Recovery Center was a residential treatment center that closed when the lease for the primary location ended.

section of this chapter discusses the development of the SafeUT smartphone application.

The School Safety Tip Line Commission Selected UNI as SafeUT Developer and Operator

The School Safety Tip Line Commission selected UNI to develop and operate the SafeUT application that connects people in crisis via text or phone.

The School Safety Tip Line Commission was established by Senate Bill 232 in the 2014 General Session. One of the commission's responsibilities, as indicated in the bill, is "designat[ing] a School Safety Tip Line provider network." After conducting some research, the commission learned that if the qualified provider is part of a political subdivision (as UNI is), a formal RFP process is not necessary. Soon after, the commission selected UNI as the SafeUT smartphone application developer and operator. SafeUT is a free smartphone app that anonymously connects people in crisis with a licensed social worker via text message or telephone call according to the user's preference.

SafeUT was modeled after a tip line in Colorado.

SafeUT was modeled after a tip line in Colorado called "Safe2Tell Colorado." The Safe2Tell Colorado model provides every parent, teacher, and community member a safe and anonymous way to report any concerns about their safety or the safety of others. Although SafeUT was originally implemented in the public education system, it has since expanded to higher education. The SafeUT tip line function allows the user to submit confidential tips to school administrators regarding bullying, threats, or violence. Additionally, the SafeUT app provides real-time, two-way communication with crisis counselors who are available 24/7. SafeUT also has a crisis line access feature.

The global intel tip management software company, P3, was contracted as the original developer of the SafeUT app. P3 was the developer of the Safe2Tell Colorado app. P3 initially offered its services for free; however, to avoid increasing expenses and to promote longevity, UUHC donated all labor costs, totaling $485,600, to develop the SafeUT app that is used today.

Audit Scope and Objectives

We were asked to conduct a performance audit of the University Neuropsychiatric Institute (UNI). This audit consisted of five areas:

- Financial Status—We reviewed the financial position of UNI for the past three years, including the bonds for the 72-bed expansion (Chapter I).

- Crisis Services—We reviewed the challenges that UNI's Crisis Services Center faces, given the dynamic environment in which the center operates. Crisis services include the National Suicide Prevention Lifeline, the Salt Lake County Crisis Line, SafeUT, Mobile Crisis Outreach Teams, and the Warm Line (Chapter II).

- Patient Assessment—We reviewed the patient assessment process at UNI's Clinical Assessment Center, including two years of assessment data (Chapter III).

- Discharge Planning—We reviewed the patient discharge process from the hospital and one year of discharge data. (Chapter IV).

- Quality Assurance—We reviewed the quality assurance processes at the Crisis Services Center and the Clinical Assessment Center (Chapter V).

This audit reviews five areas at UNI: financial position, crisis services, patient assessment and discharge processes, and quality assurance.

For each of these areas, the objective was to review the operating processes and determine if UNI is being managed effectively and efficiently and if patients are being treated consistently. During the audit, we conducted interviews with agencies and entities associated with UNI, along with partners within the mental and behavioral health community. We utilized a consultant where needed. We also compared the management of crisis services in other states with the management of crisis services at UNI.

Chapter II
Responding to the Growing Demand for Crisis Services Is Challenging for UNI

The University Neuropsychiatric Institute (UNI) provides crisis intervention services that benefit residents of Salt Lake County and the state of Utah. UNI relies on financial support from multiple agencies to fund crisis services. It is unclear to what extent the current funding model will be sustainable in the future as the demand for crisis services continues to increase. UNI projects a $3.6 million deficit for crisis services in fiscal year 2020.

UNI's Crisis Center operates five crisis services: the Salt Lake County Crisis Line, Mobile Crisis Outreach Teams (MCOTs), the SafeUT app, the Receiving Center, and the Warm Line. UNI faces the challenge of meeting the growing demand for these services. UNI and its partners appear to be making efforts to address growth-related issues. UNI has contracted with a workforce management consultant to determine workload trends that impact staffing decisions.

UNI's Crisis Services Are Reliant On Multi-agency Support

Crisis services provided by UNI rely on multiple funding streams for financial support. Six different funding sources collectively contributed $19.5 million to support crisis services over the last three fiscal years (2016-18). The operating expenditure total for crisis services for the same time period amounted to $20.6 million, which left crisis services with an overall deficit of $1.16 million. The $1.16 million deficit was covered jointly by UNI and the University of Utah Hospitals and Clinics (UUHC).

Notwithstanding multiple funding sources for crisis services, future funding concerns remain.

Although UUHC has invested significantly in crisis services, future funding concerns remain. UNI projects a $3.6 million deficit in fiscal year 2020. The projected loss is due to the growth of the SafeUT app, crisis lines (the county Crisis Line, Lifeline, and the county Warm Line), MCOT outreaches, and the Receiving Center.

Funding for Crisis Services Comes from Multiple Sources

Six funding sources contributed to UNI's crisis services over the last three fiscal years.

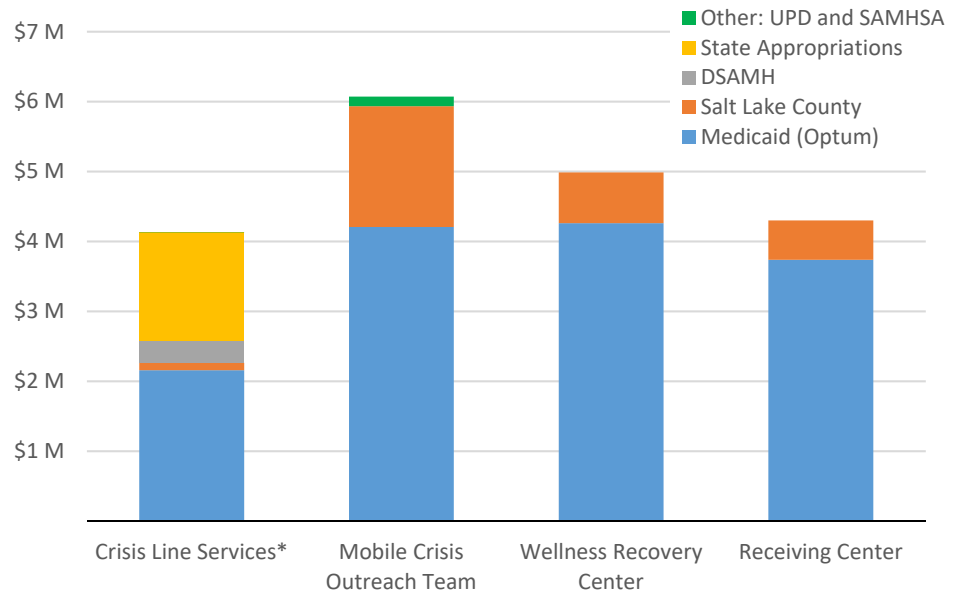
Over the last three fiscal years (2016-18), external revenue streams for UNI's crisis services consisted of six different funding sources:

- Medicaid (Optum)
- Salt Lake County (non-Medicaid)
- Salt Lake County Unified Police Department (UPD)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Utah Division of Substance Abuse and Mental Health (DSAMH)
- State Appropriations

Collectively, these sources have contributed $19.5 million in revenues for crisis services over the last three fiscal years. Figure 2.1 shows the revenue breakdown for each of the crisis services provided by UNI.

Figure 2.1 Crisis Services Revenue Streams Total $19.5 Million Over Three Fiscal Years (2016-18). Medicaid funds 74 percent of crisis services provided by UNI.

Medicaid (Optum) contributes more to crisis services than all other funding sources combined.



Source: UNI
**Crisis Line services include the county Crisis Line, the Warm Line, Lifeline, and the SafeUT App.*

Even with multiple revenue streams totaling $19.5 million over the past three years, UNI's crisis services operate at a deficit, which is discussed in the next section.

Crisis Services Operate at a Deficit

Crisis services at UNI operated at a $1.16 million deficit from fiscal year 2016 to fiscal year 2018. The collective three-year operational expense total was just over $20.6 million. Revenue streams from the six external funding sources (Figure 2.1) covered approximately 94 percent of all operational expenditures over the same three-year period. The remaining 6 percent ($1.16 million) was covered directly by UNI and UUHC. UNI transferred $339,700 of unfunded care money and UUHC contributed $821,300.

Despite multiple revenue streams, UNI operates crisis services at a deficit.

Figure 2.2 illustrates the financial position for four of the crisis services provided by UNI.

Figure 2.2 The Deficit for Crisis Services Totaled $1.16 Million Over the Past Three Fiscal Years (2016-18). UNI independently contributed $339,700 of the $1.16 million, leaving the remaining $821,200 to be covered centrally by UUHC.

Crisis Service	Revenue Total	Operational Expenses	Net Position
Crisis Line Services*	$ 4,127,900	$ 3,870,400	$ 257,500
Mobile Crisis Outreach Team	6,070,700	5,735,800	334,900
Receiving Center	4,300,900	5,096,800	(795,900)
Wellness Recovery Center	4,987,400	5,944,900	(957,500)
TOTALS	**$ 19,486,900**	**$ 20,647,900**	**$ (1,161,000)**

Source: UNI
**Crisis Line services include the county Crisis Line, the Warm Line, Lifeline, and the SafeUT App. UNI reports the SafeUT app revenue total to be $1.15 million from fiscal year 2016 to fiscal year 2018 and reports the expenditure total during same years to be $1.1 million for a net position of approximately $48,000.*

UNI and UUHC paid for six percent of the operational expenditures which other sources, such as Medicaid, did not cover.

Figure 2.2 shows that the collective revenue streams from other agencies did not completely cover operational expenditures for UNI's crisis services. Therefore, UNI and UUHC jointly made up the $1.16 million difference.

Revenues from the Wellness Recovery Center Were Reprioritized. As mentioned in Chapter I, the Wellness Recovery Center closed in February 2018 when the lease for the primary location ended. Even though the Wellness Recovery Center will no longer be an expense to UNI, the Wellness Recovery Center's $5 million in revenues is also no longer available to UNI. All revenues designated for the Wellness Recovery Center were discontinued with its closure and reprioritized by the county. Similarly, all expenditures associated with the Wellness Recovery Center were rendered obsolete with its closure.

Revenues from the Wellness Recovery Center are no longer available to help pay for crisis services.

Operational Expenses for Crisis Services Are Increasing Annually. The operational expense totals for crisis services over the last three fiscal years include the following:

- $6.5 million in fiscal year 2016
- $6.9 million in fiscal year 2017
- $7.3 million in fiscal year 2018

The total of these annual amounts (rounded) is equal to the $20,647,900 operational expense total shown in Figure 2.2. From the beginning of fiscal year 2016 to the end of fiscal year 2018, operational expenses for crisis services increased by 12 percent (close to $1 million). UNI staff report that without additional revenue, the growth of crisis services will create a larger deficit.

Without additional revenue, crisis services growth will create a larger deficit.

UUHC Has Significantly Invested in Crisis Services Over the Last Three Fiscal Years. Over the last three fiscal years, UUHC has provided a total of $3.2 million in support to crisis services. UUHC's support total includes the following:

- $821,200 for crisis services operations
- $147,300 as a one-time capital contribution
- $485,600 as a one-time investment for the development of the SafeUT smartphone application
- $1.7 million for crisis services' portion of UNI's centralized costs allocations

UUHC has provided $3.2 million in support to crisis services over the last three fiscal years, including centralized cost allocations.

Chapter I discussed how some costs are shared centrally among the six business units. UUHC covered $22.3 million of UNI's centralized

costs from fiscal year 2016 to fiscal year 2018. We estimated the crisis services' portion of UNI's centralized costs covered by UUHC to be $1.7 million.

Future Funding Concerns Remain

UNI projects a $3.6 million net loss in fiscal year 2020. The projected deficit accounts for all sources of revenue including external sources and legislative appropriations. We reviewed the projections and believe they are reasonable. The projected deficit pertains to operations relating to Crisis Line services (the county Crisis Line, Lifeline, the Warm Line, and the SafeUT app), MCOT outreaches, and the Receiving Center. Figure 2.3 shows the projected deficit for UNI's crisis services for fiscal year 2020.

UNI projects a $3.6 million net loss in fiscal 2020 pertaining to crisis line services.

Figure 2.3 UNI Projects a $3.6 Million Deficit for Crisis Services in Fiscal Year 2020. The projected deficit for crisis services accounts for all sources of funding including funding appropriated in the 2019 General Session.

Crisis Service	Projected Revenue	Projected Operational Expense	Projected Net Position
Crisis Line Services*	$ 5,327,000	$ 7,714,200	$ (2,387,200)
Mobile Crisis Outreach Team	2,576,800	3,203,100	(626,300)
Receiving Center	1,505,300	2,079,000	(573,700)
Wellness Recovery Center	N/A	N/A	N/A
Totals	**$ 9,409,100**	**$ 12,996,300**	**$ (3,587,200)**

Source: UNI
**Crisis Line services includes the county Crisis Line, the Warm Line, Lifeline, and the SafeUT App. UNI reports the SafeUT textline revenue total to be $2.97 million for fiscal year 2020 and reports the expenditure total during same year to be $3.04 million for a net loss of approximately $70,000.*

Projected operational expenses in Figure 2.3 include all operational and personnel costs. According to the projections, UNI's crisis services can expect a deficit of $3.6 million in fiscal year 2020.

In 2018, the Legislature appropriated $7 million of new crisis services funding for fiscal year 2019.

In the 2018 General Session, the Legislature appropriated $7 million of new crisis services funding, which will be shared by multiple agencies for use during fiscal year 2019. After accounting for one-time appropriation adjustments in 2019, the ongoing appropriation

amount for statewide crisis services as of fiscal year 2020 is $8.28 million.[4]

In the 2019 General Session, $1.27 million of new funding was appropriated to the University of Utah for operations relating to the SafeUT app. The total ongoing legislative appropriation is currently $9.55 million, which consists of $8.28 million from the 2018 General Session and $1.27 million from the 2019 General Session.

Of the $9.55 million, UNI's crisis services will receive about $4.6 million in fiscal year 2020. The remaining $5 million will go toward statewide crisis services activities. The approximate amounts and the intended purposes for UNI's $4.6 million in appropriations are detailed below:

UNI's crisis services will receive about $4.6 million out of the $9.55 million appropriation for statewide crisis services in FY 2019.

- $150,000 ongoing to implement SafeUT
- $550,000 ongoing to support SafeUT
- $175,000 ongoing to market/promote SafeUT
- $500,000 ongoing to expand SafeUT to institutions of higher education[5]
- $1.9 million as a proposed contractual agreement with DSAMH to expand Crisis Line services (the county Crisis Line, the Warm Line, Lifeline, and the SafeUT app)
- $1.27 million ongoing to support SafeUT operations

The projected revenue total in Figure 2.3 accounts for all ongoing legislative appropriations made to UNI to date. It also accounts for the proposed contract amount agreed upon between UNI and DSAMH. While ongoing appropriations address a need, funding concerns for crisis services at UNI remain.

[4] See Appendix for legislative appropriation details.

[5] In the 2019 General Session, the intended use of this appropriation amount was changed from expanding SafeUT in institutions of higher education to providing operational support for the SafeUT app.

Growth Contributes to Staffing Issues for Crisis Center Services

The workload for UNI's Crisis Center services (MCOT, SafeUT app services, Crisis Line, Warm Line) is increasing and will continue to increase significantly in the future. Several factors could affect the Crisis Center's ability to adequately staff those services and have clinical social workers provide prompt and compassionate crisis services 24 hours a day, 7 days a week. The Crisis Center has begun taking steps to mitigate the effects of rapid growth. It should continue pursuing innovative practices for managing the effects of growth.

As mentioned in Chapter I, UNI crisis and intervention services provide rapid help to anyone experiencing substance abuse or mental health issues in Salt Lake County. UNI's Crisis Center provides these services free of charge to Salt Lake County and Utah residents, 24 hours a day, 7 days a week. Figure 2.4 highlights the four services offered at the Crisis Center.

UNI provides crisis and intervention services to Utah residents, 24 hours a day, 7 days a week.

Figure 2.4 Services Offered at UNI's Crisis Center. UNI Crisis Center services include, the Crisis Line, MCOTs, SafeUT app services, and the Warm Line.

Source: UNI

As shown in Figure 2.4, UNI's Crisis Center provides four crisis services. The purpose of crisis and intervention services is to stabilize individuals experiencing mental health crisis and to prevent unnecessary trips to the hospital. We explain each of these services and show the increase in utilization in the next section of the report.

Crisis and intervention services stabilize individuals in mental health crisis and prevent unnecessary trips to the hospital.

Workload Is Increasing for Crisis Center Services

The workload for organizations offering mental health and crisis intervention services is increasing nation-wide. Similarly, in Utah, the workload for UNI's Crisis Center services is increasing and will continue to increase in the future. In addition to explaining each of the Crisis Center's services, this section will show the growth for each service between 2016-18. During that period, Crisis Center services experienced the following increases in workload:

1. **Crisis Line** – 29 percent increase
2. **MCOT** – 26 percent increase
3. **SafeUT** – 1,081 percent increase
4. **Warm Line** – 54 percent increase

UNI's Crisis Line professionals field calls to the Salt Lake County Crisis Line and the National Suicide Prevention Lifeline.

1. Crisis Line Is Available 24/7 to Help Individuals in Distress. Staffed by mental health professionals with master's degrees, the Crisis Line provides phone crisis intervention and support services to individuals who call the Salt Lake County Crisis Line, and the National Suicide Prevention Lifeline—for callers with a Utah area code. Crisis Line responders help to de-escalate a caller's crisis and create a plan to address the cause of the crisis. Figure 2.5 shows that despite some fluctuation, the number of Crisis Line calls is increasing over time.

Figure 2.5 Crisis Line Call Volume Is Increasing. The number of calls to the Crisis Line increased by 29 percent from June 2016-June 2018.

Source: UNI
**Call Volume data includes calls to the Salt Lake County Crisis Line and the National Suicide Prevention Lifeline*

Crisis Line call volume spiked in June 2018 after media reports of celebrity suicides.

According to Crisis Line staff, call volume fluctuates from month to month based on various triggers such as seasonal changes and reports of celebrity suicides in the media. For example, staff explained that they received a high influx of calls in June 2018, as shown by the spike in Figure 2.5, after the media reported that celebrities Kate Spade and Anthony Bourdain died by suicide.

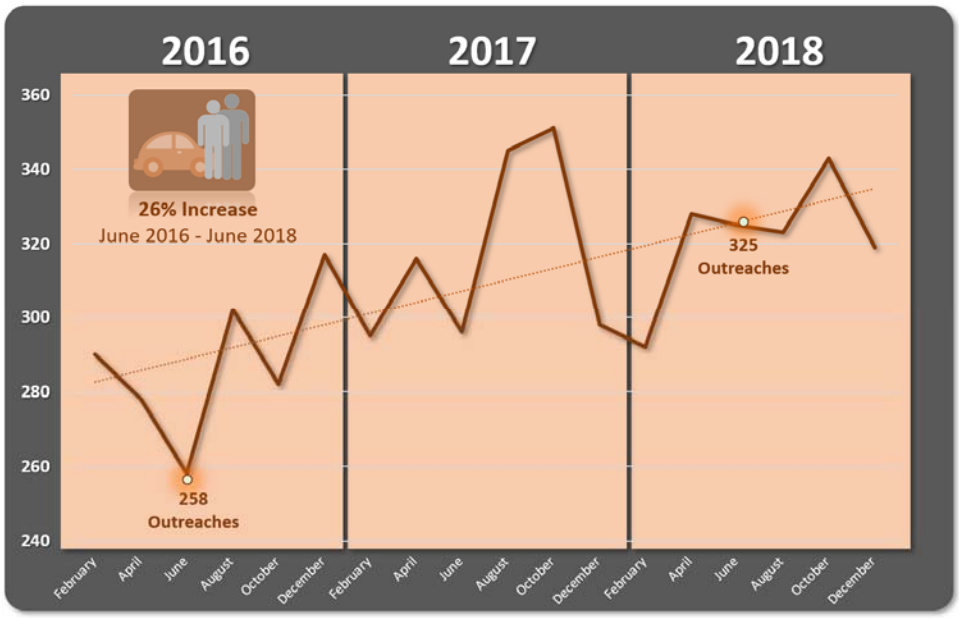
The Crisis Line is handling more acute cases of individuals with mental health problems.

In addition to receiving an increasing number of calls, Crisis Line staff report that they have noticed an increase in the severity of calls that they receive. For example, an increasing amount of the calls they deal with involve individuals whose mental health difficulties are severe and who lack adequate support systems. Other national and state crisis lines report similar trends of increasing call volume and acuity. The acute nature of crisis calls can affect the amount of time Crisis Line staff spend on the call. For example, one crisis call can occupy a mental health professional for up to an hour.

Mobile Crisis Outreach Teams (MCOTs) provide free, in-person crisis intervention. MCOT outreaches have been increasing over the last three years.

2. Mobile Crisis Outreach Teams (MCOTs) Provide Community-Based Crisis Intervention. MCOTs are composed of one social worker and one certified peer specialist—an individual with personal experience dealing with substance abuse or mental health issues. MCOT teams provide free, rapid, in-person intervention to individuals in Salt Lake County experiencing acute mental health crises. UNI's Crisis Line workers dispatch MCOT teams when telephone intervention is insufficient to de-escalate the caller's crisis or when law enforcement requests MCOT assistance in the community. Figure 2.6 shows that the number of MCOT outreaches has been increasing over the last three years.

Figure 2.6 MCOT Workload Is Increasing. From June 2016 to June 2018, the number of mobile crisis outreaches that Crisis Center MCOT teams carried out increased by 26 percent.



Source: UNI

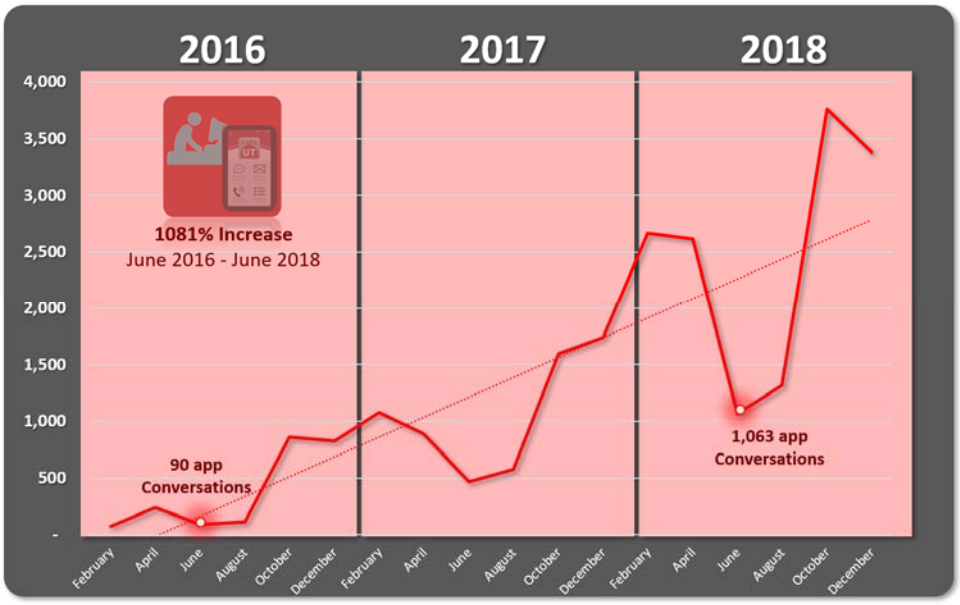
Increases in MCOT workload coincide with increases in Crisis Line workload. Mobile crisis outreaches can occupy a social worker and peer specialist team for up to two or three hours. On average, MCOT teams conduct 2-3 outreaches per 8-hour shift while crisis line staff respond to around 12-15 crisis calls per shift.

All of Utah's public secondary education, and public higher education institutions have adopted the SafeUT app which is experiencing a significant increase in usage.

3. SafeUT's Texting Capability Provides a Critical Service. Licensed mental health professionals at the Crisis Center respond to crisis text messages, phone calls, and triage tips from SafeUT app users experiencing a crisis or concerns related to safety in their educational

environment. According to Crisis Center staff, out of all the SafeUT app's features, users utilize the texting feature the most. Figure 2.7 shows that the number of crisis text conversations has dramatically increased during the last two years.

Figure 2.7 SafeUT Workload Is Increasing. The number of SafeUT app conversations to which Crisis Center staff respond increased by 1,081 percent between June 2016 and June 2018.



Source: UNI

As of March 2019, all of Utah's public high schools and middle schools have opted to use the SafeUT app. All 16 of Utah's public higher education institutions have also begun using it. As shown in Figure 2.7, the number of SafeUT conversations has been increasing as more public schools and higher education institutions have opted in to the SafeUT app. From June 2016 – June 2018, SafeUT workload increased by 1,081 percent. Since most of the app's users are students and school faculty, the workload tends to decrease during the summer months when students are not in school, which is reflected in Figure 2.7.

Usage of the SafeUT app decreases during the summer months when students are not in school.

Warm Line services help callers with less-acute problems avoid escalating into crisis. Like all other crisis services, the demand for Warm Line services is increasing.

4. The Warm Line Provides Preventative and Post-crisis Support. Staffed by certified peer support specialists, the Warm Line provides active listening, engagement, and encouragement to callers who are not in crisis, but who seek support. Warm Line services help callers with less acute problems avoid escalating into crisis. Warm Line phone calls are usually limited to 15 minutes or less. Workload for the Warm Line increased by 54 percent between June 2016 and June 2018. We do not include an in-depth analysis of the Warm Line in this report since callers are not in crisis. However, the increasing growth for Warm Line services is significant, similar to increasing growth in the other three Crisis Center services.

Some Growth-Related Factors Impact the Crisis Center's Ability to Provide Prompt and Effective Service

As demand for crisis services continues to grow, some factors have been impacting the Crisis Center's ability to provide effective service. Those factors include the following:

- The reactionary nature of staffing crisis services
- The potential for staff burnout
- Increased workload due to expansion of crisis services

Each of the three factors is explained below.

Crisis Center management grapples with having enough staff to meet demand, while not having too many staff to be inefficient with limited resources.

Staffing Crisis Services Is a Challenge. Given the varying and unpredictable nature of crisis services, it is a challenge for Crisis Center management to ensure that there are enough crisis workers to respond to the demand, while also ensuring that there are not too many workers to be inefficient with limited resources. Significant, unforeseen surges can potentially exceed the Crisis Center's ability to provide prompt service. For example, Crisis Center leadership noted that in fall 2018, due to unforeseen surges in the demand for mobile crisis outreaches, MCOT teams experienced an increase in the number of outreaches they were not able to respond to promptly. Not promptly responding to even one outreach presents a risk and highlights the importance of being able to react to workload surges.

Given the Stressful Nature of Crisis Intervention Work, Crisis Workers Are Susceptible to Burnout. The demand for crisis services can contribute to fatigue among crisis workers if they do not have adequate time for self-care and decompression. A lack of respite can limit the crisis worker's ability to provide effective crisis intervention. Crisis Center workers have reported concerns about fielding consecutive calls without breaks. Between May and October of 2018, crisis workers at the Crisis Center spent, on average, fewer than 1 minute per day logged off phones for lunch breaks and fewer than 5 minutes per day logged off for other breaks. Staff have reported feeling guilty about leaving the phones or taking breaks, especially during times of high demand when there are not enough crisis workers to field calls.

Expanding Crisis Center Services Will Increase Workload. State and federal initiatives that affect the Crisis Line will increase the number of calls that it receives. For example, in a phased process throughout 2019, counties outside of Salt Lake County will discontinue their own crisis lines and begin promoting UNI's Crisis Line as Utah's Statewide Crisis Line.

In 2019, UNI's Crisis Line (previously for Salt Lake County only) will begin operating as Utah's Statewide Crisis Line.

Additionally, the Federal Communications commission is studying the feasibility of designating a three-digit dialing code (similar to 9-1-1) to be used as a national suicide prevention and mental health crisis hotline. Once a three-digit number has national publicity, crisis lines will experience an increase in the number of calls they receive. UNI leadership believes that a three-digit national hotline number could double the Crisis Line's workload.

Federal plans to designate a three-digit crisis hotline number could reportedly double the Crisis Line's workload.

Since MCOT workload coincides with the number of Crisis Line calls, the new three-digit crisis number would likely also contribute to an increase in the number of mobile outreaches needed. Finally, workload for the SafeUT app will likely increase in the future as more schools choose to adopt the app. UNI continues to discuss these challenges and has been making efforts to manage the growth. Some of the steps they are taking are discussed in the next section of the report.

UNI and Mental Health Partners Are Addressing Growth

UNI's Crisis Center is making efforts to manage growth. UNI has been working with a workforce management consultant to gather call data to help make staffing decisions. Management now requires staff to take work breaks and has hired additional staff to meet the demand for crisis services. UNI has also begun collaboration with other crisis service providers. This appears to be an appropriate way to accommodate expanding services by sharing financial and operational responsibilities among multiple entities.

Crisis Center leadership hired a consultant to help with staffing decisions.

UNI's Crisis Center Is Responding to Growth-Related Factors. Crisis Center leadership is aware of the growth-related factors that can impact the ability to respond to callers promptly and effectively. Recent efforts by management to respond to the growth include the following:

- Hiring a workforce management consultant group to help with staffing decisions
- Requiring staff to take breaks to help avoid burnout
- Hiring additional crisis workers

In response to growth, the Crisis Center has hired additional crisis workers and has required staff to take breaks in order to avoid burnout.

Statewide Efforts Involving Multiple Agencies Helps to Manage Demand for Crisis Services. As previously mentioned, UNI faces financial and operational challenges as the demand for crisis services grows. It is unclear to what extent the current funding model will be sustainable in the future, to what extent future events will increase demand for crisis services, and how that demand will be satisfied. UNI works with other crisis and mental health entities to discuss these issues and deal with the growing demand for crisis services in Utah.

Statewide efforts to collaborate on crisis and intervention services are evident in the work of the Mental Health Crisis Line Commission (Commission), established by the Legislature in 2017 and chaired by UNI's executive director. The Commission is responding to the increased demand for crisis services by taking the following measures:

- Prioritizing the creation of additional receiving centers
- Supporting the development of medical codes for MCOT encounters with Medicaid members

Statewide efforts by multiple agencies are helping manage the demand for crisis services, but ongoing innovation is needed.

The statewide efforts involving multiple agencies are helping manage the demand for crisis services. The Commission's priorities to create additional receiving centers and to support the development of medical codes for MCOT encounters show that the responsibility for Utahn's behavioral and mental health needs is being shared throughout the state.

Recommendations

1. We recommend that UNI continue to inform the Legislature and the Mental Health Crisis Commission of future financial deficit concerns.

2. We recommend that UNI continue using innovative techniques to help manage the growth in crisis services.

Chapter III
Most Patients Are Assessed Correctly, But Documentation Can Improve

We were asked to determine whether the University Neuropsychiatric Institute (UNI) assesses patients appropriately. This request stems from concerns that uninsured and Optum Medicaid members are not hospitalized when needed. Our review did not validate these concerns. With the help of a consultant, we reviewed a statistical sample from two years of assessment data and found that 90 percent of the time (in 142 out of 158 cases), UNI staff correctly assessed the patient's need for treatment. We reviewed how staff in the Clinical Assessment Center (CAC) determine if a patient needs mental health hospitalization or inpatient medical detoxification for substance abuse (detox). Our review of patient admissions focused on Medicaid patients insured by Optum (Optum is the prepaid mental health plan provider for Medicaid patients in Salt Lake County) and uninsured patients. We found the following:

We reviewed UNI hospital admissions for uninsured and Optum Medicaid patients.

- UNI staff assess these groups of patients appropriately most of the time. However, in six cases, the consultant felt UNI should have required Optum members to be hospitalized for mental and behavioral health concerns due to the risk of harm to themselves or others, even though Optum did not authorize the hospitalization.

- Detox is not available to Optum members at UNI, and many uninsured patients lack the ability to pay the fee for detox, which is an elective treatment.

- Documentation of assessments and the oversight of certified social workers needs to improve.

An individual seeking treatment at UNI goes to the CAC and meets with a social worker for an inpatient assessment. Assessments determine whether the individual meets criteria for mental health hospitalization or detox. If not, the social worker identifies the appropriate level of care for the individual and refers him or her to other resources. UNI does not charge patients or their insurance for these assessments; they are provided as part of a service UNI offers to the community.

Assessments determine whether the individual needs to be hospitalized, either for mental health or medical detox.

Most Medicaid and Uninsured Patients Are Assessed and Referred Appropriately

We reviewed clinical assessments for uninsured patients and Medicaid patients insured by Optum to evaluate whether UNI staff appropriately assessed individuals who need hospitalization for mental and behavioral health concerns medical detox. These groups are admitted when needed most of the time and referred to appropriate resources if hospitalization is not necessary. Detox is a voluntary service, but Optum members are not eligible for treatment. Uninsured patients generally do not access detox at UNI due to cost. These factors result in lower admission rates compared to patients with commercial insurance.

In addition, even though we found that most patients were assessed appropriately, we found 6 cases out of the 74 involving Optum members where our consultant believed the patient should have been admitted to the hospital for mental and behavioral health concerns due to the risk of harm to themselves or others. UNI should admit Optum members when they meet UNI's criteria for mental and behavioral health hospitalization to ensure they receive inpatient treatment when needed, regardless of authorization.

Review Found Most Patient Assessments Result in Appropriate Treatment

We reviewed assessments to determine if patients were assessed appropriately and if documentation was sufficient. In 90 percent of the cases we reviewed in detail, CAC staff assessed the patient's need for treatment correctly according to our consultant's review. However, documentation for the assessments can be improved and is addressed later in this chapter.

We analyzed data for all 3,941 assessments performed in the Clinical Assessment Center (CAC) during fiscal years 2017 and 2018.

To compare uninsured and Optum Medicaid patients to those with commercial insurance, we analyzed CAC data for fiscal years 2017 and 2018 showing all 3,941 patients' insurance and whether they were hospitalized. We found that 50 percent of commercially insured patients[6] were admitted compared to 10 percent of Optum Medicaid

[6] There were over 70 commercial plans represented, with Blue Cross Blue Shield and United as the most common. Because UNI no longer has a contract with SelectHealth, this percentage does not include SelectHealth members who came to UNI seeking treatment. These individuals are assessed at UNI and then referred to

members and 18 percent of self-pay patients. We then had a consultant, a licensed clinical social worker (LCSW) who serves as the adult mental health program administrator for the Utah Division of Substance Abuse and Mental Health, review assessments to determine if the outcomes were appropriate for Optum members and uninsured patients who were not admitted.

Optum Medicaid members have lower admission rates because they are not eligible for detox at UNI.

During this review, we found the lower admission rates for Optum Medicaid members and uninsured/self-pay patients, as compared to commercially insured patients, are due to these different factors:

Uninsured patients have lower admission rates because detox is a voluntary service.

- Uninsured patients usually do not pay the fee for detox. In our sample, 15 of 84 uninsured patients came to the CAC wanting detox.
- Optum members are not eligible to detox at UNI. Eight cases in our sample were Optum members seeking detox at UNI.
- Receiving Center utilization decreases the number of patients who need inpatient care; 58 out of 158 patients who might have otherwise been hospitalized were stabilized in this 23-hour observation center.

We selected a random sample of uninsured patients and a separate random sample of Optum patients to review in detail.

We selected two random samples to review: one sample of assessments in which uninsured patients were not admitted and one of the assessments in which Optum members were not admitted. Figure 3.1 shows the results of this portion of the review.

an appropriate SelectHealth provider. If they meet inpatient criteria, they are transferred via private vehicle or ambulance as needed.

Figure 3.1 Summary of Assessments Reviewed by Outcome. Patients needing mental health treatment or detox are either admitted or referred to appropriate resources most of the time.

Outcome Appropriate	Sample 1: Optum Medicaid		Sample 2: Uninsured		Total	
Yes	61	82.4%	81	96.4%	142	90%
No – hospitalization needed	6	8.1%	2	2.4%	8	5%
No – referred to inadequate resources	7	9.5%	1	1.2%	8	5%
Total*	**74**	**100%**	**84**	**100%**	**158**	**100%**

**In two Optum cases and five uninsured cases we reviewed, the consultant was unable to determine if the outcome was appropriate due to poor documentation. These cases are not included in the total but are included in Figure 3.3 among cases demonstrating documentation issues.*

According to our consultant, CAC staff assessed patient's needs appropriately 90 percent of the time.

As shown in the figure, our consultant agreed with the CAC determination in 90 percent (142 out of 158) of the assessments. However, seven assessments did not have enough documentation for our consultant to evaluate the assessments. Although we also heard concerns that UNI rarely accepts uninsured patients as transfers from other facilities, we found that admission rates for self-pay patients were similar for transfer patients and those assessed in the CAC. Because of this similarity and our results showing uninsured patients were admitted when needed from the CAC, we determined there was insufficient risk to justify an in-depth review of transfer cases.

We also heard concerns about admissions for transfer patients but found insufficient risk to justify an additional in-depth review.

We address the six Optum assessments that should have resulted in hospitalization later in this chapter. The eight patients who were referred to inadequate resources either left with referrals to outpatient therapy when they needed a higher level of intensity, such as residential treatment, or they left with no referrals. Availability of appropriate resources exacerbates this problem and is addressed in Chapter 4.

Eight patients left with no referrals or referrals to outpatient therapy when they needed a higher level of intensity.

Additionally, one of the two uninsured patients who should have been hospitalized, according to our consultant, was intoxicated on alcohol when arriving at the CAC and had withdrawal symptoms. The Receiving Center does not take patients who are acutely intoxicated, and inpatient detox is elective, meaning patients cannot be put on an involuntary hold for it. The patient left UNI despite the risk of medical complications from withdrawal.

The other uninsured patient who should have been hospitalized, according to our consultant, came to the CAC with a gun and suicidal

thoughts. The patient went to the Receiving Center for a few hours and engaged in safety planning before going home with a referral to a local outpatient clinic that offers free services to low-income patients.

The next section addresses the factors contributing to the lower admission rates for uninsured patients and Optum members that we found through our case review.

Barriers to Medical Detox Contribute to a Lower Admission Rate for the Uninsured and Optum Members

Because detox is an elective treatment and patients must prepay for the first three days of their stay, cost prevents most uninsured patients from accessing inpatient detox at UNI. For those with insurance, the prepayment amount is calculated using their plan's guidelines. Those without insurance or who choose to pay out of pocket rather than bill their insurance can receive a self-pay discount, but for some patients the $3,000 remaining after the discount is still a significant barrier.[7] During assessments, patients who want detox are informed of the prepay requirement and sometimes choose not to move forward, as we found in four cases from our sample. However, UNI reserves and pays for two beds at the Volunteers of America free social detox program to facilitate treatment for patients who cannot pay the medical detox fee at UNI.

Unlike mental health treatment, detox is elective and requires pre-payment.

Optum Members Are Not Eligible for Medical Detox at UNI. Optum manages the behavioral health Medicaid benefit for Salt Lake County, but not the benefit for physical health. Because detox falls under the physical health benefit, Optum does not cover it. Detox is covered through accountable care organizations or fee-for-service networks that Medicaid members select for their physical health. UNI is not a Medicaid provider for physical health, thus Optum Medicaid members who come to UNI needing detox are transferred to a different facility, such as the University of Utah main hospital.

Because UNI is not a Medicaid provider for physical health, Optum Medicaid members needing detox are transferred to other facilities.

The Receiving Center Is More Appropriate than Hospitalization for Many Patients with Substance Use Disorders. Inpatient medical detox is often not necessary for individuals with substance-related problems. Individuals using substances such as meth

[7] Patients seeking mental health treatment do not prepay for services because they are medically necessary rather than elective.

and spice sometimes need monitoring while drugs clear out of their system, and then symptoms such as paranoia and psychosis may resolve. As a free, 23-hour observation facility, the Receiving Center is a key resource in these cases. Twenty-one percent of the assessments we reviewed involved patients who were referred to the Receiving Center for help with substance use. The Receiving Center was developed specifically to serve Optum Medicaid and uninsured patients, who represented 54 percent and 27 percent of Receiving Center patients respectively in fiscal year 2018.

Twenty-one percent of assessments reviewed involved patients using substances who were referred to the Receiving Center for observation.

UNI Defers to Preauthorization Decisions for Optum Members but Admits Uninsured Patients as Needed

Our consultant identified four cases in which UNI staff determined that the patient needed hospitalization for mental and behavioral health concerns, but Optum denied authorization, so UNI did not admit them. In another two cases, UNI did not seek preauthorization even though the patients needed hospitalization. Instead the patients were diverted to the Receiving Center because UNI anticipated Optum would require it. Optum funds crisis and intervention services, which are intended to divert patients from unnecessary inpatient hospitalizations. As a result, Optum's practice is to require a patient to go to the Receiving Center (for adults) or Juvenile Receiving Center (for youth) before considering authorization of inpatient care. One reason why Optum members have a lower admission rate compared to commercial insurance is because they go to the Receiving Center first. During their time there, the crisis may de-escalate, and they no longer meet criteria for inpatient care.

Optum requires patients to go to the Receiving Center or Juvenile Receiving Center before authorizing hospitalization.

However, in some cases, patients who require hospitalization cannot be safely treated in the less restrictive environment of a receiving center. According to our consultant, when inpatient care is necessary, UNI should admit patients even if Optum denies preauthorization. Then UNI can follow the process shown in Figure 3.2 to appeal Optum's decision and receive payment for the services rendered.

According to our consultant, UNI should admit patients when clinically indicated even if Optum denies preauthorization.

Figure 3.2 Appeals Process Available to UNI for Optum Denials. Salt Lake County reports that only 3 of the 81 appeals in fiscal year 2017 and 8 out of 68 appeals in fiscal year 2018 came from UNI.

Source: Salt Lake County

We discussed the appeals process with Salt Lake County staff who said this is the appropriate course of action for the circumstances we found during our file review. Salt Lake County reports that UNI appeals only a small percentage of the cases in which Optum notifies them that they will not pay. Following this process will ensure patients receive necessary medical care and may give UNI the opportunity to recoup costs. If patients are unwilling to enter inpatient care when it is not authorized, UNI may use the legal process for civil commitment and hospitalize the patient involuntarily to ensure his or her safety. UNI staff report that during our audit, they provided training to clinicians to reinforce that they should always do what is indicated by the assessment even if Optum denies preauthorization. This practice will help to ensure that patients who are at risk of harming themselves or others receive appropriate care.

We discussed the appeals process with Salt Lake County staff who agreed with the consultant that UNI should admit when needed and appeal Optum's denial.

Uninsured Patients Are Hospitalized When Needed. Although UNI can improve admissions processes for Optum patients, we found UNI already admits uninsured patients who meet criteria for hospitalization without regard to the patient's ability to pay. Financial assistance is available for medically necessary services to uninsured patients who cannot pay out of pocket, as well as to insured patients who cannot pay the entire patient portion of their bill.

Financial assistance is available for medically necessary services for uninsured patients who cannot pay.

University of Utah Hospitals and Clinics (UUHC) established presumptive charity care to address concerns that some vulnerable populations (such as the homeless population) who qualify for

UUHC's financial assistance do not receive it because of difficulties navigating the process to apply. From 2014-18, UNI averaged $7.3 million in write-offs for uncompensated care, indicating they have provided financial assistance to uninsured and underinsured patients.

As shown, our consultant's review of assessments found most Medicaid and uninsured patients are directed to the appropriate level of care. However, we did identify problems with documentation of these assessments, which are addressed in the final section of this chapter.

Documentation of Assessments Can Improve

Documentation of client assessments conducted in the CAC should support the social worker's recommendation to admit a patient or refer him or her to the appropriate lower level of care. Our consultant reviewed the documentation for 184 assessments[8]. Seven assessments did not include enough information to evaluate the outcome. Other assessments had enough information to evaluate the outcome, but were still lacking important documentation elements, such as a diagnosis or evidence of a safety plan.

Because of insufficient documentation, UNI staff does not have adequate information if the patient returns at a later time.

Because of insufficient documentation, UNI staff does not have adequate information if the patient returns at a later time, as we found in some cases. Also, patient history is important for future treatment considerations. Figure 3.3 summarizes the documentation problems we identified. In addition to these issues, we identified some inconsistencies in oversight procedures for certified social workers.

[8] This number includes the Optum and uninsured assessments from Figure 3.1 plus additional assessments for patients who were found to have other insurance coverage.

Figure 3.3 Recurring Documentation Problems in CAC Assessments Demonstrate Need for Improvements. Of the 184 assessments we reviewed, 61 assessments (33 percent) had at least one documentation problem.

Documentation Issue Identified by Auditors	Number of Instances	Percentage of Assessments Reviewed
Insufficient to evaluate outcome	7	4%
No diagnosis or partial diagnosis	16	8%
No evidence of safety planning	8	4%
Lack of LCSW co-signer for certified social worker	4	2%
Co-signed despite insufficient documentation	14	8%
Other issues	26	15%
Total Instances	**75***	**__****

Source: Office of the Legislative Auditor General
**The number of total instances is higher than 61 because some assessments had more than one documentation deficiency.*
***Numbers in the column "Percentage of Assessments Reviewed" cannot be totaled because of overlapping deficiencies.*

The total number of assessments with documentation problems in Figure 3.3 indicates UNI needs to better ensure that documentation is complete. Each issue is addressed in detail, which follows.

Documentation in Seven Assessments Was Insufficient to Evaluate the Outcome. During our detailed review of CAC assessments, we found seven assessments that lacked key elements such as a review of detox danger (i.e., risk of withdrawal complications). These elements are necessary to evaluate whether the determination of the social worker was appropriate.

Elements such as a review of detox danger are necessary to support the social worker's decision, but this information was missing from seven assessments.

In one case, an uninsured patient came to the CAC and was diagnosed with hallucinogen abuse. Although the notes indicate the patient would "prefer not to exist," documentation does not show that the social worker referred the patient to any resources.

Diagnosis Is a Key Element of Assessment Documentation. The 16 assessments without a diagnosis or with a partial diagnosis do not meet Optum's requirement to document "an initial primary treatment diagnosis." Five of these assessments were for Optum members. In cases where UNI needs to appeal, documentation must meet Optum's standards to facilitate an informed decision by Salt Lake County.

An initial primary treatment diagnosis was missing from 16 assessments.

Some cases lack safety plans, which outline coping strategies and sources of support for the patient.

Documentation of Safety Planning for At-Risk Patients Was Not Always Found. The consultant identified eight cases that did not have documented evidence of a safety plan. In one case, a patient who had attempted suicide two days prior to the assessment was no longer at a level of risk that would necessitate inpatient care. The patient was discharged, but there was no evidence that safety planning occurred. According to our consultant, assessors should engage patients in safety planning if they do not meet hospitalization criteria but are at risk of harming themselves or others. Safety plans serve as an individualized resource for the patient by outlining coping strategies and sources of support.

Four Assessments Performed by Certified Social Workers Did Not Have a Co-Signer. LCSWs must co-sign every note written by a social worker who is not yet licensed. In one note without a co-signer, our consultant observed that the social worker's summary did not consider the level of violence the patient exhibited before referring the patient to the Juvenile Receiving Center, which does not accept youth who are "assaultive toward peers." Lack of appropriate oversight for social workers who are not yet licensed can pose risks.

Some Assessments with a Co-Signer Were Incomplete. According to UNI staff, if the co-signer sees that the note lacks elements of the formulation (i.e., the case summary that links the assessment information and the treatment plan), he or she should ask the original writer to resolve the documentation issues. Our review with the consultant found 14 cases where this did not occur. In one case, the patient's therapist referred him to UNI because of increasing suicidal thoughts. However, the diagnosis included only his need for alcohol detox and failed to address his depression and anxiety, which should have influenced how he was referred and treated. The co-signer should have required additional documentation.

Co-signers should ask the writer to edit documentation if it is incomplete, which did not occur for 14 cases.

The Consultant Found Other Documentation Issues. Other issues included failure to address the risk of harm to self or others, lack of information on the patient's history, and failure to list substances used by the patient. According to the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the standard classification of mental disorders in the U.S., case formulations

Some assessments did not address the risk of harm to self or others.

> "must involve a careful clinical history and concise summary of the social, psychological and biological factors that may have

contributed to developing a given mental disorder. Hence, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis."

UNI should take steps to ensure all assessments meet this standard. Documentation is an important part of the assessment process. In Chapter V, we make recommendations to improve the quality assurance review for the CAC to help staff document assessments consistently and provide all the necessary information.

Recommendations

1. We recommend UNI admit Optum members when clinically indicated even when preauthorization is denied.

2. We recommend UNI improve documentation of clinical assessments to ensure outcomes are supported.

3. We recommend UNI enhance oversight of certified social workers by ensuring co-signing procedures are followed.

Chapter IV
Discharge Planning Is Consistent, but After-Care Options Are Limited

We reviewed one year of hospitalization data to examine concerns about discharge referrals after inpatient stays. The first concern is that the University Neuropsychiatric Institute (UNI) directs patients referred by residential treatment centers to different residential treatment centers. Second, patients referred by other sources are inappropriately directed to two specific centers over all others. Despite the concerns, our review of data for fiscal year 2018 found 96 percent (226 of 236) of patients referred by a residential treatment center to receive medical detoxification for substance abuse (detox) at UNI returned to their referring facility as expected after discharge. Second, we found no evidence that UNI staff direct patients to certain facilities over others.

We reviewed discharge planning in response to two concerns about UNI inappropriately favoring certain residential treatment centers. We found no evidence to support these claims.

Discharge planning is individualized for each patient but follows a consistent process, considering the patient's needs, preferences, and insurance coverage. UNI has already implemented some best practices for transitioning patients into appropriate treatment after discharging; however, cost and location of services present challenges to helping patients access appropriate levels of post-hospitalization care.

Review Shows Consistency in Referrals for Continued Treatment After Discharge

As part of the scope of this audit, we reviewed the discharge process to address two concerns regarding patients who were hospitalized for detox and then discharged to a residential treatment center. Our review of all hospitalizations for fiscal year 2018 showed these concerns could apply to only 10 percent of patients (495 of 4,937):

Our review of hospitalizations for fiscal year 2018 showed the concerns related to only 10 percent of the patients.

1. The first concern was that patients who were already connected to a residential treatment center were being directed by UNI staff to a different residential treatment center after their inpatient stay.

2. The second concern was that UNI staff were directing patients who were not already connected to a center to two specific residential treatment centers.

Our review did not validate either of these concerns. We found the discharge process is consistent and patient-driven.

Concerns Are Related to Only 10 Percent of Patients

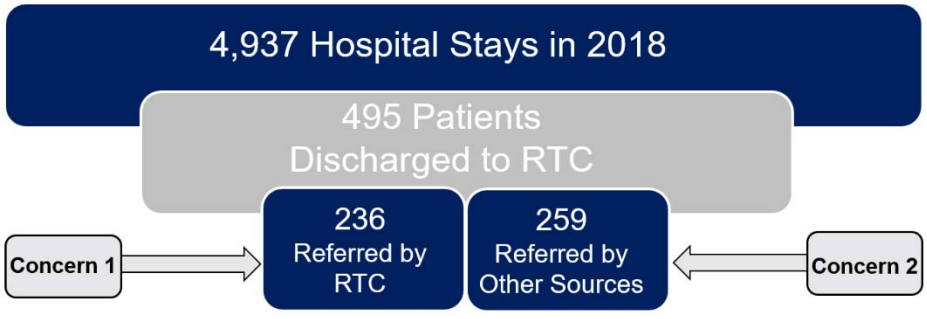
We looked at data for all hospitalizations to identify the total number of cases in which the two concerns might apply.

To address concerns about detox, we first looked at data for all hospitalizations during fiscal year 2018 to identify how many cases could fit the circumstances described to us. For each of the 4,937 hospitalizations at UNI during fiscal year 2018, our data included the following information:

- Provider or facility who referred the patient to UNI
- Start and end dates of the hospitalization
- Patient's physician while at UNI
- Insurance coverage for the patient
- Unit where the patient received treatment
- Discharge referral

Figure 4.1 shows the number of cases that we found involving detox patients who were discharged to residential treatment centers.

Figure 4.1 Patients Were Discharged to Residential Treatment Centers Ten Percent of the Time. We reviewed data on all UNI hospital stays for fiscal year 2018.



Source: Auditor generated from UNI hospitalization data

We reviewed the referring facility, insurance coverage, and discharge facility information for 495 patients (10 percent of 4,937). Of these, 236 were referred by a residential treatment facility and expected to return there, while the remaining 259 were referred by other sources. The next sections explain our review of the data as it pertains to the stated concerns, as well as additional steps we took to investigate these concerns.

We reviewed the referring facility, insurance coverage, and discharge facility information for 495 patients.

UNI Staff Do Not Encourage Patients to Change Providers

Our review did not validate the first concern about UNI staff encouraging patients who were already connected to a residential treatment center to change their plans and discharge to a different facility. We found that 96 percent (226 of 236) of the patients referred by a residential treatment center returned to the same center after discharging from UNI's medical detox, which leaves only 10 cases where the patients did not return. Four of these were discharged to a different level of care and did not go to any residential treatment center. We looked in detail at the six cases in which the patient was discharged to a different residential treatment center and found the following:

96 percent of patients referred by a residential treatment center returned to the referring center as expected.

- The families of three patients determined that different facilities would be preferable due to cost or the patients' prior experiences.
- One patient chose not to return to the same facility because of a strained relationship with another patient staying there.
- One patient's initial facility "made it very clear that [patient] could not attend their program" after heated discussions.
- One patient went to a facility focused more on mental health to better meet his treatment needs.

In the six cases where patients discharged to a different residential treatment center, there was no evidence that UNI staff encouraged them to go specific facilities.

Based on these results, we found no evidence to support the concern that UNI staff encouraged patients to change their plans in favor of particular facilities.

UNI Staff Do Not Promote Certain Residential Treatment Centers

The second concern relates to patients who had not selected a residential treatment center before being hospitalized.

To address the second concern, that staff directed patients who were not connected to residential treatment centers to two specific facilities, we looked at the 259 patients out of the 495 who were not referred to UNI by residential treatment centers. Since they were not already connected to centers, this group of patients would need to select a facility while they received inpatient care at UNI. Figure 4.2 shows the most common referrals for this group.

Figure 4.2 Referrals to Residential Treatment Facilities from Highest Number of Patients to Lowest. We were told facilities A and D (shown in red) received preferential treatment from UNI staff but found they received a similar number of referrals to some of their peers (facilities B and C).

Facility	Number of Patients	Percentage of Referrals
A	35	13.5%
B	35	13.5%
C	31	12%
D	30	11.6%
E	17	6.6%
F	14	5.4%
G	9	3.5%
H	5	1.9%
All others (<5 each)	83	32%
Total	**259**	**100%**

Source: Auditor generated from UNI data

As shown here, 75 percent of the 259 patients were discharged to a residential treatment center other than the two that we were told received preferential treatment. In addition, no one we spoke to expressed concern about the number of referrals facilities B and C received, which were similar.

Individualized Discharge Process Does Not Allow for Preferential Treatment. According to UNI staff, discharge planning is individualized and considers a variety of factors. Because patients have unique needs, the process does not allow for staff consistently directing patients to particular facilities. Development of an appropriate discharge plan requires assessment of services needed, what insurance will cover, and the patient's preferences.

Patients usually contact possible treatment centers themselves to discuss costs and determine if the facility matches their preferences and needs. Discharge planning begins as soon as a patient is admitted and continues throughout the patient's hospitalization. In addition to the patient and his or her support person (the family member or friend who is listed as their primary contact), the planning process includes the entire care team: the patient's physician, social worker, nurses and psychiatric technicians. The care team identifies the patient's ability to live independently, as well as his or her cognitive ability and family supports.

Patients play an active role in discharge planning by contacting possible treatment centers themselves to determine if the facility matches their needs and preferences.

Detox patients are discharged when their medical detox is complete. For mental health patients, discharge occurs when their symptoms are manageable, and they can function in the community at a lower level of care. Although we did not find cause for concern in UNI's discharge planning, we identified barriers that may keep patients from receiving appropriate treatment after leaving the hospital. These barriers are addressed in the next section.

Our review did not find cause for concern in UNI's discharge planning processes.

Appropriate Treatment Options in the Community Are Not Always Available After Hospitalization

After hospitalization for detox or mental health, patients should continue treatment at a lower level of care to support their recovery. Patients who are suicidal prior to admission are at particularly high risk after leaving inpatient care. However, this risk can be mitigated if patients receive appropriate ongoing treatment. Despite the robust discharge planning process, UNI can improve by implementing new guidelines from Utah's Division of Substance Abuse and Mental Health (DSAMH). However, cost and location of services as well as current Medicaid rules are barriers that prevent UNI from fully implementing these guidelines and prevent patients from connecting to appropriate treatment.

Ongoing Treatment After Discharge Is Necessary for Both Detox and Mental Health Patients

According to UNI staff, treatment is successful when hospitalization is a step in the process instead of the end. Once a patient can be treated effectively in a less restrictive setting, he or she can be discharged from the hospital and transition to another provider. Patients who were suicidal prior to hospitalization are high-

risk for suicide after discharge, demonstrating the need for ongoing treatment. DSAMH recently published a toolkit entitled "Safe Care Transitions for Suicide Prevention," which cites international research on the importance of appropriate care after discharge:

Ongoing treatment after discharge is often necessary because patients are at high risk of suicide immediately after discharging from the hospital.

> "[G]aps in care are times of heightened risk, especially after discharge from inpatient care. A 2017 systematic review found that the post-discharge population has a rate of suicide that is 100 times higher than the general global population, specifically in the first three months after discharge (Chung et. al, 2017). Suicide rates generally peak in the first week after discharge from psychiatric inpatient care (Qin & Nordentoft, 2005; Appleby et al., 1999)."

This toolkit focuses on continuity-of-care strategies to avoid gaps in service and includes best practices for both the mental health system as a whole and individual entities such as UNI.

UNI already uses many strategies from the best practice toolkit published by Utah's Division of Substance Abuse and Mental Health DSAMH, such as following up with patients by phone after they discharge.

UNI includes many of these strategies in its practices. For example, UNI is cited in the toolkit as an example for following up with caring contacts. UNI received a grant from the national Substance Abuse and Mental Health Services Administration to fund a crisis worker who makes follow-up calls to patients who have recently been discharged. UNI also involves a patient's support networks in discharge planning and utilizes peer-support specialists.

However, UNI has not yet implemented other strategies listed in the toolkit such as rapid referral agreements with outpatient providers to facilitate immediate follow up appointments. We recommend UNI work with DSAMH to identify which strategies are appropriate to implement or expand now and begin incorporating these strategies into UNI's discharge processes. However, some strategies must be approached at the system level. The remainder of this chapter focuses on systemic barriers to stepped care, which the toolkit defines as "a continuum of treatment intensity based on the needs of the individual."

Like mental health patients at increased risk of suicide after discharge, patients admitted for detox who do not continue treatment after inpatient care are more likely to relapse. Additional care is critical for both substance use and mental health recovery. Figure 4.3 shows the options for levels of care after inpatient discharge.

Figure 4.3 Levels of Care from High to Low Intensity Following Inpatient Care. Discharge referrals to appropriate levels of care are necessary to promote successful recovery. Patients are referred to the levels below depending on their needs, preferences, and insurance coverage.

Level of Care	Description
Residential Treatment Center	Deliver assessment, diagnostic services, and treatment for patients who do not require the intensity of nursing care and medical monitoring offered in inpatient care. **24-hours/day, 7-days/week**
Partial Hospital Program	Stabilize and reduce acute signs and symptoms, increase functioning, and assist with integrating into community life. **At least 20 hours/week**
Day Treatment *(Mental Health Only)*	Promote recovery through improved level of functioning, skill building, and disease management for those with severe mental health conditions. **At least 3 hours/day, 4 days/week**
Intensive Outpatient	Monitor and maintain stability, decrease moderate signs and symptoms, increase functioning, and assist members with integrating into community life. **At least 9 hours/week***
Outpatient Therapy	Address factors (e.g. changes in signs and symptoms, social and environmental factors, or level of functioning) to the point that treatment is no longer required. **At least 45 minutes per week**

**6 hours per week for children*

Partial hospital, day treatment, intensive outpatient, and outpatient therapy are all considered outpatient levels of care.

As shown in Figure 4.3, the spectrum of intensity for outpatient programs ranges from 20 hours per week in partial hospital programs to less than one hour per week for outpatient therapy. This fully developed continuum of care would allow for treatment to adjust to patients' changing needs. However, some of the levels shown in Figure 4.3 are not widely accessible to all Utahns due to location and cost.

Location of necessary transitional outpatient services is a barrier for both insured and uninsured patients. It is a larger problem in rural areas than urban areas.

Location of services is a significant barrier, for both insured and uninsured patients. UNI staff report that transportation to services is a challenge. For patients in intensive outpatient, partial hospital, or day-treatment programs, where services occur multiple times per week, distance and transportation can be prohibitive, especially for those in rural areas. The final section of this chapter explains challenges to providing residential care to Medicaid patients.

Medicaid Rules Can Discourage New Service Providers

Current rules state Medicaid will pay for only 15 days of care in a residential treatment facility with more than 16 beds. This applies to Utah's state hospital as well as residential treatment centers and leads to patients being discharged from residential treatment before they can be treated effectively in a lower level of care. Additionally, room and board are not covered in residential treatment settings. We have been told that it is difficult for facilities that accept Medicaid patients to be financially viable given the federal rules. The federal rules limit the number of facilities that accept Medicaid patients, and may be a barrier to entry for prospective service providers.

The Legislature passed SCR1 urging Congress to allow more than 15 days of coverage in residential treatment facilities with more than 16 beds, which would help more patients receive treatment.

The Legislature is aware of these rules and has recently passed a resolution. During the 2019 General Session, the Legislature passed S.C.R. 1, Concurrent Resolution on the Payment for Treatment in an Institution for Mental Illness. This resolution "urges Congress to extend Medicaid coverage beyond 15 days for services provided in certain settings to adults with serious mental illness." By allowing facilities to bill for more than 15 days when clinically necessary, patients would be able to receive appropriate treatment.

External barriers present challenges for transitioning patients to the appropriate level of post-hospitalization care. Despite limited treatment options, UNI staff engage in a robust discharge planning process to best meet the needs of patients.

Recommendation

1. We recommend UNI work with DSAMH to identify continuity of care strategies that will improve their discharge processes for patients at increased risk of suicide after hospitalization.

Chapter V
Quality Assurance for UNI's Crisis Line and Clinical Assessments Can Be Enhanced

The University Neuropsychiatric Institute (UNI) has a formalized process in place for measuring and reporting the quality assurance of its services. Through our audit review process, we focused on the quality assurance processes for the Crisis Line and the Clinical Assessment Center (CAC). The quality assurance process at the Crisis Center is relatively new and can be strengthened for the Crisis Line (this includes the Salt Lake County Crisis Line and the National Suicide Prevention Lifeline). The Crisis Center should consider making the following modifications to the Crisis Line's quality assurance procedures:

- Utilizing independent reviewers
- Adjusting the sampling methodology to consistently review all crisis workers
- Gathering caller feedback
- Conducting call monitoring

The CAC's process for document review should be more formalized, like the process for the Crisis Center. The CAC should track the results of the document review and add an outcome measure. The CAC's document review should also include an independent reviewer who is not involved in assessment decisions.

Quality Assurance Process at the Crisis Center Can Be Strengthened

UNI's Crisis Center is currently meeting most of its quality assurance goals; however, the quality assurance process can be strengthened.

Organizations offering crisis intervention are responsible for making sure that trained crisis workers continue to practice effective crisis intervention techniques and for ensuring the integrity of their operations. The Crisis Center recently began a formalized process for measuring the quality of its services (the Crisis Line, the Warm Line, the SafeUT app, and mobile crisis outreach teams (MCOTs)). The Crisis Center is currently meeting most of its quality assurance targets; however, we found that UNI can strengthen the quality assurance

process for its Crisis Line service by implementing additional procedures that are present in other crisis hotlines' quality assurance programs.

The Crisis Center Recently Established a Formalized Quality Assurance Process

In June 2018, the Crisis Center began a formalized process for performing quality assurance audits. They are continually looking for ways to improve their process.

Crisis Center management is continually adjusting and improving operations. One such improvement began in June 2018, when the Crisis Center began a formalized process for performing quality assurance audits of its crisis services. Managers at the Crisis Center identified performance measures for their services (Crisis Line, SafeUT app, MCOT, Warm Line) and used these measures to create an audit checklist for each service.

Every month, Crisis Center management evaluates documentation from 25 crisis interactions for each service (phone calls, SafeUT chat threads, MCOT outreaches, and Warm Line), for a total of 100 reviews per month. Crisis Center management reports the results of those audits to the University of Utah Health Information Management Department, which holds management accountable for audit results. Crisis Center management acknowledge that their quality assurance process is new and that they are continually looking for ways to improve it. Our review found that the quality assurance process for the Crisis Line can be strengthened.

The Crisis Center is working with a Workforce Management consultant to help improve efficiency.

In addition to formalizing its quality assurance process, the Crisis Center has begun working with a Workforce Management (WFM) consultant to analyze Crisis Line data. WFM's data analysis and consultation services assist the Crisis Center in making quality improvement decisions. With the help of WFM, the Crisis Center has improved upon its goal of reducing the number of instances when crisis workers fail to answer a call within 24 seconds or prior to 4 rings. Since May 2018, the Crisis Center has decreased the frequency of those instances by 50 percent.

The Crisis Center Should Consider Some Additional Procedures Used in Other Crisis Centers

The Crisis Center's quality assurance process for the Crisis Line is a document review of the 25 crisis interactions per month. However, we found that quality assurance processes at other crisis lines we reviewed

often include more than a document review; they also include formalized call-monitoring processes and gathering and addressing caller feedback.

The document review currently consists of 19 performance measures. Most of these measures evaluate completeness of documentation for each call, while a few measures are outcome based. For example, one of the outcome measures asks whether the documented action taken by the crisis worker was correct for the situation.

The Crisis Line document review consists of 19 performance measures, but the overall process can be further refined.

We realize that the Crisis Center's formalized quality assurance process has only been in place a short time. However, as the quality assurance process continues to be refined, we suggest UNI adopt the following procedures for Crisis Line reviews:

- Using independent reviewers
- Adjusting the sampling methodology
- Gathering and addressing caller feedback
- Conducting call monitoring

We reviewed five crisis call centers[9] as part of the audit to determine quality assurance practices for their crisis lines. Figure 5.1 shows that crisis call centers in Arizona, Colorado, and Georgia, as well as the U.S. Veterans Crisis Line (VCL) have implemented all four of the procedures listed above. New Mexico's crisis line has implemented two of the four procedures.

We reviewed five crisis call centers as part of the audit to compare quality assurance practices.

[9] In addition to reviewing crisis call centers in the nearby states of Arizona, Colorado, and New Mexico, we also included Georgia's call center, based on a suggestion from a consultant for the Division of Substance Abuse and Mental Health. Georgia's call center is a high-performing center due to its technology systems. We also reviewed the VCL, as it is a national call center.

Figure 5.1 Quality Assurance in Other Crisis Call Centers Goes Beyond a Document Review. All five call centers we reviewed have a formalized process to monitor crisis calls, and a majority collect and address feedback from callers.

	Has an Independent Review	Samples All Crisis Workers	Collects Feedback	Monitors Crisis Calls	Has a Document Review
Arizona		X	X	X	X
Colorado	X	X	X	X	X
Georgia	X	X	X	X	X
New Mexico		X		X	X
VCL	X	X	X	X	X
Utah					X

Source: Office of the Legislative Auditor General

Adding four procedures to the quality assurance process for the Crisis Line should help improve crisis intervention.

Adding these procedures to UNI's Crisis Line quality assurance process should help improve effective crisis intervention. Each point that follows demonstrates how implementation can be achieved at UNI.

UNI Should Have Independent Reviews for the Crisis Center. To help ensure that the quality assurance process is credible, those assigned to conduct the quality assurance review should be independent from Crisis Center operations. Crisis Center management developed the performance measures for their quality assurance reviews. Members of the Crisis Center management team also perform the quality assurance reviews. This same team is held accountable for the results of the reviews by the U of U Health Information Management Department—in terms of whether accuracy goals were met. Having reviewers who are also accountable for meeting accuracy goals can reduce objectivity. Therefore, independent reviewers would be preferable.

First, independent reviewers make the quality assurance process more objective and valuable.

The reviewers should not participate in developing the performance measures, and the reviewers should not be held directly accountable for the results. Three of the five crisis call centers that we reviewed have independent reviewers. Quality assurance processes for crisis lines in Arizona and New Mexico include phone call monitoring by crisis line supervisors who are not independent of operations.

UNI Should Include a Review of All Crisis Workers at the Crisis Center. Crisis Center management acknowledges that their

quality assurance practice of sampling the documentation for 25 crisis phone calls every month does not always include a review of every crisis worker. Management often devotes a relatively larger portion of the sampling each month to reviewing the documentation of newer staff. In order to ensure that crisis workers continue to practice effective crisis intervention techniques, the Crisis Center's quality assurance process should consistently review a sample of every crisis worker. Quality assurance programs at the VCL and at the crisis call centers in Arizona, Colorado, Georgia and New Mexico, monitor calls of all crisis workers consistently.

Second, the quality assurance process should consistently review a sample of every crisis worker.

UNI Should Gather and Address Caller Feedback for the Crisis Line. Crisis services are effective when the individual (1) has his or her needs met and (2) leaves with a plan that facilitates the continuation of recovery in the community. Because the quality assurance review for the Crisis Line is only document review, it does not include the caller's perspective on whether the call was helpful. The Crisis Center should have a formalized procedure for collecting and addressing feedback for Crisis Line calls. By tracking compliments and complaints, the Crisis Center will determine what is working well and identify ways to improve the quality of the Crisis Line service.

Third, by tracking feedback, the Crisis Center will determine ways to improve the quality of the Crisis Line service.

Crisis call centers in Arizona, Colorado, and Georgia, along with the VCL, collect and address caller feedback. Caller feedback is collected through end-of-call surveys, comment hotlines, and email. In Arizona, the crisis line quality assurance team uses an end-of-call survey to collect caller feedback. Arizona's survey asks callers to what extent they feel that the crisis line was able and willing to meet their needs during the call. VCL has an email questionnaire that is sent to callers to measure customer satisfaction. The VCL quality assurance team tracks the percentage of total callers whose reported experience meets the specified satisfaction goal.

UNI Should Include a Formalized Procedure for Monitoring Calls for the Crisis Line. From our sample of other crisis centers, we found it is common for crisis centers to have a formalized procedure of monitoring crisis phone calls by either a live review or by a review of recorded phone calls. According to the American Association of Suicidology (AAS) and the National Suicide Prevention Lifeline, it is important that quality assurance reviewers at crisis call centers include call monitoring to ensure quality of service. AAS recommends that crisis lines devote one out of every 40 hours of crisis work to direct

Fourth, the American Association of Suicidology recommends that crisis lines monitor calls.

supervision of crisis calls. AAS emphasizes the importance of monitoring both sides of calls during that direct supervision.

All of the crisis call centers we reviewed record crisis calls to monitor them for quality assurance and liability purposes. Reviewers at those crisis centers evaluate crisis workers' competency in areas such as empathy, active listening, suicide assessment, rapport building, and effective conclusion or intervention. By adopting the call-monitoring processes used in other states and call centers, the Crisis Center could help ensure that crisis workers are handling calls appropriately. UNI administration has had discussions regarding phone call recording but has decided not to implement a recording mechanism. Administration is concerned that people in crisis may not stay on the line if they know they are being recorded. The Crisis Line should at least have a formalized process in place to consistently monitor calls for quality assurance purposes, even if the calls are not recorded.

All of the crisis call centers we reviewed record crisis calls to monitor them for quality assurance and liability purposes.

The Crisis Center is in the process of becoming more established. It is not currently accredited but is planning accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF). Even though accreditation entities may have specific requirements, UNI should consider the crisis call center practices listed in this section of the report to continuously improve and refine operations as the center continues to grow.

The quality assurance process should consistently review a sample of every crisis worker.

CAC's Internal Document Review Should Be More Formalized

UNI's Clinical Assessment Center (CAC) provides individuals seeking treatment with an assessment to determine appropriate behavioral and mental health resources. The CAC conducts two types of audits: a monthly chart audit and a quarterly internal document review. We believe the internal document review needs additional procedures and a more formalized process, similar to the current chart review process. A more formalized process would help ensure that documentation for the assessments is sufficient and clearly written.

Individuals seeking treatment at UNI go to the Clinical Assessment Center (CAC), where they meet with a social worker for an assessment.

Individuals seeking treatment at UNI go to the CAC, where they meet with a licensed clinical social worker (LCSW) for an assessment. Assessments determine whether the individual meets criteria for hospitalization. If the individual does not meet criteria, the LCSW

identifies the appropriate level of care for the individual and refers him or her to other resources.

Two Types of Audits Are Conducted in the CAC

Two audits are performed in the CAC. The first audit, referred to as a chart audit, is overseen by the UNI Health Information Management Department. The chart audit is conducted to ensure the assessment process is well managed and that accreditation and federal requirements are met. For the chart audit, 25 assessments are reviewed monthly, and there is an annual audit each year. The chart audit includes questions such as whether the patients' race and ethnicity are documented, and whether parents/guardians are informed of their rights and responsibilities.

The chart audit is conducted to ensure accreditation and federal requirements are met.

The chart review does not include questions asking whether all information sections pertinent to the assessment were completed, nor does it include a review of the disposition of the assessment (whether the outcome was appropriate). The chart audits are submitted to the U of U Health Information Management Department, and the CAC is responsible for maintaining accuracy requirements.

The second audit is an internal documentation review of a sample of assessments to ensure documentation is sufficient and clearly written. The lead supervisor in the CAC conducts the documentation audits. In each quarter of the year, the supervisor reviews five assessments for each social worker. The supervisor provides feedback to the social worker if improvements are needed. We observed both types of audits, and we believe the documentation review should be a more formalized process.

The document review is to ensure the documentation for the assessments is sufficient and clearly written.

CAC's Document Review Process Needs Additional Procedures

Based on our observations and our audit findings discussed in Chapter III, we recommend that the CAC's internal document review process should be strengthened. Chapter III (Figure 3.3) showed that for 184 assessments reviewed by our consultant, 33 percent were not documented correctly. The following procedures can strengthen the document review process:

- Utilizing an independent reviewer
- Adding an outcome measure

- Tracking the results of the review
- Considering peer reviews

These procedures will help ensure the documentation for the assessments is complete and a consistent process. Each suggested procedure is discussed below.

Having an independent reviewer would help the CAC obtain an unbiased opinion on the thoroughness of the documentation.

An Independent Reviewer Would Add Credibility to the Document Review and Chart Review. The document review is completed by the lead supervisor in the CAC. The supervisor is also consulted in the decision-making process for the assessments being conducted. As a result, the supervisor is included in some of the assessments sampled, which can influence the reviews. Having an independent reviewer would help the CAC obtain an unbiased opinion on the thoroughness of the documentation and outcome of the assessment.

The chart review process also does not have an independent reviewer. During our audit, the lead supervisor was given the responsibility of completing the chart audits. The validity of the chart audit would be strengthened by having an independent reviewer who is not associated with the CAC.

The CAC's documentation review should add an outcome measure similar to the Crisis Center's quality assurance process.

Adding an Outcome Measure Would Help Confirm Assessment Results Were Appropriate. The documentation review focuses on whether the required information for the assessment is sufficient and clearly written. However, the review does not include an outcome measure, such as whether the disposition is consistent with the clinical information. The Crisis Center's quality assurance review includes outcome measures, such as whether the action taken is correct for the situation. An outcome measure or measures would improve the quality of the internal review.

By tracking results, CAC could make its document review process more useful for training purposes.

A Formalized Process for Tracking the Document Review Is Needed. The lead supervisor stated that the current process does not include tracking the results of the review. If an assessment needs to be clarified or lacks sufficient documentation, then the supervisor emails and/or has a conversation with the social worker who completed the assessment.

By tracking results, CAC could make its document review process more useful for training purposes, and accuracy rates could be calculated and viewed over time. UNI could consider including the

internal document review with the UNI Health Information Management Department's chart review, because the chart review already has a formalized process in place for tracking and summarizing the results. Also, the department could set the goals for accuracy levels, like it has done for other UNI quality assurance reviews.

Peer Review Would Help Ensure Documentation Is Consistent. Our consultant noted some inconsistency in the way the assessments were documented. We spoke with the manager at the Behavioral Health Access Center at Intermountain LDS Hospital about their quality assurance review, since they are a comparable center outside the University of Utah's healthcare system. We noted that they have a peer review as part of their process. Each clinician is assigned four random assessments to review each month. This provides feedback for the clinician and helps ensure the documentation is consistent among the staff. The center's manager stated that having a peer review process has helped improve the quality of writing for the assessments. UNI should adopt a peer review process to help improve the documentation of assessments in the CAC.

A peer review process could help improve the quality of writing for the assessments in the CAC.

Recommendations

We recommend that UNI's Crisis Center modify the quality assurance process for the Crisis Line by implementing the following procedures:

1. Having independent reviewers
2. Sampling all crisis workers consistently
3. Gathering and addressing caller feedback for the Crisis Line
4. Monitoring Crisis Line calls consistently

We recommend that UNI formalize its document review process for the Clinical Assessment Center by implementing the following procedures:

5. Having an independent reviewer
6. Adding an outcome measure or measures
7. Tracking the results of the review
8. Developing an ongoing peer review

Appendix

Legislative Appropriations for Activities Related to Crisis Services

Appendix

Appropriation Source	Recipient[10]	Purpose	FY 2018	FY 2019	FY 2020
2015 General Session					
SB175	UNI	SafeUT	$150,000	$150,000	$150,000
2017 General Session					
SB2	UNI	SafeUT	$550,000	$550,000	$550,000
2018 General Session					
HB2 Item 69	UNI	Market SafeUT		$175,000	$175,000
HB 370	DSAMH	Crisis response trainings	-	$250,000 *	-
HB3 Item 42	DSAMH	Expand crisis line services	$477,700 *	-	-
HB3 Item 72	AG's Office	Administrative costs	-	$1,300	$1,300
HB3 Item 187	DOH	Medicaid waiver (crisis medical codes)	-	$530,000 *	$1,060,000
HB3 Item 192	DOH	Medicaid waiver (crisis medical codes)	-	$295,000 *	$590,000
HB3 Item 207	DSAMH **	Expand crisis line services	-	$2,380,000	$2,380,000
HB3 Item 208	DSAMH	Five new MCOT teams	-	$2,595,000	$2,595,000
HB3 Item 261	USBE	Suicide prevention trainings		$275,000	$275,000
HB3 Item 261	UNI	SafeUT	-	$500,000	$500,000***
HB3 Item 275	Senate	Mental Health Crisis Line Commission participation	-	$1,600	$1,600
HB3 Item 287	House	Mental Health Crisis Line Commission participation	-	$1,600	$1,600
2019 General Session					
HB 373	UNI	SafeUT	-	-	$1,270,000
TOTAL			**$1,177,700**	**$7,704,500**	**$9,549,500**

Source: Auditor Generated
** Signifies one-time appropriations and appropriation adjustments.*
*** DSAMH contract with UNI to expand crisis services. It is anticipated that UNI will receive $1.9 million of this amount in fiscal year 2020.*
**** In the 2019 General Session, HB373 changed the intended use of this appropriation amount from expanding SafeUT in institutions of higher education to operational support for the SafeUT app.*

[10] See Chapter II page 6 for UNI specific legislative appropriation amounts.

Agency Response

HEALTH
UNIVERSITY OF UTAH

March 29, 2019

Kade R. Minchey, CIA, CFE
Auditor General Office of the Legislature Auditor General
Rebecca Lockhart House Building, SuiteW3l5
Salt Lake City, Utah 84114-5315

RE: Response to the Performance Audit of the University Neuropsychiatric Institute and Crisis Services (Report #2019-02)

Dear Mr. Minchey:

The University of Utah Neuropsychiatric Institute (UNI) appreciates the opportunity to respond to this legislative audit of its Crisis Services operations. The Crisis Services team have seen dramatic growth over the last couple of years and have responded as noted in the audit with a sense of community as there was not a similar growth in funding. The University of Utah Hospitals and Clinics (UUHC) leadership team considers the UNI organization and the mental health services they deliver to be a critical benefit to the health of Utah citizens.

UUHC leaders and the UNI team have carefully reviewed the report and are in agreement with Auditor General's recommendations. Many of the recommendations have already been implemented and the remaining are in the process of being implemented.

A significant finding of the audit was the inadequate funding level that will be needed in the future as our citizens continue to reach out for help via the UNI supported SafeUT App, various Crisis Lines, and the Mobile Crisis Outreach Team. Quoting from the audit, "While ongoing appropriations address a need, funding concerns for crisis services at UNI remain."

The UUHC and UNI teams will continue to look for ways to streamline service delivery, but the volume growth will likely go beyond our ability to keep up.

We appreciate the work of the Auditor General's team and the professional and collaborative way they completed the work. It was especially noteworthy that they went above expectations to observe our operations around the clock, including visits to several of our after hours and weekend shifts.

Sincerely:

Ross VanVranken, Executive Director
U of U Neuropsychiatric Institute

Gordon Crabtree, CEO
University of Utah Hospitals and Clinics

cc: Dr. Ruth V. Watkins, President UofU
Dr. Michael V Good, SVP U Health