



**Maryland House Detox, LLC
CON Application
Completeness Response**

May 4 | **2016**

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Please explain the respective roles and responsibilities of Delphi Behavioral Health Group, LLC and DCX Group, LLC with the proposed MHD.

Delphi Behavioral Health Group and DCX Group exist in a symbiotic partnership to jointly operate MHD. Each entity is equally accountable to the other and equally responsible for the operation, standards of care, fiduciary solvency, and overall success of MHD.

There will be no noticeable disconnect between the two entities within MHD. The separation of entities merely exists for legal ownership purposes. Each entity owns a portion of the MHD entity, as with any jointly owned operation. This model follows the DBHG model predicated on drawing from DBHG's successful track record of identifying suitable de novo sites, securing properties, overseeing zoning, licensure and development of facilities and integrating de novo centers into its treatment facility network where centers share a common service platform (i.e., bookkeeping, accounting, admissions processing and marketing). DBHG's strategy is to target facilities with 16-60 bed potential and high clinician-to-patient ratios. Importantly, the DBHG seeks highly qualified and committed operators that share Management's philosophy of patient treatment.

DCX can be considered the on-the-ground operations in MD. With special knowledge of the healthcare landscape in the state and experience in operating medically monitored inpatient detoxification, DCX Group assumes the day-to-day operations of patient care within MHD.

DBHG can be considered a parent company as such. DBHG is responsible for funding the operations, supporting MHD with economies of scale for financing options, marketing efforts, human resources, bookkeeping and accounting, intimate knowledge and experience of billing and collecting practices, and relationships with commercial insurance carriers.

MHD is considered a fully self-sustaining separate entity, but stands with DBHG within its larger network of care as another substance use treatment option. This set up allows MHD and DBHG to create synergy by sharing resources, sharing best practices, and providing localized options for patient care.

2. Does Maryland Healthcare Real Estate, LLC, have a relationship with either Delphi Behavioral Health Group, LLC and/or DCX Group, LLC? If so, please describe this relationship.

Maryland Healthcare Real Estate is a real estate holding company held solely by DBHG Board Member and MHD Board Member, Ryan Collison. DBHG, DCX,

and MHD all operate autonomously from MHRE as entities. Maryland Healthcare Real Estate does not have any legal relationship with DBHG or DCX other than holding the lease to the property located at 817 S. Camp Meade Rd as the landlord to MHD. MHD is bound to the parameters as a tenant set forth in the lease, including the payment of fair market rent to MHRE. MHRE is also bound to the parameters as a landlord set forth in the lease and is held accountable as such.

3. **The application directs the applicant to include scalable schematic drawings of the facility at least at 1/16" scale that are completely legible and include dates. These drawings should include the following, before (existing) and after (proposed), as applicable:**
 - i. **Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".**
 - ii. **For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.**
 - iii. **Specify dimensions and square footage of patient rooms.**
4. **Please provide a brief summary of the age and current condition of the building formerly operated by Hospice of the Chesapeake in Linthicum, Maryland. Please provide a short summary on the type of renovations and work needed to convert the former Hospice of the Chesapeake to the 16-bed Maryland House Detox.**

The original structure was built in 1972 and a major addition and renovation was completed in 2007. From 2007 through 2014 the building served as a hospice facility for the Hospice of the Chesapeake. The building currently has eight rooms for single patient use; three have full bathrooms and five have half bathrooms. The building is in good condition but will require modifications to serve as a medically monitored inpatient detoxification hospital. Because this building will now be classified as institutional use, all structural elements will have a one-hour fire resistance rating. There will be seven residential units that house 16 total patients. Each unit will have its own full bathroom with shower. A portion of the space to the left side of the building will be reconfigured to provide administrative offices, a medical exam room, lab, common staff area, lobby/waiting area and an ADA accessible residential unit. A commercial kitchen is being provided in the space of the previous kitchen and the dining area/community room is extending into the enclosed porch. Mechanical,

electrical and plumbing systems will be updated to serve the revised spaces. Exterior modifications will be extremely minor – limited to the replacement of doors for windows in some patient rooms.

PART II – PROJECT BUDGET

- 5. On p. 8 of the Project Description the application states that the total cost will be \$1,936,275. However, the Project Budget (Table E) indicates a Total Cost of \$1,194,800. The difference appears to be \$741,475 in start-up costs during 2016 prior to opening which appear in the operating budget. Please confirm whether these expenses are meant to be considered part of the project budget?**

In an effort towards complete transparency to MHCC and to increase the accuracy of internal accounting and earmarking processes, the \$741,475 in start-up costs listed in the application are indicated as a part of the total project costs. Because these include certain carrying costs such as lease obligations and finishing costs including furniture and equipment, it was necessary to include the costs as a part of the overall project budget. The budget was broken down into two categories: construction costs and start-up costs. The construction costs are meant to contain only those costs explicitly related to the design, permitting, and actual construction. To clarify, the construction costs of \$1,194,800 are broken down into line items in Table E. The start-up costs are broken down on pages 84-84 of the application. To reconcile the differences, these start-up costs have been added to Table E Project Budget in Line Item A.3. Working Capital Startup Costs. The annual lease holding costs incurred during the start up phase have also been included in this number and removed from the Building Lease Cost line item with a note added to indicate this.

- 6. The project budget does not show permit fees; is this an oversight?**

The permit fees were originally included in the project budget as a part of the Architectural/Engineering Fees. The permitting fees have been calculated to be \$6,496.59. This number is based off of fee schedule on Anne Arundel County's website - http://www.aacounty.org/departments/inspections-and-permits/permit-center/IP_Permits/Building-Permit - whereas the permitting fees are \$140.00 plus .007 times estimated cost above \$25,000 (total construction costs are \$933,084). The permitting fees have been separated from the architectural/engineering fees and reflected in the Table E Project Budget.

- 7. Please state the assumptions and calculations that determined the amount of contingency allowance (\$103,798).**

The contingency was based on 10% of construction, insurances, overhead, and profit. At this level of mechanical, electrical, and plumbing work with the specifications indicated, MHD's contracting consultant's experience dictated that it would be wise to establish a contingency line item. This contingency took into account lost or forgotten items and unknown conditions that might not be revealed until the project is underway. Both architectural and contracting entities agree that this is a reasonable number because MHD is renovating an existing building and unforeseen problems can arise during the construction process.

PART V - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

a) The State Health Plan

10.24.14.05D(1) Provision of Service to Indigent and Gray Area Patients

- 8. MHD's plan to reserve two beds at all times for indigent and gray area patients is a creative and proactive approach to meeting this criterion. As described in the application, such a procedure "translates into a 12.5% dedication of total bed days to charity care..." and MHD expressed the expectation that "the total portion of bed days committed to actual care of these patients will reach 15% or higher annually."**

- a) Please describe how that outcome would come about.**

MHD expects the possibility that the indigent and gray area patients occupying its dedicated beds may account for a longer average length of stay than its commercially insured patients. Average length of stay for patients at this level of care is determined by medical necessity and authorizations by third party payers. The socioeconomic factors affecting the health and delivery of care to indigent and gray area patients may cause an increased frequency and intensity of co-morbidities in these patients. Proliferation of acute symptoms will arise with the amplified co-morbidities. Increased acuity will strain medical necessity – a medical necessity that is not bound by authorizations by third party payers. Though its experience, MHD expects that a length of stay not bound by authorization and complicated by co-morbidities will certainly be longer than average.

- b) Clarify if MHD is seeking an exception from the 15% threshold in outcomes, or merely in the operational procedure of dedicating beds (which yields 12.5%).**

MHD is seeking an exception from the 15% threshold in outcomes. MHD plans to reserve two beds at all times for indigent and gray area patients. Due to the logistics of this operation, MHD can say with 100% certainty

that it can dedicate 12.5% of its patient days to meeting the provision set forth by the State Health Plan. While the total patient days accrued in these beds may actually account for 15% or more of the total patient days for the reasons discussed above, MHD cannot forecast these amounts with the accuracy it would deem appropriate to guarantee to MHCC. Because it can absolutely guarantee 12.5% of its bed days, MHD requests that it be granted an exemption from the 15% threshold.

10.24.14.05M. Sub-Acute Detoxification

- 9. Policies for Staffing Standards and Physical Plant Configuration are missing from Exhibit 8; please submit.**

See attached policies.

TABLES IN EXHIBIT 4

- 10. Tables B and C show different square footage totals. Please explain. If there are any changes, you will need to update all the numbers on Table C, especially for the perimeter.**

In the original application, the areas on Table B were calculated as net areas, while Table C reflected accurate gross areas. Table B has been updated to reflect the gross areas for each function and now matches the total areas in Table C.

- 11. Are the projections on Table I for calendar or fiscal year? Please reconcile the difference in 2017 utilization projections for the 16 bed substance abuse unit reported in Table 2 on p. 58 with the numbers reported in Table I on p. 143.**

All of the Tables in the MHD application reflect the Calendar Year, including Table I. Table I was originally interpreted by MHD to provide overall capacity availability rather than projected utilization. Table I has been updated to reflect projected utilization for 2017 rather than total capacity and now matches Table 2.

- 12. Please provide a copy and documentation of Treatment Improvement Protocol (TIP) 45, which MHD cites numerous times in the CON application.**

NEED

- 13. The application makes reference on p. 54 to the support of BWMC, as evidenced by referral and transfer agreements. A letter of support speaking**

to the need and MHD's ability to help meet that need would be more convincing than these agreements.

A letter of support from BWMC was originally discussed in meetings with MHD and BWMC's Director of Psychiatry and Director of ED. While these parties expressed sincere excitement about the MHD project and the prospect of working together, the referral agreements (already obtained) and the letter of support needed approval from BWMC's CEO. While BWMC's CEO was optimistic about MHD and executed the referral agreements, the CEO wished to delay a letter of support until she had an opportunity to read the entire MHD application. A meeting between MHD and BWMC to discuss this letter of support has been scheduled for May 10, 2016. MHD will report the disposition of this meeting to MHCC once it has occurred.

- 14. On p. 54 the application states: "Real time evidence of phone inquiries to all existing residential treatment III.7.D providers, requesting only detoxification services, revealed there are no track one providers within the state that will solely provide the detox level of treatment." Please confirm which facilities were surveyed.**

Father Martin's Ashley, Warwick Manor, and Pathways were surveyed. These are the only existing track one III.7.D providers within the state that were identified by MHD in its application.

- 15. Reference is made to "warm handoff." Please define that and contrast it with the alternative. Is the implication being made that MHD's "warm handoff" distinguishes it from other providers?**

To clarify, MHD's warm handoff procedure is detailed in select policies previously provided in the application. It can be located in Exhibit 8 in the Clinical Policies and Procedures – Discharge of Patients Planned from pp. 204 – 207.

The warm hand-off is an introduction to the treatment provider delivering the next level in the continuum of care culminating in a phone, video call or face-to-face meeting. The process is initiated early in the patient's stay with MHD and executed prior to discharge. It is a familiar approach used by complex case management and healthcare providers of all disciplines. It is an extended process-method to ensure that MHD's case management team has completed a hand-off to a provider that includes a scheduled admission or appointment, patients have had substantive communication with their new provider, and that the patients actually arrive to their referral destination. MHD places operational emphasis on this

process so that patients do not simply receive medical detox without engaging in subsequent extended substance use treatment.

Discharge planning is complex but is guided by evidence-based case management standards of practices. The warm hand-off is a term used to easily coin a component of the referral process. This component entails comprehensive collaboration between MHD, the subsequent provider, and the patients and their stakeholders. When implemented between the current provider, the patient and future parties involved in the treatment and care of that patient, it generally includes a significant exchange of information and assures linkage.

The warm hand-off procedure is a hallmark of MHD operations. MHD plans to act as an entrance into the larger treatment system. In this spirit, the warm hand-off procedure is integral to MHD's success. MHD's executive staff maintains relationships with treatment providers across the state (as evidenced by executed referral agreements) and across the country (from years of experience in the field). In a meeting to discuss the opening of MHD, the Anne Arundel County Health Department voiced concerns about what it sees during transition of care - patients often falling through the cracks shortly after discharge. To be certain that all patients concluding stabilization at MHD arrive and connect with their referral providers for continued care, MHD decided to enhance the referral process with much greater emphasis on the collaborative communication aspect early in patients' stays.

This patient-centered activity will set the stage for the patient to become acquainted and familiar with the subsequent provider. The planning of a much "warmer" hand-off is a major emphasis and treatment component at MHD. It is initiated during the admission process, further explored, then incorporated into the treatment plan with implementation initiated any time during the patient stay, and fully executed 1-2 days prior to the anticipated day of discharge. MHD will accomplish this integrative and collaborative process with 100% of discharge referrals actually connected into the continuum of care and to their primary medical care providers.

The highly integrative approach will have a positive impact on the patient beyond detox and treatment, and serve to close any gap in services. The implication is not that MHD's warm hand-off procedure distinguishes it from other providers. MHD does not contend that other providers do not complete their own successful referral procedures – only that a special internal emphasis will be placed on MHD's referral process.

In addition to the therapeutic and social staffing, MHD also plans to employ two full time case managers to facilitate warm hand-offs to providers in the treatment

system. As the hallmark of MHD's modality is to stabilize and refer, it is committed to staffing the positions responsible for successful handoffs beyond what is required by code. The new behavioral health standards in COMAR 10.47.02.09 dictates that a program provides clinical staff at an 8:1 patient to staff ratio. By employing two full time case managers in addition to two full time clinical staff, MHD has doubled the required staff ratio in order to dedicate staff for the sole purpose of discharge planning and ensure the success of the referral process.

At the inception of MHD, it was evident that an enhanced procedure at discharge would be employed to assure a seamless transition from detox treatment services at MHD into the continuum of care. Patients at MHD depart from the facility a vulnerable point in early recovery after detox concludes, so no other alternative to the warm hand-off procedure would be acceptable. MHD deems it virtually impossible to consider any alternative to the warm hand-off referral process as an appropriately planned discharge. This process assures the patient has connected with the referral and will provide the most responsible discharge option to support ASAM guided recommendations for continued treatment along the continuum.

The alternative to this process would be for MHD to take a passive, reactive approach to discharge planning by merely providing discharge referrals in the form of recommendations or printed document given at discharge. This would allow patients to walk out of the door without a concrete plan for continued treatment and in some cases it would be likely that the patient may not ever arrive at the referral destination. Any gap in service accompanied by a lowered drug tolerance level in the patient would potentially place the patient at risk.

Referral Processes Highlighted from select policies previously provided in the application:

CL 5:001 DISCHARGE OF PATIENTS-PLANNED

Discharge Policy:

Case managers will provide support for the individual during the intake admission process, through the entire course of detoxification treatment, implementing a warm hand off referral to subsequent level of treatment assuring a seamless transition to the subsequent level in the continuum of care

MHD's WARM HAND OFF REFERRAL PROCEDURES:

- 1. MHD will arrange teleconferencing with the referral provider to augment communication efforts and maximize patient desire and willingness. The contact will occur prior to discharge.*

2. *In the event the chosen referral provider maintains a reasonably accessible geographical location, and/or is unable to teleconference with the patient, MHD may deem it appropriate to transport the patient to the location for the face-to-face component of the warm hand-off process.*
3. *Whenever possible, MHD will provide transportation and accompany patient to their intake appointment with the referral provider.*
4. *The case manager will clarify the discharge referral plans and continuing discharge instructions with patient and family, which includes agreement to receive follow-up survey calls at 90-180-365 days*
5. *MHD will obtain additional consent from the patient for follow up within the first 14 days and again at 30 days post discharge with referral provider to ensure patient's engagement in treatment.*
6. *If patient has not engaged in treatment with the referral provider, MHD will contact patient and offer assistance in locating additional resources and treatment sources for patient.*

CL 1:003 CASE MANAGEMENT STANDS OF PRACTICE

Through the entire course of detoxification treatment, the case manager will identify referral resources implementing a warm hand off referral to subsequent level of treatment, thereby assuring a seamless transition to the subsequent level in the continuum of care.

A “warm hand-off” referral procedure initiated shortly after admission will assure uninterrupted provision of services into the identified subsequent level of treatment along the continuum of care.

VIABILITY

- 16. On Table 3 and Table 4 there is a \$2.4 million allowance for bad debt; is this meant to be contractual allowances?**

As stated in the application, MHD will begin operations an out-of-network provider; therefore MHD technically will not have any “contractual allowances”. Until MHD is able to establish a billing history with insurance companies to negotiate contracts, it will operate in this matter. Until contracts can be obtained, MHD would consider this bad debt for write off rather than a contractual allowance. However, the basic concept of the way the allowance for bad debt is utilized in the application is the same as a contractual allowance.

- 17. Table 3 shows no participation in Medicare and Medicaid. Please explain.**

MHD does not plan on participating with Medicare and Medicaid. Officially, Medicare does cover substance abuse services. Medicare only has a benefit for inpatient psychiatric services. While some providers co-mingle these services, MHD will operate as a substance abuse treatment provider and will not co-mingle the official psychiatric services as one of its own.

MHD does not plan on participating with Medicaid either. MHD plans to operate as a private, track one facility. The bottleneck that exists in MD in regards to the track one beds is real, as evidenced by our discussion of need. MHD will in fact end up treating Medicaid patients as part of its indigent and gray area provision, but will not be reimbursed for these services.

18. MHCC has discovered that Table 4 in the on-line application was truncated and incomplete. A corrected version of the application has been emailed to you. Please complete Table 4.

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)				
	CY or FY (Circle)	2016	2017	2018	20__
1. Revenues					
a. Inpatient Services	0	\$7,200,000	\$9,600,000		
b. Outpatient Services	0	0	0		
c. Gross Patient Services Revenue	0	\$7,200,000	\$9,600,000		
d. Allowance for Bad Debt	0	\$2,400,000	\$3,360,000		
e. Contractual Allowance					
f. Charity Care	0	\$1,200,000	\$1,200,000		
g. Net Patient Care Service Revenues	0	\$3,600,000	\$5,040,000		
h. Total Net Operating Revenue	0	\$3,600,000	\$5,040,000		
2. Expenses					
a. Salaries, Wages, and		\$477,025	\$2,293,760	\$2,293,760	

Professional Fees, (including fringe benefits)				
b. Contractual Services	\$10,000	\$60,000	\$60,000	
c. Interest on Current Debt	N/A	N/A	N/A	
d. Interest on Project Debt	N/A	N/A	N/A	
e. Current Depreciation	N/A	N/A	N/A	
f. Project Depreciation				
g. Current Amortization	N/A	N/A	N/A	
h. Project Amortization				
i. Supplies	\$49,000	\$25,000	\$25,000	
j. Other Expenses (Specify)	\$205,450	\$325,060	\$327,560	
k. Total Operating Expenses	\$741,475	\$2,703,820	\$2,706,320	
3. Income	(\$741,475)	\$896,180	\$2,333,680	
a. Income from Operation	(\$741,475)	\$896,180	\$2,333,680	
b. Non-Operating Income				
c. Subtotal	(\$741,475)	\$896,180	\$2,333,680	
d. Income Taxes		(\$61,882)	(\$933,472)	
e. Net Income (Loss)	(\$741,475)	\$834,298	\$1,400,208	
4. Patient Mix:				
A. Percent of Total Revenue				
1. Medicare				
2. Medicaid				
3. Blue Cross	20%	20%	20%	
4. Commercial Insurance	62.5%	62.5%	62.5%	
5. Self-Pay	5%	5%	5%	
6. Other (Specify)	12.5%	12.5%	12.5%	
7. TOTAL	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)				

1. Medicare				
2. Medicaid				
3. Blue Cross	20%	20%	20%	
4. Commercial Insurance	62.5%	62.5%	62.5%	
5. Self-Pay	5%	5%	5%	
6. Other (Specify)	12.5%	12.5%	12.5%	
7. TOTAL	100%	100%	100%	100%

STAFFING STANDARDS

Maryland House Detox will provide medical monitoring, detoxification and stabilization services directed by an Interdisciplinary Team of Professionals, knowledgeable and experienced in providing appropriate care, treatment and services for the substance use disorder patient. Following approval for admission, the patient will be assigned to a team of providers that include the physician, physician assistant or nurse practitioner; registered nurses and licensed practical nurses; mental health technicians; therapist and case manager.

Treatment philosophy is based upon a medical disease model and will address substance use disorder as a chronic disease, with the understanding that co-occurring disorders and comorbidities may also and usually do exist in tandem. Individualized care, treatment and services provided will address the primary diagnosis(s) of SUD, to include initial stabilization of withdrawal symptoms as they emerge, with ongoing detoxification and monitoring that will include utilizing a medication assisted treatment protocol.

Medically monitored detoxification services are provided under the direction and guidance of a Board Certified Medical Director; a Physician, Psychiatrist or Doctor of Osteopathy (DO), familiar and certified by the American Society of Addiction Medicine. The full complement of licensed medical providers will draw from a host of current evidence-based medication assisted detox protocols, individualizing treatment approach to maintain treatment safety, while meeting the goals and objectives relevant to the patients' unique needs.

The interdisciplinary approach will focus on the physical, emotional, social, and spiritual characteristics of the substance use disorder patient. This integrative program is for adult men and women with active substance dependency. Intensive case management is implemented on admission with crisis stabilization and referral management is the primary focus for discharge into the continuum of care.

Specialty Services Provided:

- Bio-psychosocial & comprehensive assessment
- Intensive case management
- Dual disorders evaluation and treatment
- Co-occurring disorders screening and referral
- Introduction to community-support networks
- Linkage(s) to primary care provider and/or specialist

- Warm hand-off referral process with continued care provider
- Opiate Use Disorder (OUD) overdose prevention education

Team Assignment

Primary Clinical team - Upon admission, each patient will be assigned a Primary Clinical team that will lead and be responsible for full service coordination and provision of clinical care, treatment and services during their inpatient detox treatment course.

Primary assignment promotes a seamless transition with the warm hand-off referral process.

Rotating Medical team - Each day the patient will be assigned to a medical team, responsible for implementation of withdrawal management, ancillary medical and nursing care services. Team assignment will vary from day to day. Daily re-assignment will allow for increased staff monitoring and expanded oversight during stabilization and continued detoxification management.

Medical: Nurse
 Mental Health Tech

Clinical: Therapist
 Case Manager

General Medical / Clinical services and staff availability

Medical services are provided 24/7, including all holidays. Staff availability is:

Medical Director/ Physician/Nurse Practitioner: combined on-site/on-call 24/7

Director of Nursing/Nursing: both on-site/on-call 24/7

Mental Health Tech: on-site 24/7

Clinical services are provided 8:00am – 8:00pm, including holidays. Staff availability is:

Clinical Director: combined on-site/on-call 24/7

Case Management: on-site 8:00am – 6:00pm/on-call as needed

**Therapist: on site 8:00am – 8:00pm, on-call 24/7

**Counselor: on-site 8:00 – 6:00pm (contracted for specific education/topics)

**Licensure or certification as an alcohol and drug counselor by the Board of Professional Counselors and Therapists; or licensed, certified, or permitted under the Health Occupations Article, Annotated Code of Maryland to provide substance abuse treatment will be required of Therapists and contracted counselors.

Staff to Patient Ratio

Patient care, treatment and services are provided by interdisciplinary teams, which include a Registered Nurse, Mental Health Tech, Therapist and a Case Manager. Nursing and Clinical staff ratio will be as follows:

Nursing

Day (7a-3p) and **Evening** (3p-11p) staffing are similar, as follows:

*Nurse 1 : 6 patients (this includes any new admissions)

*Mental Health Tech 1 : 8 patients

Night (11p-7a) staffing:

*Nurse: 1

*Mental Health Tech: 2

Clinical

Day/Evening (8a-8p)

*Therapist 1 : 8 patients

*Case Manager 1 : 8 patients

The patient to therapist/alcohol and drug counselor ratio will not exceed eight patients to one full-time alcohol and drug counselor

**Upon high acuity status, medical and clinical staffing may be adjusted in accordance with this policy, as described in further detail below.

Minimal / 24-hour staffing

MHD will have an on-site physician or nurse practitioner to provide the admission physical exam and comprehensive needs assessment, and to monitor treatment response and progress.

Around the clock on-call medical and clinical services are provided 24/7. Licensed medical and clinical providers will rotate scheduled “on-call” assignment from 10pm to 6am for overnight coverage regarding patient specific concerns, including screening incoming calls for potential admissions.

The Medical Director, Nursing Supervisor and Clinical Director will also be available for concerns elevated to a higher level

Licensed Nursing and Mental Health Tech services will be provided 24 hours a day, of which a registered nurse will provide 16 hours of service.

During night shift hours (11p-7a), there will be at minimum 1 nurse and 2 MHT, adjusted in accordance with acuity status.

High Acuity Assessment

Staffing patterns will be utilized to support the changing nature of patient's detoxification needs. Each shift, the Charge Nurse will review the current shift census and outstanding scheduled admissions. The Charge Nurse will plan and supervise ongoing delivery of care and treatment based on patient needs. Increased nursing requirements will initially reflect the acuity level assessed for individual patient care needs, determined at admission and reevaluated with monitoring for progress. Direct care assessment factors are:

- Detoxification and stabilization needs
- Presence and/or acuity of comorbid medical and/or co-occurring mental health disorders
- Acute physical limitations with ADLs
- Impairment in cognitive function or comprehension

Additional considerations that may dictate increase in staffing beyond the usual utilization patterns are:

- Transportation of patients to outside referral or other care services
- Anticipated admissions
- Higher medical or clinical acuity
- Unanticipated events of significant nature

The Charge Nurse will frequently reassess acuity level and report to the Director of Nursing regarding status in staffing requirements.

Events to trigger a “High Acuity Review”:

- *Any shift census that reaches 12 with at least 2 scheduled admissions;
- *Any shift currently on high acuity for 1 full shift. If the next shift is a night shift, the acuity adjustment will occur on the next day shift with adjustments when/ if appropriate.
- *The High Acuity status is to be reevaluated each shift with a final review determination reached by 4 hours but no less than 3 hours prior to start of next shift.

The Nursing Supervisor/Charge Nurse on each shift makes team assignments for nursing and mental health techs that reflect the current census; the number of admissions scheduled; the present acuity level and projection of patient care needs.

Executive, Administrative, Community Engagement, Nutrition and Ancillary services staffing

Executive offices and staff are available from 8:00am – 5:00pm M-F, excluding recognized holidays. Executive Staff are:

HR Manager

Finance Manager

Director of Nursing

Clinical Director

Executive Assistant

Chief of Operations

Chief Executive

Administrative offices and staff are available from 8:00am – 5:00pm M-F, including some holidays. Administrative Staff are:

Facility Manager: on-call 24/7 (as needed for emergency)

HIT / HIM Coordinator: (may be combined with other position)

Admissions (Intake & Screening) Coordinator (may be combined with CM)

Receptionist Administrative Assistant

Driver: on-call as needed

Community Engagement services and staff are available 8:00am – 6:00pm M-F, Development and Outreach Staff are:

Director of Business Development

Director of Community Outreach

Ancillary Services may be a function of other departments and are available as scheduled:

Facility Care (housekeeping): 6:00am-8:00pm

Lab: 9:00am – 12:00pm, 3:00pm – 7:00pm for admissions and routine.

Nutrition Services and staff are available from 5:30am – 7:30pm daily. Nutrition services staff are:

Executive Chef

Executive Chef Assistant

Nutritionist: as needed

Dietician: 10 hours/week

Staffing Standards Review

The Performance Improvement Committee will provide oversight of MHD staffing utilization. Monthly data will be compiled from the Utilization Management, Patient Safety, Risk Management, Human Resources, Strategic Planning and the Performance Improvement functions for analysis. Staffing Plan review for patient care services will include the following elements:

- 1) Effectiveness in meeting both life safety code standards and care, treatment and service requirements
- 2) Recommendations and/or concerns from all internal and external processes and customers regarding improvement in the quality of care
- 3) Scope of services
- 4) Regulatory core compliance
- 5) Ability to recruit / retain appropriate and qualified clinical/medical staff
- 6) Staffing variance reports; including trends or untypical patterns.
- 7) Patient care delivery quality and safety standards
- 8) Customer satisfaction survey data
- 9) Current fiscal position

The Staffing Plan will be re-evaluated by the Performance Improvement Committee on an annual basis; with intermittent modifications warranted by heightened acuity levels based on patient care needs, patient safety and performance measures.

Staffing utilization patterns will reflect and support patient-centered activities such as therapy groups, meeting with therapist, evaluations and medical assessments. Education and physical wellness sessions are scheduled to occur primarily during the day shift. Focus groups to include referral options will occur primarily in the afternoons with family focused sessions in the afternoon and evening, incorporating both patient and family participation and education.

PHYSICAL PLANT POLICY

Purpose

The purpose and objective of this plan is to provide a policy and guideline to provide a safe, functional, and therapeutic physical environment of care for patients, visitors, and staff at Maryland House Detox.

Scope

For purposes of this policy, facility means all structural components, equipment and physical spaces. This includes the building and the spaces within the building, equipment and interior finishes and furnishings; plumbing and electrical systems; communications and security systems; parking lot; outdoor garden areas; and all other present but unidentified spaces not listed herein.

This policy applies to all employees of Maryland House Detox

Responsibility

It is the responsibility of the CEO and/or designee to implement this policy and procedure. It is the responsibility of Facility Manager/Safety Officer and/or designee to disseminate this information to employees.

Policy

The CEO and President provide final decisions regarding any provision(s) which may arise from this policy and the intention for use of space at MHD.

General Overview

The Facility Manager/Safety Officer is to facilitate the process for inspections, procedures, drills, or maneuvers to assure the MHD facility will consistently provide a safe and appropriate treatment facility environment. This be accomplished by daily/monthly review of quality indicators that impact existing (and future) use of the facility, its' space allocation and equipment requirements for programs. Its objective is to insure education and training, monthly inspections, fire drills, risk management oversight, with allocation, procurement, and maintenance to maintain established or new safety standards within the physical environment elements.

New employee and annual training along with encouraging and supporting interdisciplinary cooperation and participation will be key to consistent implementation and a factor to consider prior to any repurpose or reallocation of space. The building and its intended use of space are subject to assignment to meet the best interests and needs of the patients utilizing the facility. The facility must provide an environment of care that assures safety at all times and will assign space in an effort to meet changing needs.

Maryland House Detox will promote safety, efficiency and optimal utilization, through guidance and implementation of this policy that is designed to ensure:

(1) effective decision making, (2) accurate record keeping, and (3) communication among users, service providers and decision makers concerning safe and effective utilization of the facility and space.

Procedures

The Facilities Management department will provide routine inspections, maintenance and operations requirements for the facility. This includes both routine and non-routine inspection and maintenance required to operate and maintain standards of safety in the facility's interior utility and security systems, internal structure build out and external environment and grounds. A special subcommittee will provide a quarterly "proposed use for peak performance" report use to the Performance Improvement Committee.

Routine inspection, maintenance and operation of facilities includes:

- Monthly Inspection, maintenance and repair of buildings and building systems and equipment.
- Regular drills to support emergency evacuation plan activities; fire, weather, security.
- Safe operation to support normally scheduled activities including making necessary adjustments to building equipment and systems, scheduling the operation of equipment and security alarm systems, responding to improper temperature complaints, etc.
- Performing regular, intermittent and periodic inspections and maintenance such as changing filters, lubricating, greasing, adjusting, cleaning, testing and inspecting equipment, adding chemicals to systems, replacing light bulbs, etc.
- Minor repairs such as replacing a faulty light switch or wall outlet, repairing egress lights, repairing/replacing worn materials, door hardware, replacing an irrigation head, etc.
- Seasonal maintenance such as cleaning and testing to prepare for summer operation or testing boilers prior to heating season.
- Resetting time clocks and changing batteries in alarm systems, maintaining the master clock system. Resetting changing batteries in clocks in offices, conference rooms and department areas.
- Providing custodial and grounds services.
- Providing set-up and support for special events

Non-routine department related service may require a written request for scheduling purposes and include:

- Set-up support for events including grounds preparation and custodial support.
- Special projects, temporary alterations of use of space in the facility.
- Furniture and equipment moves or relocations.

Non-routine institutional service requests include:

- Repairs necessary and caused by abuse or vandalism (see below).
- Replacement of major building equipment or components such as boilers, water heaters, pumps, fans, lighting control systems, ADA door operators, auto equalizer door closers, etc.
- Repairs necessary due to natural disaster or event.

Building and Department Equipment:

Building equipment is defined as equipment that is permanently installed as a part of a building that would be required by any user. Department equipment includes all movable or stationary equipment and furnishings, and/or any special equipment or systems, whether permanently installed or not.

Examples of Building Equipment:

- General purpose lighting
- Exit lights
- General building HVAC systems
- Building exterior elements such as roofs, windows, doors, etc.
- General door hardware including door closers

Examples of Building Equipment (continued):

- Building plumbing systems
- Water fountains
- Boilers
- Water heaters
- Restroom fixtures
- Fire alarm system
- Fire protection system
- Master time clock system

- Security key card system
- Building electrical systems
- Building signage
- General group room marker boards
- Air compressors, generators for building pneumatic controls
- Building backflow preventers
- Outdoor lighting

Examples of Department Equipment:

- Special purpose and task lighting and lighting controls such as office lighting, display cases, etc.
- Security systems
- Access systems
- Appliances
- Furniture
- Refrigerators, freezers, ice bins
- Food service equipment including ovens, grills, hoods, dish washing machines, beverage machines, food processors, etc.
- Window coverings and hardware
- Department marker boards
- Department specific signage
- Display cases
- Specialized electrical circuits, equipment, controls, power conditioners, UPS, emergency generators, etc.

Examples of Department Equipment (continued):

- Additional electrical outlets
- HVAC systems, deionization systems, water softeners
- Medical equipment such as: BP cuffs, pulse oximeters, exam table, etc.
- Medication storage security system
- Dust collection systems
- Grease and sediment traps
- Bio-safety cabinets
- Cooling systems for IT closets or other specialized cooling systems
- Clocks in offices, conference rooms and department spaces
- Laundry equipment
- Cleaning equipment

Prioritization of Work Requests:

Facilities Management will inspect and provide equipment to meet the needs of the facility, with safety as the priority. The Facility Manager will establish a work ticket request schedule based on the following priorities and the date submitted:

- Safety requirements
- Operational requirements
- Essential maintenance
- Departmental equipment maintenance and repair
- Repurposing, department equipment installation and special services

Vandalism (All Cases)

- Vandalism is defined as misuse or willful abuse of facility property.
- Facilities Management will maintain a standing report on expenditures resulting from vandalism.

Repurpose of space, Department Equipment Installation and Maintenance, and Special Services:

Any space, equipment or furnishings identified by the Facilities Management that is in question will be removed:

- Not inspected for safety prior to first use,
- Does not conform with approved use for equipment; for unapproved specifications,
- Is not in compliance with approved NFPA 101 life safety codes and/or standards and codes, or
- Is of unacceptable or visibly poor workmanship,

Furnishings identified as approved for the building shall not be altered or removed without written approval of the Facilities Management. This includes such items as chairs, benches, built-in benches, pictures, blackboards, bookcases, projection screens, door hardware, etc.

If a piece of equipment or furnishing has malfunctioned in some way, it is to be immediately reported on writing, to the Facility Manager, placed to the side and clearly labeled with “out of service-temp”, with the name of individual, date and time of temporary removal.

Facility Space Use Subcommittee:

The Facility Space Use Committee purpose is to assist MHD in keeping with its goals and objectives to provide an appropriate environment for treatment services. The committee is chaired by the Facility Manager, and reports back to Performance Improvement. It allows one representative from each of the following departments, and the supervisor of their area appoints the members:

Executive; IT; Administrative; Clinical; Medical; Nutrition; Housekeeping

Committee Goals and Objectives:

- The committee will identify areas of concern or interest, communicate findings, and develop an action plan for modifications or repurposing of space.
- The committee may recommend additions to policies and procedures as necessary to achieve the purposes of the facilities goals and mission.
- The committee will make recommendations
- Provide data, analysis, recommendations and reports as requested.

The Physical Environment Plan will be reviewed annually to determine if the scope and objectives, performance and effectiveness of the plan are consistent with the intent of the plan and meet all NFPA 101 life-code safety standards. Data gathered from surveillance rounds, questionnaires, patient satisfaction surveys and review by Performance Improvement functions will provide the basis for evaluation.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/4/16

Date



Signature of Owner or Board-designated
Official

CEO Maryland House Detox, BOD MHD

Position/Title

David Stup

Printed Name

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/4/16
Date


Signature of Owner or Board-designated Official
CFO, Delphi Behavioral Health Group
Position/Title
Michael Borkowski
Printed Name

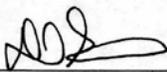
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

Date 5/2/10


Signature of Owner or Board-designated Official
Chairman of Board, Delphi Behavioral Health Group, Chairman of Board, Maryland House Detox
Position/Title
Ryan Collison
Printed Name

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/4/16
Date


Signature of Owner or Board-designated
Official
CEO, Delphi Behavioral Health Group
Position/Title
Dominic Sirianni
Printed Name

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5.4.16
Date


Signature of Owner or Board-designated Official
COO, President, Maryland House Detox
Position/Title
Cynthia Curtis
Printed Name

