STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

INSTRUCTIONS FOR APPLICATION FOR CERTIFICATE OF NEED: ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively.

The Table of Contents must include:

- **Responses to PARTS I, II, III, and IV of the this application form**
- **Responses to PART IV must include responses to the standards in the State Health Plan chapter that apply to the project being proposed.**
  - All Applicants must respond to the Review Criteria listed at 10.24.14.05(A) through 10.24.14.05(F) as detailed in the application form.
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original

application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1.] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

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[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

Table of Contents

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Addiction Recovery Inc. dba Hope House Treatment Centers**

Address:

26 Marbury Dr	**Crownsville**	**21032**	**Anne Arundel**
Street	City	Zip	County

2. Name of Owner Addiction Recovery Inc. Private Non- Profit

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. APPLICANT. *If the application has a co-applicant, provide the following information in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed

Addiction Recovery Inc

Address:

26 Marbury Dr	**Crownsville**	**21032**	**MD**	**Anne Arundel**
Street	City	Zip	State	County
Telephone:	**410-923-6700**			

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

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5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & Date of Incorporation ☐
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

Peter D'Souza

A. Lead or primary contact:

Name and Title: **Peter D'Souza CEO**

Company **Hope House Treatment Centers**

Name

Mailing Address:

26 Marbury Drive	**Crownsville**	**2103 2**	**MD**
Street	City	Zip	State

Telephone: 410-923-6700

E-mail Address (required): pdsouza@hopehousemd.org

Fax: 410-923-6213

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title:

Company Name
Mailing Address:

Street	City	Zip	State

Telephone:
E-mail Address (required):

Fax:

If company name is different than applicant briefly describe the relationship
CEO

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1)	A new health care facility built, developed, or established	☐
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	X ☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

Addiction Recovery Inc. is a private, non-profit, alcohol and drug rehabilitation center that provides various levels of care: non-hospital detoxification, Inpatient/ICF, residential (RTC), PHP and IOP/OP/DWI/DUI. Addiction Recovery Inc. is owned and operated by Addiction Recovery, Inc. (ARI) and has been in operation since 1983. Addiction Recovery Inc. is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and certified by the Maryland State Department of Health and Mental Hygiene.

The President, or designee, is responsible for overall direction and control of the organization. The organization believes that effective service to clients with behavioral health/substance abuse problems must include a comprehensive array of assessment and treatment services. ARI, with its development of a full range of services, has assumed a leadership role in developing and implementing a community wide

support system to address the mental health and chemical dependency needs. ARI works collaboratively with area and other professional organizations throughout the country and key stakeholders to insure the availability of a continuum of services and an effective community support system to address the special needs of the target populations served.

Mission

To provide high quality, comprehensive, integrated, holistic, patient-centered treatment for addiction and co-occurring mental illness in a caring and supportive environment that equips patients to achieve sobriety and pursue a fulfilling life in recovery.

Vision

To achieve status as the premier provider of addiction and mental health recovery treatment for patient, support and advocacy services for families, and as a positive change agent in the communities we serve.

Core Values

- **Person Centered Approach: Our people are our greatest asset. Our programs and policies and procedures are designed to optimize the therapeutic experience of patient, family members, and professional staff, maximizing the dignity and respect shown to all.**
- **Maximum Extension of Reach: We seek to provide affordable, high quality services to the greatest number possible, not ignoring the most fragile, by pursuing aggressive expansion and cost management strategies.**
- **Continuous Improvement through Innovation and Best Practive:We are dedicated to incorporating innovative treatment and management practices to optimize the existing business model.**

Hope House Treatment Centers operate Inpatient Programs for Addiction & Mental Illness at 2 locations. At Crownsville, we operate a Detox Program and Inpatient Rehab with 49 beds. At 419 Main Street we operate a Detox Program and Inpatient Rehab with 18 beds. Our Proposal for a Certificate of Need is for 429 Main Street, Laurel (which is adjacent to 419 Main Street), is to operate a Detox Program for 22 beds. We have always been an Inpatient Facility providing Addiction & Mental Health services to the Maryland Community. We have grown from a 20 bed facility to an 89 bed facility to become the largest community-based Inpatient Program in Maryland. Most of the patients we serve are indigent and on Medicaid.

All these beds, presently, are Medicaid funded beds. The Rational for this project is that this helps us with the economies of scale by sharing the resources (Detox) that we already have at 419 Main Street. We have a waiting list for the beds at Laurel and a patient on our waiting list overdosed and died. There is a bottleneck for the

Detox Beds at 419 Main Street and expanding the Detox Beds at 429 Main Street will facilitate more Detox Beds to take care of more patients. We are going to use a room at the ground floor level as a Doctors/Nurses station. There is no Predevelopment Costs or Capital Expenditures involved in implementing the Detox beds. All the work and material needed for furnishing the room as a Doctors/Nurses station will be completed by our full-time maintenance staff. There is minimal cost involved in furnishing the room. We are not bound by any jurisdiction to service patients. We will service patients primarily from Maryland but not exclusively. We already have an MOU from Behavioral Health of Prince George's County. We are the ONLY INPATIENT DETOXIFICATION FACILITY IN PRINCE GEORGE'S COUNTY.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

We are planning to convert our existing 3.3 level of care beds at 429 Main Street into 3.7D and 3.7Residential beds. We do not need a construction, renovation and demolition plan, no changes in square footage, physical plant or location changes. The changes to affected services following completion of the project would be the conversion of our existing 3.3 level of care beds to 3.7D and 3.7Residential beds.

9. CURRENT CAPACITY AND PROPOSED CHANGES: Complete Table A (Physical Bed Capacity Before and After Project) from the CON Application Table package

10. REQUIRED APPROVALS AND SITE CONTROL

Not Applicable

A. Site size: _____ acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES_____ NO _____ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: _____

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

Not Applicable

(Instructions: In completing this section, please note applicable performance requirement time frames set forth in Commission Regulations, COMAR 10.24.01.12)

For new construction or renovation projects.
Project Implementation Target Dates

A. Obligation of Capital Expenditure _____ months from approval date.
B. Beginning Construction _____ months from capital obligation.
C. Pre-Licensure/First Use _____ months from capital obligation.
D. Full Utilization _____ months from first use.

For projects not involving construction or renovations.
Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

For projects not involving capital expenditures.
Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

12. PROJECT DRAWINGS

Not Applicable

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, 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”.

B. 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.

C. Specify dimensions and square footage of patient rooms.

13. **AVAILABILITY AND ADEQUACY OF UTILITIES**

Not Applicable

Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

PART II - PROJECT BUDGET

Complete Table B (Project Budget) of the CON Application Table Package

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

   See Appendix A

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   No

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by

the applicable authority.

No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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.

2/28/18

Date

Signature of Owner or Board-designated Official

CEO

Position/Title

Peter D'Souza

Printed Name

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

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(a) through 10.24.01.08G(3)(f).

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and to the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services[2]. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.

<u>10.24.14.05 Certificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities.</u>

.05A. Approval Rules Related To Facility Size. Unless the applicant demonstrates why a relevant standard should not apply, the following standards apply to applicants seeking to establish or to expand either a Track One or a Track Two intermediate care facility.

(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40

[2] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its approval would result in the facility exceeding a total of 40 adolescent or 100 adult intermediate care facility beds, or a total of 140 beds, if the applicant is applying to serve both age groups.

.05B. Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need.

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(1) An applicant seeking Certificate of Need approval to establish or expand an intermediate care facility for substance abuse treatment services must apply under one of the two categories of bed need under this Chapter:

(a) For Track One, the Commission projects maximum need for alcohol and drug abuse intermediate care beds in a region using the need projection methodology in Regulation .07 of this Chapter and updates published in the *Maryland Register*.

(b) For Track Two, as defined at Regulation .08, an applicant who proposes to provide 50 percent or more of its patient days annually to indigent and gray area patients may apply for:

(i) Publicly-funded beds, as defined in Regulation .08 of this Chapter, consistent with the level of funding provided by the Maryland Medical Assistance Programs (MMAP), Alcohol and Drug Abuse Administration, or a local jurisdiction or jurisdictions; and

(ii) A number of beds to be used for private-pay patients in accordance with Regulation .08, in addition to the number of beds projected to be needed in Regulation .07 of this Chapter.

(2) To establish or to expand a Track Two intermediate care facility, an applicant must:

(a) Document the need for the number and types of beds being applied for;

(b) Agree to co-mingle publicly-funded and private-pay patients within the facility;

(c) Assure that indigents, including court-referrals, will receive preference for admission, and

(d) Agree that, if either the Alcohol and Drug Abuse Administration, or a local jurisdiction terminates the contractual agreement and funding for the facility's clients, the facility will notify the Commission and the Office of Health Care Quality within 15 days that that the facility is relinquishing its certification to operate, and will not use either its publicly- or privately-funded intermediate care facility beds for private-pay patients without obtaining a new Certificate of Need.

Applicant Response:

2. A) We are a (1) (b)(i) (ii) type of facility. See Appendix C for Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers' history of waitlist numbers to support the need for detox beds.

B) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers agrees to co-mingle publically-funded and private-pay patients within the facility.

C) Indigents, including court-referrals, will receive preference for admission.

D) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers agrees that if the contractual agreement and funding is terminated, the Commission and the Office of Health Care Quality will be notified within 15 days that the facility is relinquishing its certification to operate and will not use either its publically- or privately-funded intermediate care facility beds for private-pay patients without obtaining a new Certificate of Need.

.05C. Sliding Fee Scale. An applicant must establish a sliding fee scale for gray area patients consistent with the client's ability to pay.

Applicant Response:

Addiction Recovery Inc. d.b.a. Hope House Treatment Centers self-pay rates are based off minimum operating costs for treatment. Therefore, the self-pay rates are the lowest possible rates for any given service.

.05D. Provision of Service to Indigent and Gray Area Patients.

(1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:

(a) Establish a sliding fee scale for gray area patients consistent with a client's ability to pay;

(b) Commit that it will provide 30 percent or more of its proposed annual adolescent intermediate care facility bed days to indigent and gray area patients; and

(c) Commit that it will provide 15 percent of more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

(2) A existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

(3) In evaluating an existing Track One intermediate care facility's proposal to provide a lower required minimum percentage of bed days committed to indigent or gray area patients in Regulation D(1) or an alternative proposal under Regulation D(2), the Commission shall consider:

(a) The needs of the population in the health planning region; and

(b) The financial feasibility of the applicant's meeting the requirements of Regulation D(1).

(4) An existing Track One intermediate care facility that seeks to increase beds shall provide information regarding the percentage of its annual patient days in the preceding 12 months that were generated by charity care, indigent, or gray area patients, including publicly-funded patients.

.05E. Information Regarding Charges. An applicant must agree to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and must document that this information is available to the public upon request.

Applicant Response:
Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers agrees to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and will document that this information is available to the public upon request.

Self-Pay Rates	
Assessment	$160.00
Screening/Processing	$125.00
Detoxification	$375.00/day
Residential	$350.00/day
Intensive Outpatient Group	$60/session
Outpatient Group	$40/session
Individual IOP/OP	$60/session
DUI/DWI Course	$600.00

.05F. Location. An applicant seeking to establish a new intermediate care facility must propose a location within a 30-minute one-way travel time by automobile to an acute care hospital.

Applicant Response:
The 429 Main Street location is 15 minutes away from the Howard Hospital and the Laurel Regional Hospital.

.05G. Age Groups.

(1) An applicant must identify the number of adolescent and adult beds for which it is applying, and document age-specific treatment protocols for adolescents ages 12-17 and adults ages 18 and older.

(2) If the applicant is proposing both adolescent and adult beds, it must document that it will provide a separate physical, therapeutic, and educational environment consistent with the treatment needs of each age group including, for adolescents, providing for continuation of formal education.

(3) A facility proposing to convert existing adolescent intermediate care substance abuse treatment beds to adult beds, or to convert existing adult beds to adolescent beds, must obtain a Certificate of Need.

Applicant Response:

1. All beds are designated for adults 18 years of age and older. See Appendix D for Treatment Protocols.
2. Not applicable. All beds proposed are designated for adults 18 years of age and older.
3. Not applicable. All current beds are designated for adults 18 years of age and older.

.05H. Quality Assurance.

(1) An applicant must seek accreditation by an appropriate entity, either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), in accordance with CFR, Title 42, Part 440, Section 160, the CARF…The Rehabilitation Accreditation Commission, or any other accrediting body approved by the Department of Health and Mental Hygiene. The appropriate accreditation must be obtained before a Certificate of Need-approved ICF begins operation, and must be maintained as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its accreditation continues in good standing, and an applicant seeking to establish an ICF must agree to apply for, and obtain, accreditation prior to the first use review required under COMAR 10.24.01.18; and

(b) An ICF that loses its accreditation must notify the Commission and the Office of Health Care Quality in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended.

(c) An ICF that loses its accreditation may be permitted to continue operation on a provisional basis, pending remediation of any deficiency that caused its accreditation to be revoked, if the Office of Health Care Quality advises the Commission that its continued operation is in the public interest.

(2) A Certificate of Need-approved ICF must be certified by the Office of Health Care Quality before it begins operation, and must maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its certification continues in good standing, and an applicant seeking to establish an ICF must agree to apply for certification by the time it requests that Commission staff perform the first use review required under COMAR 10.24.01.18.

(b) An ICF that loses its State certification must notify the Commission in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended, and must cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.

(c) Effective on the date that the Office of Health Care Quality revokes State certification from an ICF, the regulations at COMAR 10.24.01.03C governing temporary delicensure of a health care facility apply to the affected ICF bed capacity.

Applicant Response:

1. A) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers is currently accredited by CARF and in good standing until accreditation renewal on September 30, 2019. See Appendix E for current CARF accreditation.
   B) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers agrees to notify the Commission and the Office of Health Care Quality in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended.
   C) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers understand that if an ICF loses its accreditation, it may be permitted to continue operation on a provisional basis, pending remediation of any deficiency that caused its accreditation to be revoked, if the Office of Health Care Quality advises the Commission that its continued operation is in the public interest.

2. A) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers is currently certified by the Office of Health Care Quality and maintains the certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland. See Appendix F for certifications.
   B) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers agrees to notify the Commission in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended, and will cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.
   C) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers understand that effective on the date that the Office of Health Care Quality revokes State certification from an ICF, the regulations at COMAR 10.24.01.03C governing temporary delicensure of a health care facility apply to the affected ICF bed capacity.

.05I. Utilization Review and Control Programs.

(1) An applicant must document the commitment to participate in utilization review and control programs, and have treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral.

(2) **An applicant must document that each patient's treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.**

Applicant Response:

1. Appendix G – Utilization Review
Appendix D – Treatment Protocols
Appendix H – Admission Protocols
Appendix I – Length of Stay
Appendix J – Discharge Planning and Referral
2. Appendix D.

.05J. Transfer and Referral Agreements.

(1) An applicant must have written transfer and referral agreements with facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.

(2) The applicant must provide documentation of its transfer and referral agreements, in the form of letters of agreement or acknowledgement from the following types of facilities:

(a) Acute care hospitals;
(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);
(d) The jurisdiction's mental health and alcohol and drug abuse authorities;
(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

Applicant Response:

1. Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers has written transfer and referral agreements with facilities capable of managing cases, which exceed, extend, or complement our capabilities, including facilities, which provide inpatient, intensive, and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.
2. Documentation of transfer and referral agreements in the form of letters of agreement or acknowledgement from the following types of facilities: See Appendix J
    - Acute care hospitals: Laurel Regional Hospital
    - Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs: A+ Counseling
    - Local community mental health center or center(s): QCI
    - The jurisdiction's mental health and alcohol and drug abuse authorities: PG County
    - The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration: PG County
    - The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services: A+ Counseling
    - The Department of Juvenile Justice and local juvenile justice authorities: Not applicable.

.05K. Sources of Referral.

(1) An applicant proposing to establish a new Track Two facility must document to demonstrate that 50 percent of the facility's annual patient days, consistent with Regulation .08 of this Chapter, will be generated by the indigent or gray area population, including days paid under a contract

with the Alcohol and Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority.

(2) An applicant proposing to establish a new Track One facility must document referral agreements to demonstrate that 15 percent of the facility's annual patient days required by Regulation .08 of this Chapter will be incurred by the indigent or gray area populations, including days paid under a contract with the Alcohol or Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program.

Applicant Response:

(1) More than 80% of the patients that we serve are on Medicaid and are considered indigent or gray area population. See Appendix L.
(2) Not applicable. We are a track two facility.

.05L. In-Service Education. An applicant must document that it will institute or, if an existing facility, maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel, whether paid or volunteer.

Applicant Response:
Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers requires that all staff complete onboarding training at orientation and continued training through the following modalities: See Appendix M

- Accreditationnow.com training first day of orientation
- Accreditationnow.com training annually
- CARF required drills for emergencies, including medical emergencies
- Department meetings- review and role play of scenarios
- Monthly all staff meetings- review and role play of scenarios

.05M. Sub-Acute Detoxification. An applicant must demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate admission standards, treatment protocols, staffing standards, and physical plant configuration.

Applicant Response:

- Admission Standards: Appendix H
- Treatment Protocols: Appendix D
- Staffing Standards: Appendix N
- Floor Plans: Appendix A

.05N. Voluntary Counseling, Testing, and Treatment Protocols for Human Immunodeficiency Virus (HIV). An applicant must demonstrate that it has

procedures to train staff in appropriate methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients.

Applicant Response:

- Infection Control: Appendix O
- Blood Borne Pathogen Training: Appendix P

.05O. Outpatient Alcohol & Drug Abuse Programs.

(1) An applicant must develop and document an outpatient program to provide, at a minimum: individual needs assessment and evaluation; individual, family, and group counseling; aftercare; and information and referral for at least one year after each patient's discharge from the intermediate care facility.

(2) An applicant must document continuity of care and appropriate staffing at off-site outpatient programs.

(3) Outpatient programs must identify special populations as defined in Regulation .08, in their service areas and provide outreach and outpatient services to meet their needs.

(4) Outpatient programs must demonstrate the ability to provide services in the evening and on weekends.

(5) An applicant may demonstrate that outpatient programs are available to its patients, or proposed patient population, through written referral agreements that meet the requirements of (1) through (4) of this standard with existing outpatient programs.

Applicant Response:

1. Appendix Q: p. 100
2. Appendix Q: p. 99
3. Appendix Q: p. 101
4. Appendix Q: p. 99
5. Appendix K

.05P. Program Reporting. Applicants must agree to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

Applicant Response:

Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers agrees to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

.06 Preferences for Certificate of Need approval.

A. In a comparative review of applicants for private bed capacity in Track One, the Commission will give preference expand an intermediate care facility if the project's sponsor will commit to:

(1) Increase access to care for indigent and gray area patients by reserving more bed capacity than required in Regulation .08 of this Chapter;

(3) Treat special populations as defined in Regulation .08 of this Chapter or, if an existing alcohol or drug abuse treatment facility, treat special populations it has historically not treated;

(4) Include in its range of services alternative treatment settings such as intensive outpatient programs, halfway houses, therapeutic foster care, and long-term residential or shelter care;

(5) Provide specialized programs to treat an addicted person with co-existing mental illness, including appropriate consultation with a psychiatrist; or,

(6) In a proposed intermediate care facility that will provide a treatment program for women, offer child care and other related services for the dependent children of these patients.

B. If a proposed project has received a preference in a Certificate of Need review pursuant to this regulation, but the project sponsor subsequently determines that providing the identified type or scope of service is beyond the facility's clinical or financial resources:

(1) The project sponsor must notify the Commission in writing before beginning to operate the facility, and seek Commission approval for any change in its array of services pursuant to COMAR 10.24.01.17.

(2) The project sponsor must show good cause why it will not provide the identified service, and why the effectiveness of its treatment program will not be compromised in the absence of the service for which a preference was awarded; and

(3) The Commission, in its sole discretion, may determine that the change constitutes an impermissible modification, pursuant to COMAR 10.24.01.17C(1).

Applicant Response:

A. 1.) Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers currently provides access for indigent and gray area patients for more than 80% of bed capacity. See

Appendix L.

A. 3.) Besides Detoxification, we provide Residential Services for Stabilization and Treatment. We also provide MAT (Medication Assisted Treatment) in an Outpatient Program setting.

A. 4.) We provide Intensive Outpatient Program as well as a Medication Assisted Treatment in an Outpatient setting. We consider these as long term Outpatient Programs.

A. 5.) CARF Accreditation already acknowledges Hope House as a Co-Occurring Enhanced Facility. We have a Psychiatric Nurse Practitioner who provides Psychotropic Medications and we have Mental Health Counselors to provide Mental Health Services.

A. 6.) Not applicable

B. 1. – 3) Not applicable

B. NEED

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete Table C (Statistical Projections – Entire Facility) from the CON Application Table Package.

Applicant Response:

Maryland is already experiencing a Heroin Epidemic and the Governor has declared a State of Emergency. The implementation of this service will directly provide life-saving Detoxification, Stabilization and Effective Treatment to patients in Prince George's County (where we are the only Inpatient Addiction Service Provider) and the surrounding Counties. We have an extensive Waiting List of Patients who want to come to our program. Our Waiting List presently has 199 patients wanting services of Hope House Treatment Center.

See Appendix C for waitlist numbers.

See Appendix R for Patient-Served Days

Letters attesting to the need of detox beds have been submitted to our stakeholders. We are currently waiting for those letters to be returned and will send an amendment to the Certificate of Need as they are received.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

Hope House Treatment Center in Laurel is the only Inpatient Addiction Program in Prince George's County with the ability to provide 3.7D and 3.7 Residential Services. As part of the planning process, we experienced a growing number of patients wanting these dire services to the point that we had to have a Waiting List. Additionally, the alternative treatment approach is for patients to receive detoxification treatment in a local hospital

setting and the cost of hospital treatment far exceeds the cost of placement at our freestanding facility.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete Tables D (Revenues & Expenses, Uninflated – Entire Facility) and F (Revenues & Expenses, Uninflated – New Facility or Service) from the CON Application Table Package.

- Complete Table G (Work Force Information) from the CON Application Table Package.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see question 12, “Project Schedule”) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Applicant Response:

- See Table D - Revenues & Expenses, Uninflated – Entire Facility
- See Table F- Revenues & Expenses, Uninflated – New Facility of Service
- See Table G – Work Force Information

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

We have been in full compliance with the previous Certificate of Need. We have executed the conditions with ongoing approvals for Licensing from the State of Maryland and the stringent requirements from CARF International. The Certificate of Need for Crownsville had been granted prior to 15 years.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

If the applicant is an existing facility or program, provide a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

We are the only Inpatient Addiction Service Provider in Prince George's County. The Governor of Maryland has declared that we have an Opioid Crisis in Maryland. It will help the Healthcare Delivery System to get rid of the Gridlock for Detoxification, Stabilization and Treatment for those affected by Addiction and Mental Illness.

The increase of detoxification beds will allow individuals to receive treatment at a freestanding facility vs. being treated at a hospital emergency room, which poses a higher cost. Hospitals are also able to quickly transfer their patients to the facility for treatment. Additionally, receiving referrals from drug-court, parole, and probation offices allows patients to receive treatment vs. the cost incurred from incarceration.

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

Created March 24, 2017

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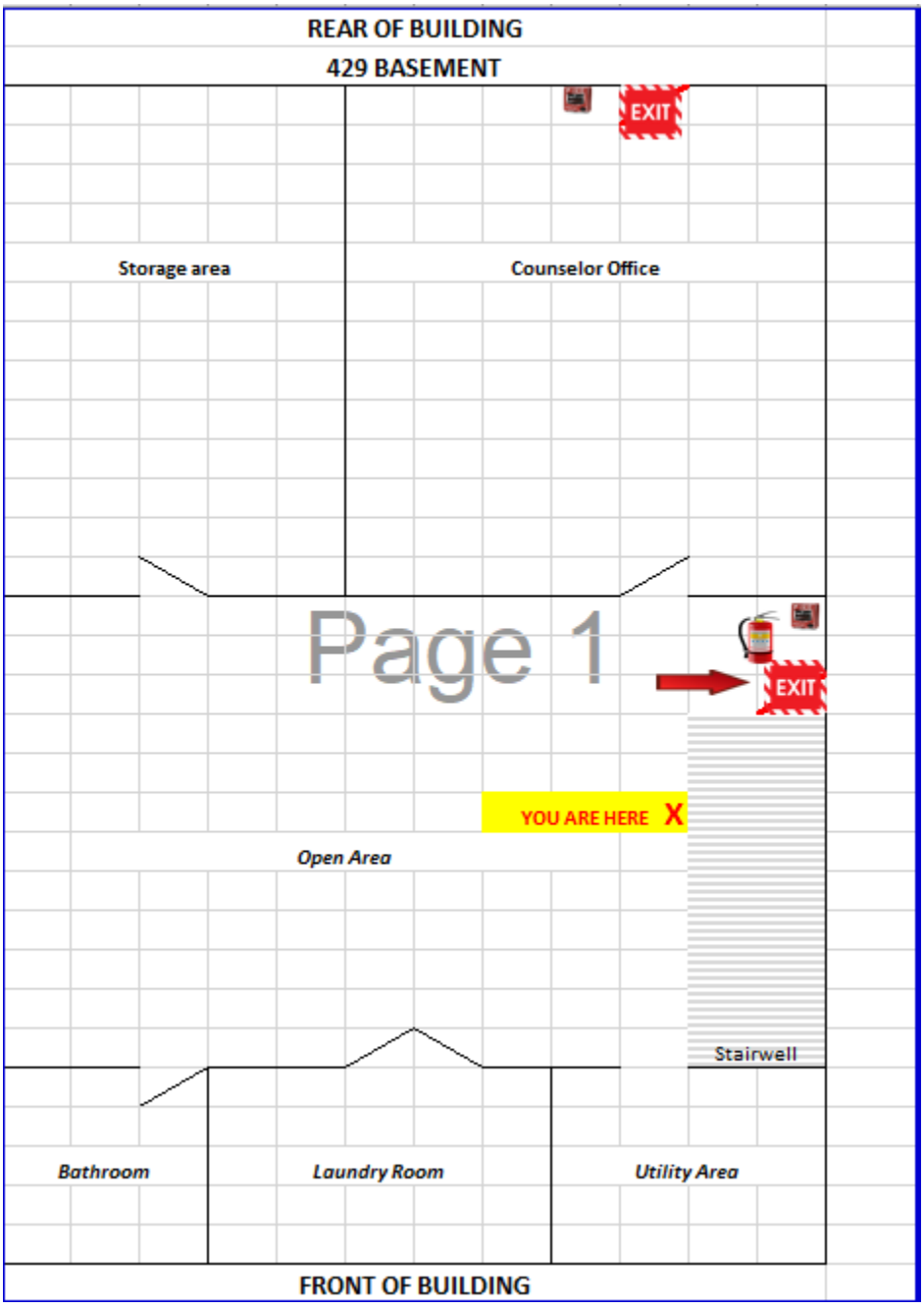
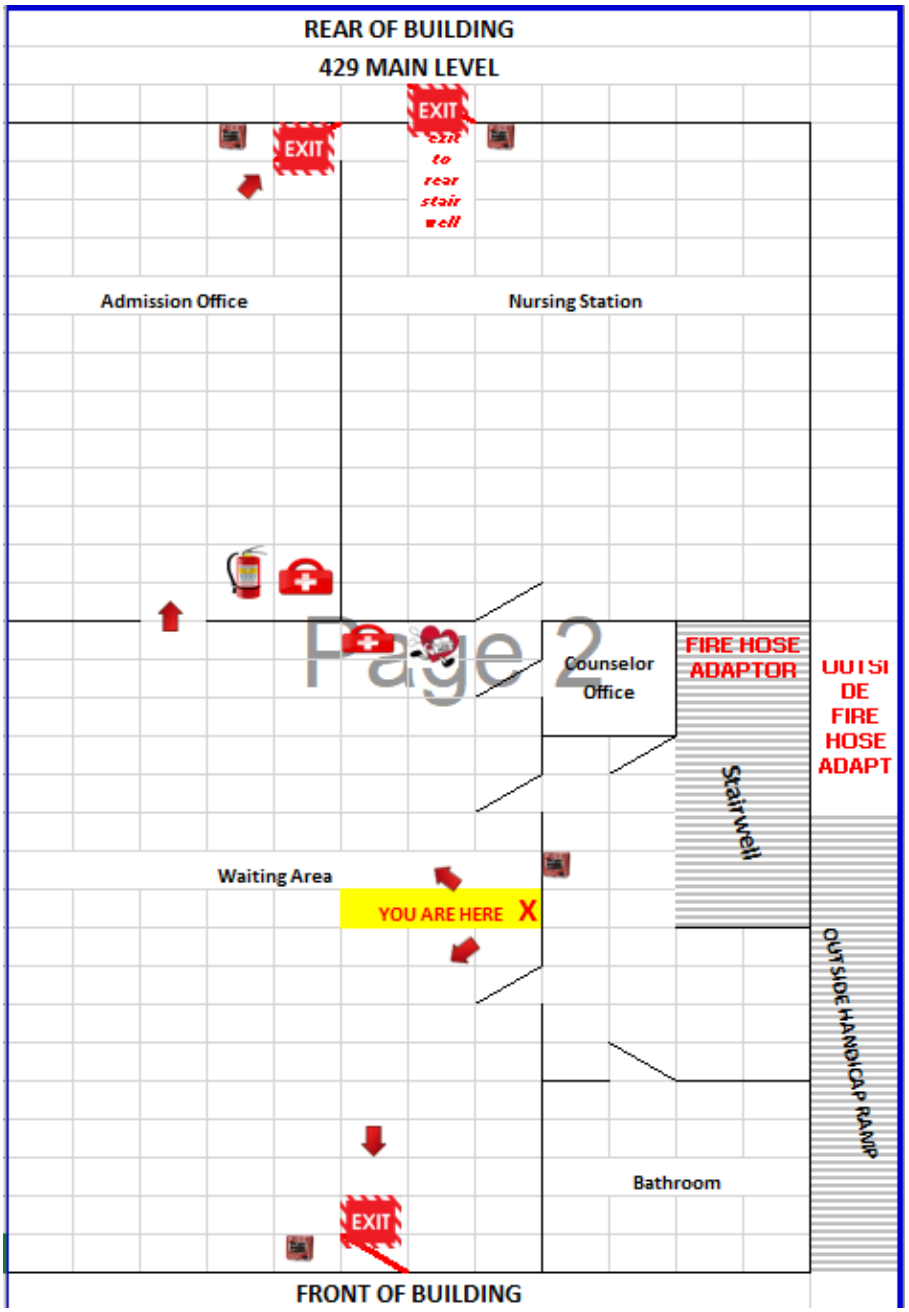
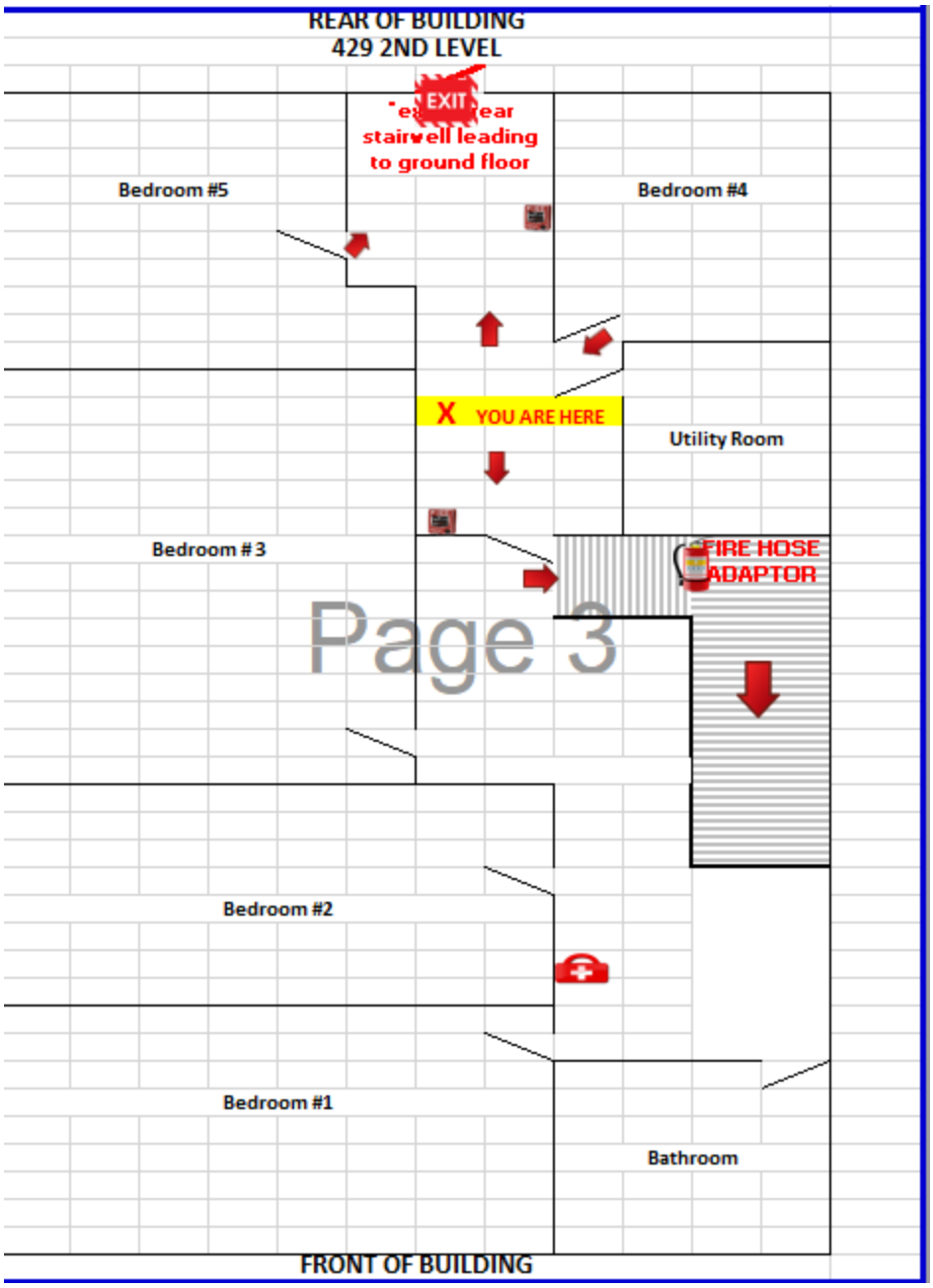
Appendix

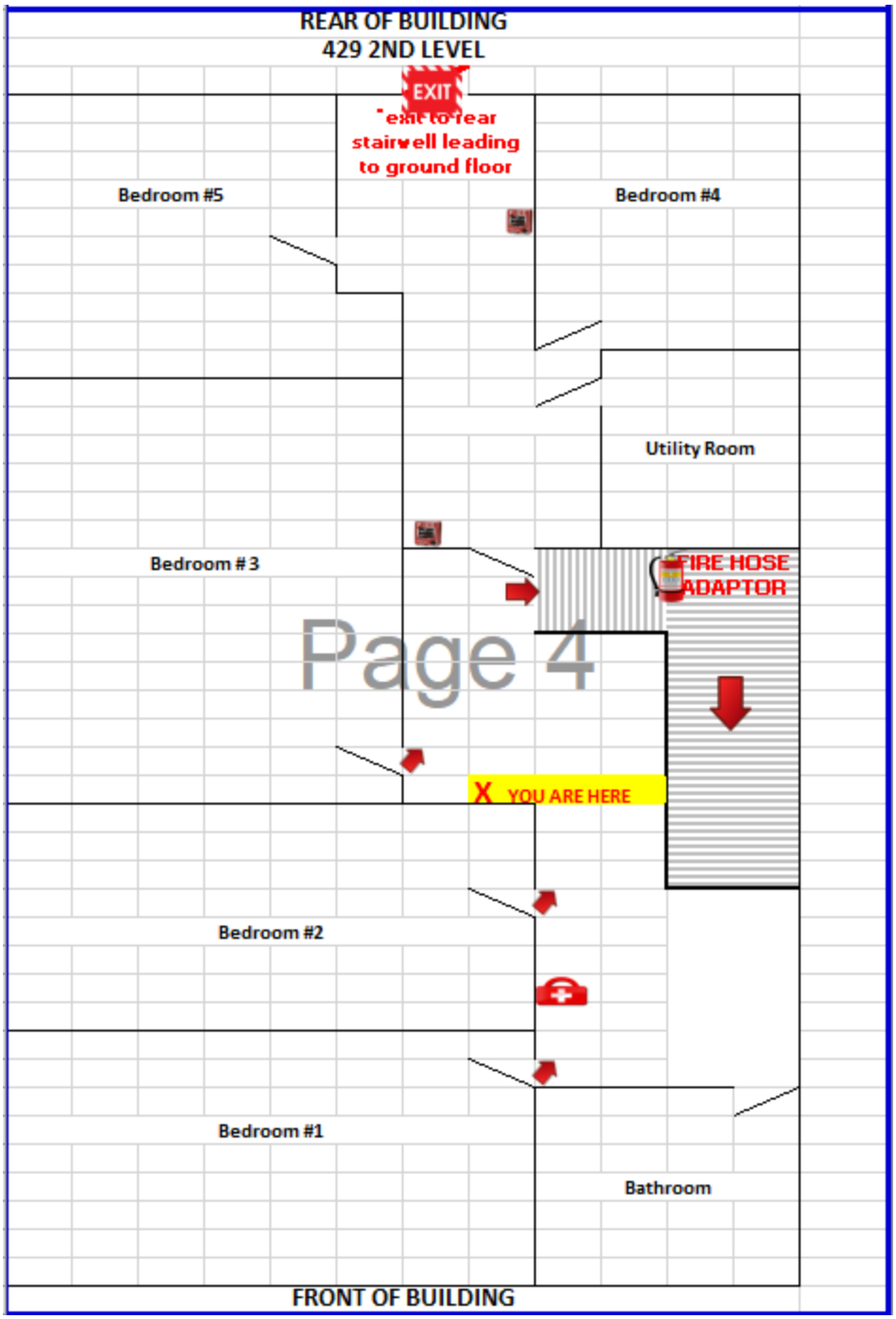
Appendix A

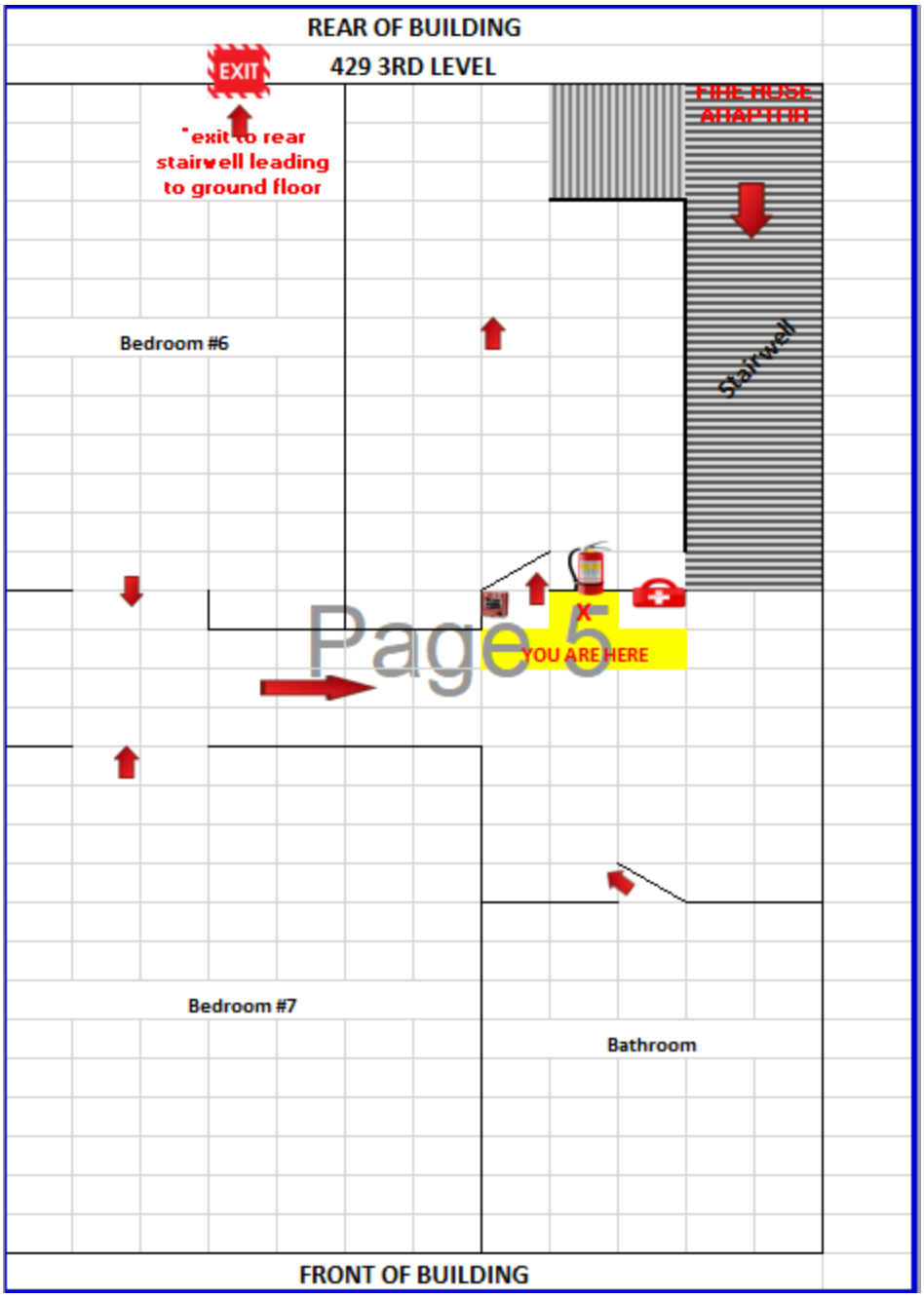
Floor Plans

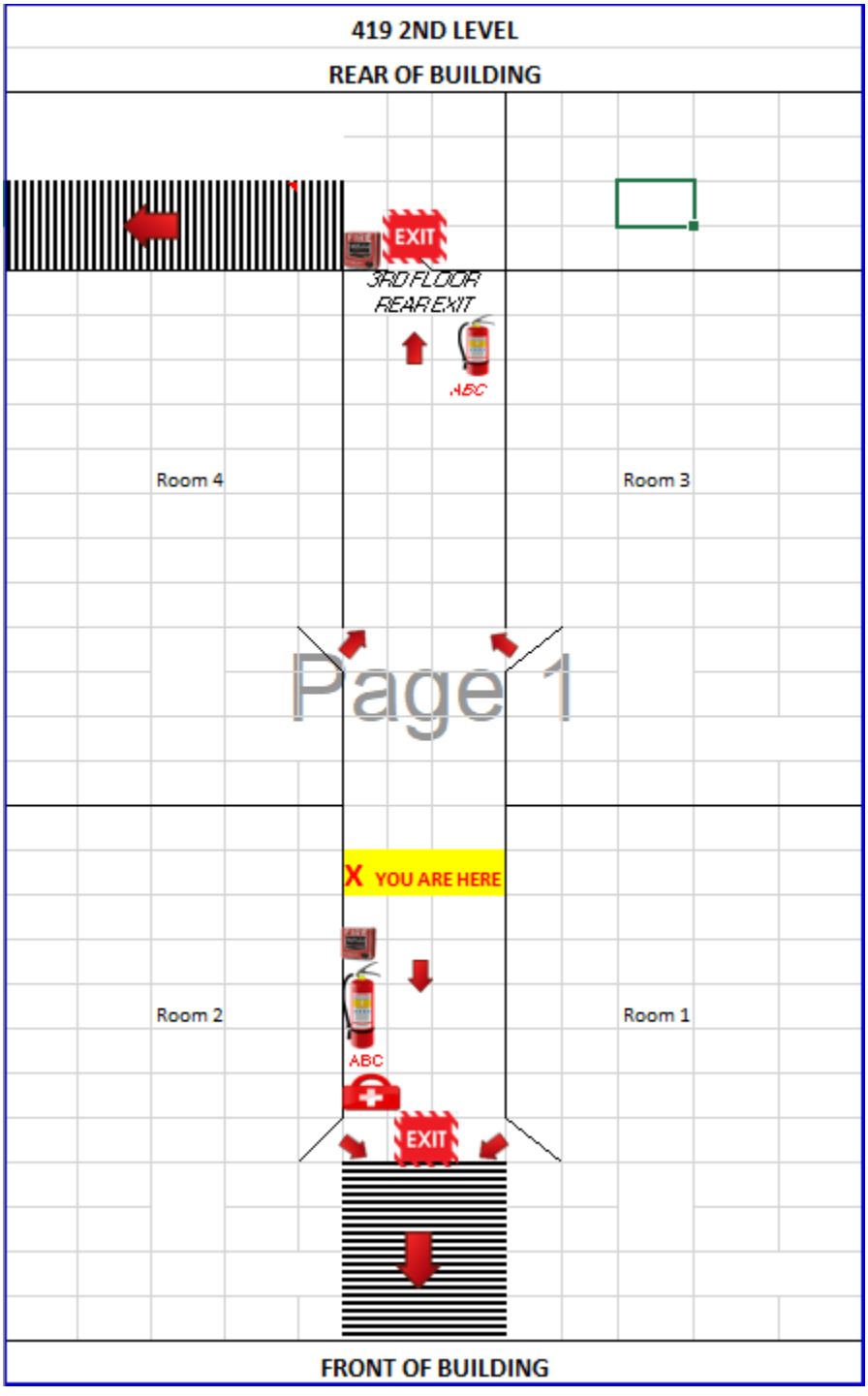


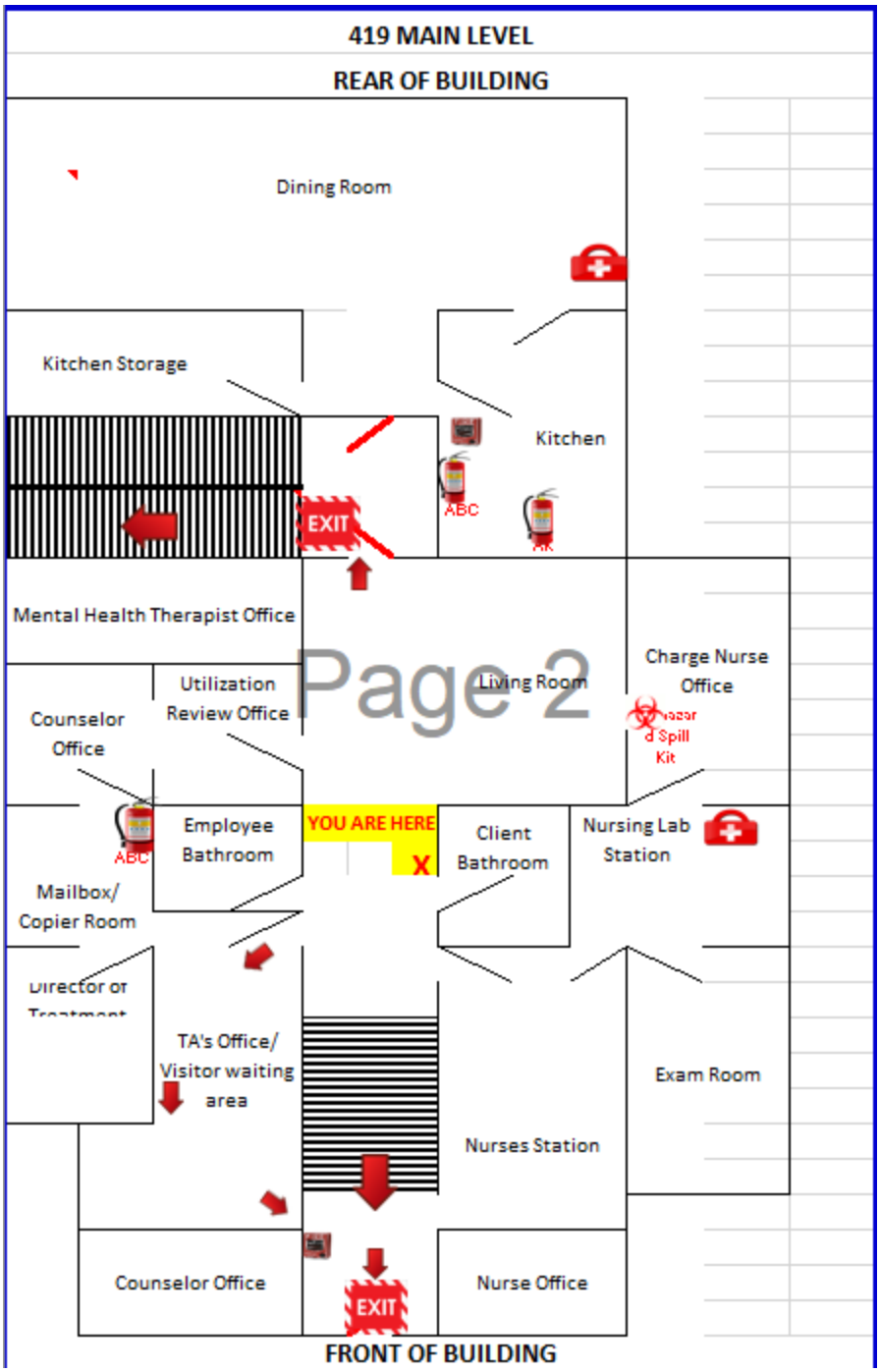

REAR OF BUILDING
429 MAIN LEVEL
EXIT
EXIT
exit to rear stair well
Admission Office
Nursing Station
Page 2
Counselor Office
FIRE HOSE ADAPTOR
OUTSIDE FIRE HOSE ADAPT
Stairwell
Waiting Area
YOU ARE HERE X
OUTSIDE HANDICAP RAMP
Bathroom
EXIT
FRONT OF BUILDING

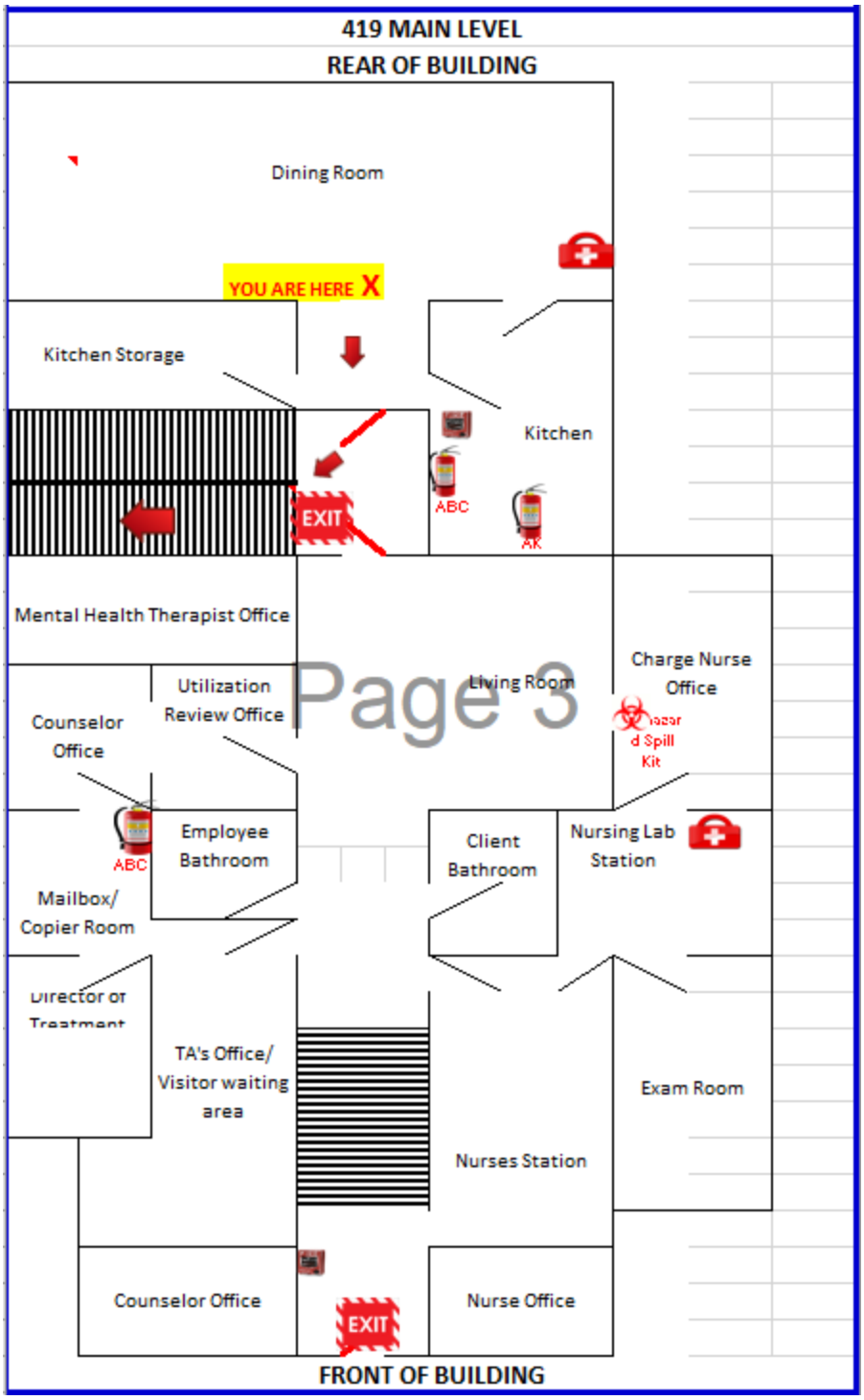

REAR OF BUILDING
429 2ND LEVEL
EXIT
stairwell leading
to ground floor
Bedroom #5
Bedroom #4
X YOU ARE HERE
Utility Room
Bedroom # 3
FIRE HOSE
ADAPTOR
Page 3
Bedroom #2
Bedroom #1
Bathroom
FRONT OF BUILDING

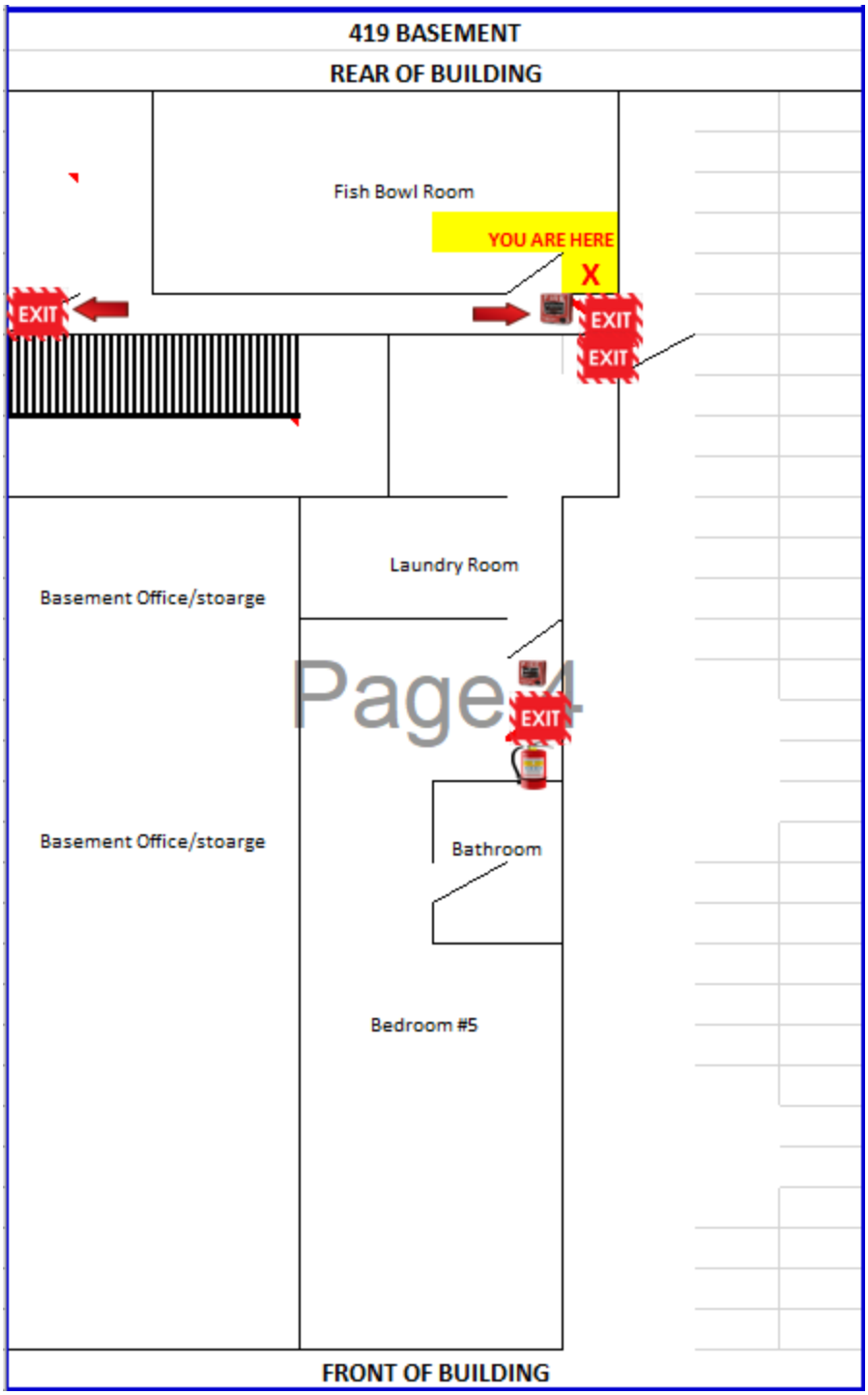

REAR OF BUILDING
429 2ND LEVEL
EXIT
exit to rear stairwell leading to ground floor
Bedroom #5
Bedroom #4
Utility Room
Bedroom # 3
FIRE HOSE ADAPTOR
Page 4
X YOU ARE HERE
Bedroom #2
Bedroom #1
Bathroom
FRONT OF BUILDING


REAR OF BUILDING
429 3RD LEVEL
EXIT
exit to rear stairwell leading to ground floor
FIRE HOSE ADAPTER
Bedroom #6
Stairwell
Page 5
X
YOU ARE HERE
Bedroom #7
Bathroom
FRONT OF BUILDING


419 2ND LEVEL
REAR OF BUILDING
EXIT
3RD FLOOR
REAR EXIT
ABC
Room 4
Room 3
Page 1
X YOU ARE HERE
Room 2
Room 1
ABC
EXIT
FRONT OF BUILDING


419 MAIN LEVEL
REAR OF BUILDING
Dining Room
Kitchen Storage
Kitchen
EXIT
ABC
Mental Health Therapist Office
Page 2
Utilization Review Office
Living Room
Charge Nurse Office
Counselor Office
Spill Kit
Employee Bathroom
YOU ARE HERE
X
Client Bathroom
Nursing Lab Station
Mailbox/ Copier Room
TA's Office/ Visitor waiting area
Exam Room
Nurses Station
Counselor Office
EXIT
Nurse Office
FRONT OF BUILDING


419 MAIN LEVEL
REAR OF BUILDING
Dining Room
YOU ARE HERE X
Kitchen Storage
Kitchen
EXIT
ABC
AK
Mental Health Therapist Office
Utilization Review Office
Living Room
Charge Nurse Office
Counselor Office
Page 3
Employee Bathroom
Client Bathroom
Nursing Lab Station
Mailbox/ Copier Room
TA's Office/ Visitor waiting area
Exam Room
Nurses Station
Counselor Office
Nurse Office
EXIT
FRONT OF BUILDING


419 BASEMENT
REAR OF BUILDING
Fish Bowl Room
YOU ARE HERE
X
EXIT
EXIT
EXIT
Laundry Room
Basement Office/stoarge
Page 4
EXIT
Basement Office/stoarge
Bathroom
Bedroom #5
FRONT OF BUILDING

Appendix B

Names and Addresses of all owners and individuals responsible for the proposed project.

Board of Directors			
President Tammy Kennedy Wolfe	2636 Compass Drive Annapolis, MD 21401	443-871-7813	Tkw0812@aol.com
Vice President Jerome Stanbury	1302 Beckenridge Cir Riva, MD 21140	410-956-0554 (Home) 301-459-1414 (Cell)	sailjerry@aol.com
Shashi Patel	1000 Lake Claire Drive Annapolis, MD 21409	443-629-3498	shodh@aol.com
William G. Simmons	227 Springloch Rd Silver Spring, MD 20904	240-620-3366	william.simmons@mdcourts.gov
Executive Director, Hope House Peter D'Souza	26 Marbury Drive Crownsville, MD 21032	410-923-6700 x 103	pdsouza@hopehousemd.org
Joseph Berry	320 Cadle Ave Edgewater, MD 21037	410-798-6891 (Home) 410-533-8861	joefranberry@aol.com
Christine Hines	4950 Mercedes Blvd Camp Springs, MD 20746	410-963-8848	Ksyb01@aol.com
Pastor Terry Allen	7409-A Baltimore Annapolis Blvd Glen Burnie, MD 21061	410-869-7823	godsperfectwill@hotmail.com
Michael Hollins	931 King James Landing Annapolis, MD 21403	410-295-0615	mhollins@hollinspartners.com
Shelly Brouse	126 Crossfox Cir Catonsville, MD 21228	410-504-2020	sbrouse@medchiagency.com
Brian McCarthy	276 Greenleaf Cir Arnold, MD 21012	202-400-0759	Brianmccarthy714@comcast.net
Board Member Emeritus			
Kimberly Shults	1621 Wyatts Ridge Crownvsille, MD 21032	410-849-3430	n/a
Patricia Weathersbee	834 Valentine View Crownsville, MD 21032	410-923-0853	Pweath1@hotmail.com
Tom Casey	1615 L St NW, STE 600 Washington, DC 20036	410-533-7357	Tomc816@verizon.net
Gerard Evans	3506 Victoria Lane Davidsonville, MD 21035	410-703-6262	gevans@lobbymd.com

Appendix C

Waitlist Numbers

January 2018	**138**
February 2018	**109**
March 2018	**113**
April 2018	**154**
May 2018	**180**
June 2018	**181**

*The waitlist is a living list that is often changed due to a patient's status change from waitlist to active, hold, or contacted status. Our electronic medical record system does not have the capability to pull waitlist numbers from a given day/month/year. In January 2018, Hope House Treatment Centers joined an initiative with the local health department to communicate waitlist numbers for data tracking purposes. For that reason, waitlist numbers are only available from January 2018 until the present day.

Appendix D

Treatment Protocols

ADDICTION RECOVERY INC. DETOXIFICATION, IN-PATIENT, RESIDENTIAL AND PHP LEVEL OF CARE POLICY AND PROCEDURES ON TREATMENT PLANNING

PURPOSE:

A comprehensive and individualized description of the treatment to be undertaken is prepared in the format of a treatment plan for each patient. The treatment plan is based upon the biopsychosocial assessment process (described in the Assessment Section) which identifies each patient's specific needs for the inpatient level of care. The treatment plan becomes a contract between Addiction Recovery Inc. and the patient and outlines specific behavioral objectives. The purpose of the treatment plan is to elicit the patients' active participation in his/her treatment and agreement to work toward goals and objectives to facilitate building a recovery foundation. With all disciplines involved, the patients' input is sought in the development of the treatment plan, with the individual indicating agreement with the objectives, tasks, and/or procedures by his/her signature on each plan.

Treatment planning and review is a dynamic, ongoing process, which occurs throughout the inpatient stay, and involves all members of the multidisciplinary team. At any time, as new issues are identified and/or the patient is unable to achieve written objectives, new treatment plan objectives may be developed or revised to facilitate the patients' process of recovery.

Treatment plans are organized in accordance with ASAM PPC-2-R Dimensions. Each treatment plan is identified with the number corresponding to the dimension to which it applies, and then sequentially with a letter. For example, the first treatment plan addressing withdrawal would be numbered 1a, to correspond to the ASAM withdrawal dimension.

PROCEDURES:

NURSING INITIAL/SUBSEQUENT TREATMENT PLANS

The treatment plan may be initiated by the nurse on the day of admission. This plan addresses any immediate problems that the patient presents. It is based upon information gathered from the nursing assessment, and the history and physical, and is developed prior to the full completion of the bio-psychosocial assessment. These treatment plans for actual and potential problems, which, unless addressed, would be a threat to ongoing health and recovery from chemical dependency, can be initiated at admission or during the next 3 days after the client has met with his/her nurse case manager. This includes acute and chronic somatic or mental health diagnosis and "at risk" issues. The admitting nurse also initiates the safety plan during the admission process.

Examples include, but are not limited to:

a. Potential for harm related to drug/alcohol withdrawal.

b. Lacks knowledge about affects of (drugs/alcohol) on self and unborn child.

c. Potential for self-harm demonstrated by…

d. Depressed mood related to…

e. Body weight less than required due to…

f. Lacks knowledge of health protective behaviors that promote wellness.

Collaborative medical and nursing diagnoses will also be in treatment plan format. Examples include, but are not limited to:

a. Diabetes
b. Hypertension
c. Major depression
d. Anxiety disorders
e. Seizure disorders
f. Positive HIV status
g. Acute Withdrawal
h. Post Acute Withdrawal

Common and usual minor health problems identified in the patient will not be in treatment plan format. Evidence of care will be seen in other documentation, such as physician orders, protocols, and progress notes. Examples include, but are not limited to:

a. Minor respiratory infections.
b. Seasonal allergies
c. Sprains
d. Occasional headaches.

Goals are established in collaboration with the client and are stated in the client's words to the extent possible. Each objective is written in behavioral, measurable, and achievable terms understandable to the client, and specifies a target completion date.

In the event that an issue has been identified which is not an immediate problem, it may be deferred until discharge to the next level of care.

In the event that an issue has been identified which is beyond the scope of the Addiction Recovery Inc. program and requires ongoing treatment in an outside agency, the nurse indicates to whom the problem is being referred. The nurse will make a referral in consultation with the Medical Director and facilitate access to required services. Examples of such referrals include, but are not limited to:

a. Dental services
b. Pre-natal/reproductive health
c. Vision services
d. HIV/AIDS case management

The nurse will fully explain the treatment plan goals and objectives to the patient, including any tasks, assignments, monitoring, or other behavior the patient must undertake to work toward completion of the objectives. The patient will indicate his/her agreement with the treatment plan objectives by electronically signing the plan. This signature indicates that the patient agrees that the objectives are appropriate and suitable to his/her needs. The patient is given a copy of the treatment plan to help guide his/her stay at Addiction Recovery Inc.

On the day after admission, the nurse will present the case to the multidisciplinary treatment team during the morning team meeting. Information presented to the team will include, but not be limited to:

a. Name, age, gender, race
b. Drug(s) of choice and last use; drug history

c. Current living situation
d. Mental health history to include:
    1. Hospitalizations
    2. Suicide attempts
    3. Response to intervention
e. Legal requirements, if any
f. Current health problems and medications
g. Patients' perceived motivation for treatment
h. Withdrawal status and any limitations to patient participation
i. Treatment plans already developed

If a counselor has met with the patient's family on the day of admission, he/she will present any additional information to assist the team in understanding the patient's needs.

PRIMARY COUNSELOR/CONTINUATION OF TREATMENT PLANNING

Following completion of the bio-psychosocial assessment/TAP and the diagnostic summary, the primary counselor utilizes individual needs and strengths which have been identified to prepare the next sections of the treatment plan. These include, but are not limited to:

a. Self-diagnosis and development of a commitment to recovery.
b. Experience and integration of 12-step principles into recovery.
c. Identification of relapse patterns and development of relapse prevention plans.
d. Intervention in to family dynamics which interfere with recovery.
e. All individually identified issues that impact the patients' ability to commit to, understand, and adopt recovery behaviors (These may include emotional, physical health, family, and spiritual needs, which are referred to the appropriate discipline for intervention).

Treatment plans are numbered to correspond to the appropriate ASAM PPC-2-R Dimension under which they fall, and lettered sequentially under each dimension. Each objective is identified in behavioral, measurable terms and specifies a target completion date.

In the event that an issue has been identified which is beyond the scope of the Addiction Recovery Inc. Program and is expected to interfere with treatment, requiring a referral to an outside agency during the inpatient treatment phase, the primary counselor will list the

problem on the Master Problem List, and indicate to whom the problem is being referred. The primary counselor will make a referral in agreement with the multidisciplinary treatment team and facilitate access to required services. Examples of such referrals include, but are not limited to:

a. The Abuse Counseling Center.
b. Private psychologist or psychiatrist, as appropriate if they have been seeing one upon admission.
c. Family counseling services that may have already been in place prior to admission.

The primary counselor will fully explain the treatment plan goals and objectives to the patient, including any tasks, assignments, monitoring, or other behavior the patient must undertake to work toward completion of the objectives (see sections on Therapeutic Interventions for examples of patient tasks and assignments). The patient will indicate his/her agreement with the treatment plan objectives by signing the plan. This signature indicates that the patient agrees that the objectives are appropriate and suitable to his/her needs. The patient is given a copy of the treatment plan to help guide his/her stay at Addiction Recovery Inc..

Treatment plans will be reviewed with the patient on a weekly basis for clients other than Detox clients. Detoxification treatment plans will be reviewed on a daily basis. Both the counselor and the patient will electronically sign the original treatment plan..

Due to the short length of stay, the primary counselor will usually not write specific treatment plans for the family unit. He/she will provide appropriate educational resources for the family unit by facilitating family conferences designed to encourage and help members to begin their own recovery program, and to assist in identification of unhealthy patterns of interaction that continue to support active addiction (see section on Family Services for situations in which the primary counselor will write specific treatment plans for the family unit). Detoxification family members can meet with the patient and the counselor when necessary.

a. Family members are usually referred to Al-Anon or Nar-Anon, and may also be referred for ongoing family counseling when the need for such is identified.

b. If the primary counselor identifies a significant family problem which can be adequately addressed with in the Addiction Recovery Inc. program, a specific family treatment plan may be prepared, utilizing the same steps as outlined above.

Due to the patient's' early recovery status, identified issues may be deferred for later attention, so long as they do not interfere with the ability of the patient to fully participate in the treatment/recovery process. Although it is vital to address these issues to ensure healthy recovery from substance

dependency, the patient may require significant clean time and a willingness to address addiction as the primary problem before effectively addressing them. Such issues may be addressed in a treatment plan at a later time while at Addiction Recovery Inc., or referred to the appropriate agency following discharge. Such problems include, but are not limited to:

a. Past sexual assault or abuse.
b. Co-dependency issues resulting from family dynamics.
c. Relationship (current or past) issues.
d. Past physical abuse or battering
e. Unresolved grief over loss

Individuals who experience a significant life or status issue change during treatment will have an abbreviated treatment plan put in place to stabilize symptoms and refer to outside agencies to continue to address.

ORIENTATION/INITIAL TREATMENT PLAN:

The primary counselor initiates the treatment plan within 7 days of admission. This plan addresses the client's need to become familiar with the overall program in which he/she will be working for the few months. It may also address any immediate problems the client presents that may interfere with his/her ability to integrate into the client community.

1. The primary counselor initiates the treatment plan based upon collected data prior to and during the admission process. The initial focus is on issues related to the process of adjustment upon entering a long-term program as well as any significant, problematic health issues that may require immediate attention.

2. In the event that an issue has been identified which is not an immediate problem, it will be addressed, referred or deferred following the completion of both the nursing and primary counselor's psychosocial assessments.

3. In the event that an issue has been identified which is beyond the scope of the Addiction Recovery Inc. program and is expected to interfere with the client's integration into long-term treatment, requiring an immediate referral to an outside agency indicate to whom the issue is being referred. The primary counselor and/or nurse will make the referral in consultation with the treatment team and facilitate access to required services. Examples of such immediate referrals include but are not limited to:

    a. Emergency Dental Services
    b. Pre-natal/reproductive health
    c. Emergency Mental Health Assessment
    d. HIV/AIDS case management.

4. The primary counselor will fully explain the orientation treatment plan goals and objectives to the client, including any tasks, assignments, monitoring, or other behavior the client must undertake to work toward completion of the initial, orientation objectives. The client will indicate his/her agreement with the treatment plan objectives by electronically signing the plan.

5. Following the orientation period, further treatment planning will include but not limited to:

    a. Engagement in self-help support services through 12-step fellowships
    b. Further education on the disease of addiction and its consequences
    c. Identification of relapse patterns and development of relapse prevention plans

d. Intervention into family dynamics that interfere with recovery
e. All individually identified issues that impact the client's ability to commit to, understand and adopt and strengthen recovery behaviors (these include emotional needs, physical health needs, family needs, spiritual needs)
f. The need for financial stability, employment, vocational assistance
g. Development of positive self-esteem
h. Time management; stress management; financial management
i. Treatment for any co-occurring psychiatric disorders.

Deferring of Key Issues:

Because of a client's status in the first year of recovery, identified issues may be deferred for later attention when the client has established several months of abstinence and stability. These identified problems may be addressed in a treatment plan at a later time while at Addiction Recovery Inc., or referred out to community agencies while the client is at Addiction Recovery Inc.. Examples of such problems include but are not limited to:

a. Sexual Assault or Abuse from the past
b. Co-dependency issues from family of origin dynamics
c. Relationship (current and/or past) issues
d. Physical abuse or battering from past
e. Unresolved grief over losses

While these issues are vital to address to insure a healthy recovery from substance dependency, they often require significant clean time and a willingness to address addiction first as the primary problem. Unless they are prohibiting the client from working toward building an early recovery foundation, they are deferred until physical and emotional stability (and often financial stability) has been achieved.

Referring of Key Issues:

If identified problem areas are significantly inhibiting the client's ability to focus on recovery from addiction; they are then referred out to specialty agencies that work

concurrently with the client while he/she is at Addiction Recovery Inc.. Examples of those agencies include:

a. The Abuse Counseling Center
b. YWCA Battered Spouse Groups
c. YWCA Counseling Career Services
d. Business Workforce and Development

Problems concurrently being treated by an outside counseling agency are included as an objective on the corresponding Addiction Recovery Inc. treatment plan as:

Client will maintain compliance with appointments at….

C. Detoxification:

Following completion of the brief bio-psychosocial assessment, the Counselor utilizes individual needs and strengths that have been identified to prepare the Detoxification Treatment Plan. These include, but are not limited to:

a. Assessing level of motivation for continued treatment.
b. Listing resources that can support recovery efforts.
c. Becoming educated on the disease process.
d. Participating in in-house treatment functions.
e. List ways in which 12-step programs are vital to remaining abstinent.
f. Seeking staff assistance and evaluation during the detoxification process daily.
g. Referral/transfer to appropriate level of care

Appendix E

CARF Accreditation

carf INTERNATIONAL

A Three-Year Accreditation is awarded to

Addiction Recovery, Incorporated dba Hope House

for the following program(s):

Detoxification/Withdrawal Support: Alcohol and Other Drugs/Addictions (Adults)
Inpatient Treatment: Integrated: AOD/MH (Adults)
Intensive Outpatient Treatment: Integrated: AOD/MH (Adults)
Outpatient Treatment: Integrated: AOD/MH (Adults)
Partial Hospitalization: Integrated: AOD/MH (Adults)
Residential Treatment: Integrated: AOD/MH (Adults)

This accreditation is valid through
September 30, 2019

The accreditation seals in place below signify that the organization has met annual conformance requirements for quality standards that enhance the lives of persons served.

Third year seal of annual conformance

This accreditation certificate is granted by authority of:

Herb Zaretsky, Ph.D.
Chair
CARF International Board of Directors

Brian J. Boon, Ph.D.
President/CEO
CARF International

Appendix F

Office of Health Care Quality Certifications

Waiting for BHA to send updated letter of good standing for all levels of care.

***Amended. See attached documents.**

Appendix G

Utilization Review Policy/Procedure

ADDICTION RECOVERY INC.

UTILIZATION MANAGEMENT PLAN FOR CLIENT'S WITH PRIVATE

INSURANCE OR MEDICAL ASSISTENCE

OBJECTIVE: The objective of Addiction Recovery Inc. Utilization Management/Review activities is to increase the effective utilization of the facility's resources of staff, space and money to maintain high quality patient care and achieve cost-efficiency. This is accomplished through concurrent, retrospective, and occasional focused studies of patterns of care. The purpose is to identify under or over utilization of resources and services in order to fulfill the overall Mission of Addiction Recovery Inc. Treatment Center.

Utilization Management functions are linked to Addiction Recovery Inc. Treatment Center's Continuous Quality Improvement and Clinical Risk Management functions and activities.

SCOPE: The Utilization Management process will address under-utilization/over-utilization and the efficient scheduling and delivery of facility resources.

Utilization Management will primarily focus on two major areas related to Patient Management.

1. The appropriateness and clinical necessity of admitting a patient to one of the levels of care reflected in the American Society of Addiction Medicine Patient Placement Criteria 2-R.
2. The appropriateness of a patient's continuation in treatment.

RESPONSIBILITY: The Treatment Team serves as the Committee for Utilization Management issues. The Front Office Staff is responsible for validating benefits of insured clients, making referrals if Addiction Recovery Inc. is not in the network to provide services. The Director of Nursing/designee is responsible for opening cases with insurance carriers including pre-certification. The Director of Treatment is responsible for concurrent reviews and working closely with clinical staff regarding discharge planning per managed care organization protocols.

PROACTIVE

PATIENT REVIEW

PROCESS:

A. APPROPRIATENESS OF ADMISSION.

1. **Pre-Admission Utilization Review**

   If, during the admission process, additional questions arise about the appropriateness of admission, the admitting/Utilization nurse, the Director of Treatment, the Director of Nursing and/or the Medical Director will case conference to determine the appropriateness for Addiction Recovery Inc. levels of care. They may also confer with the Executive Director for a final decision.

   Insurance Case Management

   On the day of admission, the designated Addiction Recovery Inc. utilization nurse will open a case and carry out the pre-certification process with the client's insurance company once the clinical nursing assessment is completed. A level of care, based on the individual insurance company's criteria, is then decided upon by the UM coordinator and the case manager of the insurance company. This outcome is communicated to the client, and any revisions in financial arrangements are relayed to the financial office. If access to benefits is denied, the patient is notified and a referral to another agency is given by the client's insurance company. A client always has the right to a self-pay option, but they will be charged Addiction Recovery Inc. full rate.

   The designated Addiction Recovery Inc. insurance reviewer will generate an Insurance Tracking Form noting all contacts with insurance. A copy of the client's insurance card is scanned into the Credible electronic record, and any written communication from the insurance carrier is also kept in this section for billing purposes as well as consent from the client to release information.

   The Insurance Tracking form and all authorizations and documentation from the client's insurance company will be obtained by the Director of Nursing/designee. The authorization numbers are entered into the Authorization tab of the Credible electronic record. The claim will be billed electronically by our in-house biller upon discharge.

RETROSPECTIVE

PATIENT

REVIEW PROCESS:

A. RETROSPECTIVE REVIEWS.

1. The Director of Treatment may randomly review records for documentation which justifies the necessity for admission. The appropriateness for admission is determined by comparing the clinical

information documented in a patient's record with the ASAM PPC-2R criteria.

2. Based upon the review of the record, the Director of Treatment determines whether or not the admission appears appropriate based on criteria.
   a. If the admission is justified and the patient is still in treatment, the case will be reviewed at the appropriate intervals by the treatment team.
   b. If the admission does not appear to be justified based upon documentation in the patient record, the Director of Treatment will confer with the Director of Nursing, and the Medical Director for input. If a consensus cannot be reached, the case may be presented to the Executive Director for final decision. If a patient is deemed inappropriate for the levels of care offered by Addiction Recovery Inc., they will be informed by their Case Manager and an appropriate referral made.

CONCURRENT

REVIEWS:

B. APPROPRIATENESS AND CLINICAL NECESSITY OF CONTINUED STAY AT ADDICTION RECOVERY INC.

Once a patient has been admitted to Addiction Recovery Inc. and certified for admission, the case manager and treatment team will monitor the patient's clinical record for documentation of progress or lack of progress and outcomes related to the need for continued stay.

1. The primary emphasis on continued stay review relates to over utilization or under utilization of services. "Over" utilization is defined as excessive need for staff intervention, patient refusal or inability to progress in treatment or disruptive behavior. "Under" utilization is defined as no longer requiring the levels of care offered at Addiction Recovery Inc., or verbalization of readiness for discharge.
2. A concurrent review is conducted at various intervals during a client's stay, depending on what level of care a client is in. If a client is in Detox, a review is conducted daily, and all other clients have a review done weekly.These reviews identify the ASAM Dimensions where improvement has been made, and those where discharge criteria has not been met. This allows input from all disciplines in

an effort to revise treatment plans already in place or institute new ones. This review may include:

a. Continuing care plans
b. Discharge plans
c. The necessity for community referrals
d. Patient's progress in meeting treatment plan objectives

3. If the necessity for continued treatment appears justified, treatment plans may be revised or maintained until the next review, based upon the patient's progress.

4. If a client no longer meets criteria for continued stay at any level of care at Addiction Recovery Inc., they will be discharged to a lower level of care. The case manager will offer the patient a variety of after-care facilities to make a selection from.

5. If a client disputes whether they meet ASAM criteria for continued stay vs transitioning to another level of care, the same procedures apply to a concurrent review as to a retrospective review. The final decision may require the Executive Director's input.

C. EXHAUSTION OF INSURANCE BENEFITS WHILE IN TREATMENT

If a client utilizes all insurance benefits for all levels of care (In-patient, Partial, IOP) while in treatment but still meets criteria for continued stay, he/she may opt to stay on a self pay level of care. This must be approved by the Director of Treatment, and the client must have an additional intake by the financial office to complete the necessary paperwork

D. REVIEW OF THE UTILIZATION MANAGEMENT PLAN

1. The Utilization Plan will be revised as appropriate to reflect any changes in protocols. The Executive Committee will have full input in this process, based upon changing Managed Care processes.

UTILIZATION MANAGEMENT FOR PATIENTS WITH PRIVATE INSURANCE

PURPOSE:

(1) To identify a specific process for accessing benefits for patients who have private or public assistance insurance and are seeking admission to Addiction Recovery Inc..

(2) To clarify the financial obligations of those patients who have private health insurance or public assistance with Managed Care Organizations.

(3) To maximize revenues for Addiction Recovery Inc. services.

POLICY :

1. Telephone screening forms are completed by the Front Office Staff the first time phone contact is made. All information regarding insurance coverage including policy number and telephone number to verify benefits must be given or else the screening process is stopped, and the client told to call back when he/she can provide this information.
2. The Office Manager verifies that Addiction Recovery Inc. is In-Network to provide treatment services, or that the client has Out-Of -Network benefits. If a client's private insurance can not be accessed, they will be referred back to their member services department so they may be given the name of a provider who is in their network. If a client insists on being considered for admission to Addiction Recovery Inc. against the directives of their insurance, they will be charged Addiction Recovery Inc. full daily rate. Patients are, however, always encouraged to access treatment through their own network of providers.
3. If the client has **no** substance abuse benefits connected with their insurance coverage, the patient will be processed by the Financial office as having no insurance, and the sliding fee structure will apply per the self-pay option. The client will be informed of this on the day of admission.
4. If private insurance provides benefits but requires specific assessments and/or contacts to access benefits, the client is expected to comply with this direction. If the client does not do so and benefits are unavailable or denied because of failure to comply, the client will be assessed the full costs of services.
5. On the day of admission, a client's insurance company will be contacted by a designated Addiction Recovery Inc. insurance Utilization reviewer for pre-certification of benefits once the client has had his nursing assessment and been accepted for admission by the Medical Director. A consent to release information is obtained from the client prior to contacting the insurance company. At Addiction Recovery Inc., designated insurance reviewers are the Utilization Review Coordinator, the Director of Nursing, and Director of Treatment.
    a. Every effort will be made to access in-patient benefits based on ASAM PPC 2-R criteria. If the client does not meet criteria for in-patient treatment, Partial Hospitalization or IOP benefits will be sought. If a client has Medicaid/Medical Assistance, a $350 facility fee is due at the time of admission.
    b. It should be noted that "court mandated" treatment is usually not considered as satisfying the criteria for "medical necessity" regarding in-patient benefits, and, in some cases, is a key exclusion from any benefits.
    c. An Insurance Tracking form will be completed and kept in a separate section of the client's active record. It will contain patient demographic information, insurance information regarding a client's policy, date and time of the pre-certification, name of the case reviewer, Level of Care accessed, number of days obtained, and any authorization codes received. It will also specify the date of the next review. The case manager/nurse will provide the information available when formulating the individual's treatment plans.
7. The designated insurance reviewer will carry out vigorous efforts to continue to access a client's benefits in the form of ongoing concurrent reviews

a. On the date of the concurrent review, the designated insurance reviewer will review the patient's chart regarding clinical progress and justification for continued stay. Information may be obtained from but is not limited to :
    1. The case manager
    2. The Nursing Department
    3. Any independent consultants such as the Medical Director, Nurse Practitioner, or Physician Assistant.

    4. Documentation of clinical team reviews during the morning Team Meeting and outcomes of revised treatment plans. An Insurance Review Form may be requested to be completed.

8. The above information is reported to the clients insurance case manager in order to justify additional treatment days at the current level of care. Once the review has taken place, the outcome will be documented on the Insurance Tracking form.
    a. If additional days are approved at the previous level of care, the number of additional days received, authorization number, and date of next review is recorded as well as the date, time, and name of case reviewer.
9. If client is transitioned to a lower level of care, the number of days at the next level of care and authorization number is recorded. The date and time of the review as well as the name of the case reviewer is also documented.
10. If the case reviewer does not feel additional time at any level of care offered at Addiction Recovery Inc. is warranted and the Addiction Recovery Inc. designated insurance reviewer feels that client does meet at least IOP criteria, a physician to physician review will be requested.
11. The Medical Director/or designee will then be contacted directly and informed of the need to conduct a physician to physician review. All clinical information will be relayed to the Medical Director supporting the need for additional time at the IOP level of care. In addition, the Medical Director may obtain clinical updates from the following Addiction Recovery Inc. staff members:
    a. The Case Manager

    b. The Nursing Department

    c. Any independent clinician rendering services to the client (ie: dietician,

    PA, outside medical agencies)

12. The designated insurance reviewer will act as facilitator and liaison between the insurance case worker and the Medical Director. The review date and time will be coordinated according to each physician's schedule.
13. Following the review, all approved days and authorization numbers will be recorded on the Insurance Tracking form and the case manager and client informed regarding the outcome and any assessments based on new level of care explained.
14. If the client is not approved for any additional days, a meeting will be held between the client, the case manager and the Director of Treatment. The need to follow the insurance company recommendation will be explained, and a referral to an outpatient provider in the clients insurance company network will be made. The client will always

have the choice of selecting a self-pay option and remain at Addiction Recovery Inc. for additional treatment, but will be subject to full costs of services.

15. If a client exhausts his substance abuse benefits through his insurance company while in treatment and he/she meets criteria for continued stay, they will be given the option of completing treatment on a sliding fee schedule.

16. Some insurance require submission of written, concurrent treatment plans for review. These plans will be completed and submitted as required by the designated insurance reviewer. Some insurance companies are requiring reviews to be done electrically through the insurance company web portal.
17. Billing is a joint activity involving the designated insurance reviewer and the Director of Finance.
    a. The designated insurance reviewer, upon discharge of a client with insurance, will obtain copies of the client's insurance card, Insurance Tracking form, and any printed authorizations received from the insurance company. If the hardcopy authorizations have not arrived, billing will be delayed until they do arrive.
    b. The Director of Finance/designated insurance reviewer then completes a Billing Advice cover sheet for processing. If the Director of Finance has any questions regarding any levels of care to be billed, he/she contacts the designated insurance reviewer directly.
    c. If payment is not received in 3 months, the insurance company is contacted directly by the Director of Finance for a status report.
    d. If payment is denied by the insurance company, the client will be contacted directly by the Director of Finance to determine if a grievance should be filed client's behalf.
    e. The Health Advocacy Unit of Maryland's Consumer Protection Division may be contacted for assistance with the process. All documentation of grievance proceedings will be listed on an Insurance Denial Worksheet.
18. All readmissions must resolve any outstanding financial obligations of prior treatment episodes at Addiction Recovery Inc. prior to readmission.

Appendix H

Admission Policy/Procedure

ADDICTION RECOVERY INC.'S POLICY ON PRE-ADMISSION AND ADMISSION ACTIVITIES

I. INITIAL TELEPHONE CONTACT:

The administrative office staff accepts referrals from outside agencies or individuals seeking treatment, Monday through Friday, 8:00 AM – 4:30 PM. The administrative office staff enters initial information into a new Credible electronic record and puts the record ON HOLD or SCHEDULED. This includes information regarding the demographic information, patient's condition, drugs of choice, living environment, past treatments, current health problems, and insurance information. In the case of referrals from AACo HD MORR program, refer to MORR manual. The administrative office staff screens for age appropriateness (18 or over) and answers initial questions regarding the treatment program.

1. If the client's screening information does not have to undergo a review for admission by the DOT or DON, the administrative office staff will have that individual come in that day if possible for admission once the client's insurance has been checked on-line or telephonically. If the client is unable to come in that day for admission, they are scheduled for the next available admission date/time.

2. After 24 hours, the client will be offered enrollment in the Hope House Treatment Center
   IOP program for interim services which will include at a minimum counseling and education about HIV and tuberculosis (TB), the risks of needle sharing, the risks of transmission to sexual partners and infants and steps to ensure that HIV and TB transmission does not occur. These interim services will include, if necessary, a referral for HIV and TB treatment services. Finally, the client will receive counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women.

II. VERIFICATION AND EXPANSION OF INITIAL INFORMATION:

Categories of applicants who may require a pre-admission review or Treatment team review include:

a. Unstabilized Co-occurring Disorder

b. Pregnancy (Known or suspected)

1. Addiction Recovery Inc. only accepts clients who are less than 32 weeks pregnant and do not require medication assisted detoxification. Clients who are less than 32 weeks but require medication assisted detoxification are referred to Johns Hopkin Bayiew Center for Addiction Pregnancy (CAP) for the medication assisted detoxification portion of treatment. All pregnant clients must demonstrate they have had care from an obstetrician and or a recent normal sonogram within the last 30 days. If deemed manageable at this level of care by the Medical Director, Addiction Recovery Inc. will admit approved pregnant individuals within 24 hours of requesting treatment.

c. Re-admission of previous patients

d. HIV Positive applicants – recent CD4 counts are usually requested.

Priority status for admission is given in accordance with directives from the Maryland Alcohol and Drug Abuse Administration to include:

a. Individuals who are pregnant, or have given birth within the past 12 months

b. HIV Positive applicants

c. IV drug abusers

Transfers of Levels of Care:

The nurse or counselor at Addiction Recovery Inc. makes the referral to transfer from admission level of care approved by the insurance company to a lower level of care on the date of their last detoxification medication, and this information is relayed in the AM team meeting.

The front office will then discharge the client in the Credible electronic record and change to the level of care they are transitioning to.

III. CLIENTS INELIGIBLE FOR ADMISSION:

1. Clients who are requesting a different level of treatment not available at Addiction Recovery Inc.

2. Clients requiring medical/dental intervention for a problem not manageable Addiction Recovery Inc. resources or requiring immediate intervention. Clients are encouraged to re-apply when the problem has been evaluated and/or resolved.

3. Mental health issues requiring immediate intervention such as active SI or hallucinations.

4. Married couples, significant others or related family who are currently in treatment.

The Directory of Community Services in Maryland is used as a resource as well as service providers known to Addiction Recovery Inc. locally and through the Alcohol and Drug Abuse Administration. Specific programs, telephone numbers, addresses and contact persons are provided to the client. Persons requiring mental health/medical/dental intervention are referred to available public agencies, private treatment providers, or if none is available, to a local emergency room or University of Maryland Dental Clinic.

Documentation of the referral is made on the Screening Assessment.

IV. NOTIFICATION OF THE ANNE ARUNDEL ADDICTION COORDINATOR REGARDING TOTAL CAPACITY

Within 1 week of reaching 90% capacity, the Intake office will notify Anne Arundel Addiction Coordinator that 90% capacity has been met. Addiction Recovery Inc. will admit individuals in need of treatment who are currently IV drug abusers not later than 14 days after the request for treatment has been made.

V. CAPACITY NOTIFICATION TO THE STATE OF MARYLAND – IV Drug Users

Within 7 days of reaching 90% capacity, Addiction Recovery Inc. will notify the State of Maryland that 90% capacity has been reached. The jurisdiction of Prince George's County is the State's designee.

VI. WAITING LIST

Individuals accepted into the program that cannot be admitted within 24 hours will be placed on waiting list. Each client on this list will be assigned a unique patient identifier which is the last 4 digits of a patient's SSN. The front office will call individuals who are on the waiting list daily. If the potential client can not be admitted into Addiction Recovery Inc. within 10 days, or if the potential client has a crisis, the DOT or DON will contact other appropriate treatment programs in order to arrange

admission or transfer within a reasonable geographic area. All contacts and attempted contacts are documented in the ARI information system, and wait times are monitored for purposes of quality improvement. Documentation shall contain, at a minimum, date of placement on the list and identified needs of the person.

The priority of the waiting list for admission slots will be as follows: HIV positive individuals, pregnant women who have been detoxed and IV drug users. After those individuals have been given slots, the final criteria for an admission slot is the date the individual was placed on the list.

When an admission slot becomes available, the clients will be contacted in order of priority. If that individual is not reachable, then the next individual who has been on the list the longest will be contacted. Addiction Recovery Inc. will remove individuals on the waiting list only if they cannot be located or when they refused treatment when they were contacted.

POLICY AND PROCEDURES FOR ADMISSION/INTAKE

PURPOSE: Intake is a process whereby an individual, who has previously been screened for eligibility and diagnostic impression, presents on day of admission for final determination of appropriateness for admission. This involves a preliminary assessment by the nurse and orders from the Medical Director to admit the patient based upon the diagnosis and needs of the patient. At any time during this process, if the individual is determined to be ineligible, inappropriate, or more suited to a different level or type of care not available at Addiction Recovery Inc., referral to another treatment provider who more closely meets the needs of the patient is facilitated by the case manager and or the Director of Treatment, Director of Nursing, or Physician.

PROCEDURE:

FRONT OFFICE STAFF:

1. For admissions Monday through Friday, the administrative office staff scan in the patient's electronic record a copy of the patient's identification (driver's license, social security card, insurance card).. (***If the admission comes on Saturday or Sunday, this admission data entry into the electronic record is done on the first day when the business office is open). If patients call at other times, and they need immediate admission, they are either directed to Anne Arundel Medical Center or Laurel Regional Medical Center.

****The Nursing Department may take the client before they have processed through the front office so timely insurance pre-authorization can be done.

FINANCIAL REGISTRATION AND FEE ASSESSMENT – Monday through Friday (If the client is admitted by Nursing on a Saturday or a Sunday, then this paperwork is done the 1st day the business office is open).

1. The patient then meets with the administrative staff member who describes all treatment costs to be borne by the patient. The administrative staff member will complete the following forms in the Credible electronic record:

    a. Promissory notes for clients and clients approved for waiver of admission/copay amounts are by the Executive Director.
    b. Promissory note for any pharmacy co-pays/laboratory costs
    c. Patient Rights review and explanation
    d. Family Assessment completed by the client on Credible
    e. Consent for Department of Health MORR clients
    f. Consent for Bridging the Gap
    g. Consent to any third party payer (ie MORR, Medical Assistance VO, private insurance carriers, and various other contracted agencies/counties.)
    h. Emergency contact consent
    i. Consent for any financial concerns if patient is having another individual pay for their stay, or under a primary insurance holder's policy.
    j. A General Consent/Consents if patient wishes communication with other person/persons.
    k. Verification of income form which assesses a patient's ability to pay fees for program services.
    l. Consent for Intervention psychiatric services.

2. Fees are assessed on the day of admission depending on the funding source of the individual's treatment stay. A synopsis of the current fees assessed is reviewed one on one with the client. Some of the various funding sources and associated fees are :

Privately insured clients (other than Medical Assistance)

Addiction Recovery Inc. maintains contracts with a variety of insurance companies and Health Maintenance Organizations to assist in paying for treatment for covered individuals. These clients/patients work with the Utilization Review Nurse for precertification and authorization for by the insurance company throughout their stay. If an individual has inpatient benefits, Addiction Recovery Inc. will require authorization to assign payment to Addiction Recovery Inc. and will accept the contracted amount as payment in full, less any patient deductible and/or co-pay or uncovered medication and laboratory costs, for which the patient will be responsible. Reimbursement rates differ, as do billing practices for each company.

Insured individuals will also be responsible for any medication or lab costs not covered by their insurance and these charges will be deducted from the person's deposit.

Clients who are funded by Medical Assistance.

Medicaid individuals are responsible for all RX copays.

All MORR, uninsured authorization clients and self-pay clients who are uninsured complete a MA application which is forwarded with any identification the client provides to Addiction Recovery Inc. to the State of Maryland for possible approval.

The Security desk provides family members or significant others a Family Packet. If family members or significant others have accompanied the patient and have questions and concerns a Treatment Aide, a front office staff person, or the Director of Treatment will be notified.

Clients who are self-pay and do not meet Medicaid requirements pay our self-pay fee structure for services and are responsible for all RX and lab fees.

TREATMENT AIDES:

1) Luggage containing patient personal clothing, etc. is kept in the downstairs Treatment Aide Office on the day of admission and up until the time of search by the Treatment Aide or other staff member. Patients may not remove any item unless first examined by a staff member.
2) While still in the admission area, the patient/client will be asked to empty the contents of all pockets (dress, trouser, jacket, coat, etc.) The Treatment Aide must also observe the patient turn pockets outside to insure all items are removed. The patient/client may retain cigarettes and matches after being inspected to insure no drugs or other items are in cigarette boxes/packages. Opened cigarette packages must be emptied and examined for contraband before being given to the patient. Any money over $20.00 is placed in the safe in HR's office for security. Any weapons found on a prospective client will be disposed of in the nurse's station red sharps box unless it is determined the legal authorities should be contacted.
3) Wallets and/or women's purses are also searched before the patient/client proceeds to the Administrative Office. No purses, packages, backpacks, etc. may go to the Administrative Office or the Nursing Station with the patient until they have been searched in the presence of the patient.
4) Prescribed medication for the patient is placed in a plastic baggie and delivered to the Nursing Station. These medications are held by the Admission nurse until she verifies that they will be continued in treatment. If an individual brings in a controlled substance that is not continued while the person is in treatment, the person is advised to give the medication to the family member or significant other that brought them to treatment. If they have no one waiting in the lobby, the person is given 24 hours to have a family member pick up the medication before it is destroyed. Addiction Recovery Inc. will not take responsibility for storing this

medication and or returning this medication on the day of discharge.

NURSING ASSISTANT:

1. When the client comes to the nursing station, the patient is then given a urine cup and asked to give a urine specimen. The nursing assistant then re-verifies the insurance information and bags the urine specimen for pick up after she performs a rapid urine dip. If client tests positive for Fentanyl the procedures for Carfentanyl Exposure Protection will be followed. (see procedure at bottom.)
2. A set of vital signs are taken by the nursing assistant or admission nurse.
3. The nursing assistant will next review the consents for treatment, the orientation contract and sign paperwork for a drug screen to be performed by an outside laboratory.
4. The patient is then escorted to the bathroom in the nurse's station and weighed by the nursing assistant/admission nurse. The patient is then professionally searched for contraband in the bathroom. Cavity searches are never performed.
5. The nursing assistant then escorts the client to a separate office to begin the nursing data collection section of the Intake form in Credible which includes assessment of the language needs of the client both written and oral. If the client reports they need translation or interpreter services, they will be provided either by the Addiction Recovery staff who are bi-lingual or through an outside entity such as DHMH or an outside business offering these services.
6. The licensed nurse then completes the nursing Assessment section of the Nursing Intake for including allergies, treatment plans, OOWS or CIWA if detoxification issues are involved, and safety plans.
7. The nurse then has the client sign that the information given is accurate and true to the best of his/her knowledge.
8. Assessment data on applicants who are impaired/intoxicated with alcohol, other sedative/hypnotics, barbiturates or benzodiazepines or in withdrawal from these chemicals will be discussed with the physician at the conclusion of the assessment, by telephone if necessary, to obtain admission or referral orders. The client is not allowed to electronically sign forms until his BAL is less than .20.
9. If admission is ordered, appropriate interventions will be determined and the withdrawal (if any) will be monitored.
    a. ***Nicotine Assessment, Past medication Usage Assessment, and Infection Control issues are addressed in the Credible electronic record later in the client's treatment stay.
    b. If referral is ordered, the nurse, with the assistance of the Charge Nurse or DON will refer the patient to the appropriate level of care. The patient will be asked to re-contact the front office staff to discuss possible transfer back to Addiction Recovery Inc.
10. The nurse reviews the assessment findings with the physician and obtains an admission order or referral to another level of care.
11. The nurse reviews her assessment findings with the patient and develops an initial nursing treatment plan/plans to address the immediate needs. This plan is based upon information gathered from the pre-admission screening, intake and nursing assessment. Each objective specifies an anticipated completion date. Further assessment for treatment planning

purposes occurs within the first 48 hours by the assigned Case Manager.

12. The nurse will also conducts a TB and HIV Risk assessment as outlined below:
    a. HIV Risk Assessment/Education – All clients receive an HIV risk assessment and are offered HIV testing through on-site testing at Reality House Treatment Center Treatment Center who is an accredited CTR site. Individuals who are admitted and are HIV positive will be re-connected with their clinic if they have been noncompliant before entering treatment. Anne Arundel County Health Department or People's Community Healthcare can assist in identifying the closest geographical clinic or assume care themselves.
    b. TB Risk Assessment/Education/Planting of TB test - All clients who are admitted to Addiction Recovery Inc. with active drug/alcohol addictions are identified as individuals at high risk of becoming infected with TB. All clients admitted undergo the planting of a TB test unless they have had a negative test within the last 30 days and can get a copy of those results. In addition, if a client has a history of a prior positive TB test, no TB test is planted. However, based on Addiction Recovery Inc. physician's recommendation, they may either be sent for a chest X-ray or referred to the Anne Arundel County Health Department Infectious Disease Control Clinic for further evaluation and or case management. If a client has a positive result from their TB test, the test may be re-planted by the Addiction Recovery Inc. MD/PA or they may be referred for a chest x-ray. All individuals who have active TB are referred to the Anne Arundel County Health Department as required by State law and in accordance with confidentiality requirements including 42 CFR part 2. Case management activities are conducted by AACo. HD Infectious disease.
13. The nurse introduces the patient to a Treatment Aide who assists the patient with room check in procedures.
14. The physician has a face to face interaction with the client within 24 hours of admission. The NP or MD completes a history and physical either within 24 hours if detoxification is required or within 96 hours if no detoxification is required. The H & P includes but may not be limited to the following:
    a. A medical history and physical examination
    b. The history of physical problems associated with dependence
    c. Appropriate laboratory screening tests based on findings of the H & P.

The patient's admission information is relayed to the Treatment Team the next morning. If at all possible, the treatment team attempts to honor the client's preference for a male or female counselor, but the case managers client load as well as what is best for the client are also taken into consideration.

Addiction Recovery Inc.'s Crownsville location has an MOU with the Interventions in Anne Arundel County to provide psychiatric evaluations and or therapy based on active symptomology or past history. Interventions provides a liaison to Addiction Recovery Inc. to help identify individuals in need of these services. Addiction Recovery Inc. staff (especially the primary counselor or nurse)

can present individuals in need of these services directly to the liaison or schedule an actual appointment directly with Interventions if applicable.

Addiction Recovery Inc.'s Laurel location has an MOU with the PG County Crisis Intervention to provide psychiatric evaluations and or therapy based on active symptomology or past history. Addiction Recovery Inc. will provide onsite psychiatric services through Aspen Day Treatment to patients identified as needing these services. Addiction Recovery Inc. staff (especially the primary counselor or nurse) can present individuals in need of these services directly to the liaison or schedule an actual appointment directly with the nurse psych practitioner if applicable.

FAMILY INVOLVEMENT:

1. Family members are asked to wait until the intake procedures are complete to insure the patient has been accepted in care at Addiction Recovery Inc. and has received initial orders from the Medical Director/NP. If at any time there are concerns that Addiction Recovery Inc. cannot meet the needs of the patient, admission procedures may be stopped and an alternative referral given.
2. Family members are given Family packets. Inside this packet is an outline of the family services offered by Addiction Recovery Inc.. Also included in the packet is a Family Assessment form which must be completed and handed into the family counselor before the family is allowed to visit. These forms are given to the Director of Treatment on Mondays, and any forms with requests for individual referrals/services are forwarded to the individual case manager. The primary nurse will collect collateral information on use and medical or mental health concerns.

DIRECT CARE STAFF: (Treatment Aides)

1. The nurse introduces the patient to a Treatment Aide after the initial nursing data base is completed. The Treatment Aide provides a facility tour, escorts the patient to his/her assigned room, and continues the orientation process.
2. Personal belongings are searched by the Treatment Aide in the presence of the patient for drugs or alcohol. If any found, those substances are destroyed (see section on admission search). Medications, both over the counter and prescription, are given to the nursing staff.
3. The Treatment Aide provides a patient packet that includes the rights and responsibilities of the patient and reviews the packet with the patient within 24 hours of admission. This packet explains patient rights regarding but not limited to the following:
    a. Telephone use

b. Receipt of mail and packages

c. Leaving the facility

d. Visitors

3. Emergency evacuation/facility hazards information is provided as well as information regarding confidentiality of patient records, fire and safety regulations, and patient behavioral guidelines including violations that are grounds for immediate discharge.
4. The Treatment Aide member fully explains all the behavioral guidelines outlined in the patient packet including the rights and responsibilities of the patients, rules governing their conduct and the types of infractions that can result in disciplinary action or discharge from the facility.

ALL PERSONNEL:

If the admission process continues through the lunch or dinner hour, the staff member who is working with the patient at that time stops the process and takes the patient to the lobby area. The client will receive a food tray brought by the Treatment Aides. The admission process will then proceed following meal time.

INTAKE INTERVIEW

1) All applicants eligible and appropriate for admission will be scheduled for a face to face interview with the Counselor within the first 3 days after. The Intake interview is an assessment to insure that the patient's needs correlate with the services available at Addiction Recovery Inc. based on admission criteria. Exceptions to this are on a case by case basis.
2) Criteria for determining the eligibility of patients for admission to the various levels of care are clearly described in the following in the Credible Treatment Plan:

    a. DSM - IV Diagnostic Criteria

    b. ASAM PPCII –R

3) The counselor uses the collected data to complete the DSM-IV Criteria to determine a presumptive diagnosis of Substance Dependence. If three or more criteria are met, the counselor proceeds with the ASAM PPC-2–R. The purpose of the criteria and check lists is to ensure that treatment required by the patient is appropriate to the intensity and restrictions of care provided by Addiction Recovery Inc.
4) A Gambling Assessment is also conducted by the counselor.

***In the event that the screening process reveals there are medical, psychiatric, legal or other complicating factors which require further assessment in order to determine the appropriate

disposition of the applicant, the review conducted by one or more of the following individuals will be performed: Director of Treatment, Director of Nursing, Physician, and/or Charge Nurse.

***It is the intention of this process to insure the appropriateness of the patient and the ability of Addiction Recovery Inc. to meet the patient needs and/or suggest alternative services. The patient is matched to the type and level of services that best meets his/her needs.

CARFENTANYL EXPOSURE PROTECTION

PROCEDURE

Every new client reports to designated area for fentanyl urine testing (**Crownsville – Nursing station, Laurel – bldg. 429)** If urine is negative, proceed with admission process as usual. **If urine is positive, implement the following steps:**

1. Client is taken to designated shower area (Laurel – basement of bldg. 429, Crownsville – Room 216) where they shower and change into clothing we provide for them. Client's clothing is bagged and put with other clothing client brought in.
2. All client belongings are taken to laundry area to be searched.
3. Staff doing search will don PPE (personal protective equipment.)
4. All clothing is put directly into washer after it is searched.
5. All personal items are wiped down with wet rag or run under water if possible.
6. All suitcases, backpacks, duffle bags, etc., and any excess or prohibited items are bagged and stored until client is discharged.
7. After client's personal clothing has been washed and dried, Hope House clothing and footwear will be bagged **(excluding underpants)** and returned to staff, who will place items directly into the washing machine.
8. After HH clothing is washed and dried, it is returned to designated area and sorted or repackaged according to size so it will be available for next client.

Appendix I

Length of Stay

I. Core Program Descriptions

A. Detoxification

Program Description

Addiction Recovery Inc. provides non-hospital detoxification services to clients who require uncomplicated opiate, alcohol and benzodiazepine detoxification. Services are provided 24 hours/7 days per week. Clients must be medically screened to determine the safety of conducting a detoxification protocol outside of a hospital setting. Detoxification generally lasts from 5-10 days, depending upon the drug(s) used and complications. All individuals detoxified are referred to the next appropriate level of care for continued treatment. Detoxification is the beginning of a recovery process which must be followed by ongoing care and addiction treatment in subsequently lower Levels of Care. However, some clients who only wish detoxification services at ARI will be transitioned to community aftercare programs.

Detoxification (Detox) Services are provided to clients who have marked functional impairment due to their substance addiction and who exhibit signs of withdrawal. These individuals require more intensive structure and oversight in order to stabilize their addiction(s) and to (re)establish a pattern of life that does not rely on the use of chemicals. Detox Services are provided at two locations: in the Crownsville and Laurel, MD area. Detox clients are under supervision 24/7.

B. Residential Treatment

Program Description

Addiction Recovery Inc. offers short-term treatment residential for people who meet the ASAM criteria for Medium Intensity Residential. Services are provided 24 hours/7 days/week.

Admission to this level of care usually begins with complete medical and psychosocial assessment, including a mental health assessment when psychiatric problems are suspected if not already done in previous levels of care. The treatment component consists of group, individual, and family counseling using ROSC, Motivational Interviewing and other evidence based practices, health teaching, education about drugs and recovery, introduction to 12-step, self-help support groups, interactive peer support, psychiatric services as required and intervention/referral when physical problems are noted. The short-term component of treatment generally lasts from 7 to14 days, depending upon individual need and completion of treatment plan goals develop with

client input. Residential treatment is always followed by a transition to ongoing, continuing care in a different level of treatment such as PHP or IOP.

C. IOP/OP

Program Description

Addiction Recovery Inc. offers short-term treatment for people who meet the ASAM criteria Partial Hospitalization treatment. Services are provided 7 days week and include at least 5 hours of therapeutic programming, dependent on contractual obligations with payers, and these services are funded by private insurance, County/State funding, or a self-pay option. Treatment is supervised by a qualified behavioral health practitioner that is on site during clinical hours. Admission to this level of care usually begins with a complete medical and psychosocial assessment, including a mental health assessment when psychiatric problems are suspected if not already done in previous levels of care. The treatment component consists of group, individual, and family counseling using ROSC, Motivational Interviewing and other evidence based practices, health teaching, education about drugs and recovery, recreational activities, introduction to 12-step, self-help support groups, such as alumni, interactive peer support, psychiatric services as required and intervention/referral when physical problems are noted. The short-term component of treatment generally lasts from 7 to 28 days, depending upon individual need, and is always followed by a transition or referral for ongoing, continuing care in a different level of treatment such as IOP or OP.

Appendix J

Discharge Planning

ADDICTION RECOVERY INC. PROCEDURES FOR DISCHARGE FOR IN-PATIENT, RESIDENTIAL, AND PHP LEVELS OF CARE

PURPOSE: A patient's readiness for discharge from all levels of care is determined by the treatment team through the process of treatment plan review (see policies on therapeutic reviews) and based upon ASAM PPC II R. However, the process of discharge planning from is initiated at the time of admission as the treatment team assists the patient in making responsible, discharge decisions. It is the philosophy of Addiction Recovery Inc. to provide the least restrictive environment, which is conducive to the recovery process based upon each individual's need and their ability to achieve therapeutic goals and objectives.

All discharged patients are given referrals for continuing chemical dependency treatment at a level of care best suited to their needs. Medical, dental, psychiatric, or other types of referrals are offered as individually needed.

DISCHARGE PLANNING

PROCEDURES:

1. Discharge planning procedures begin on the day of admission when the patient assessment process begins. The patient is questioned, at the initial screening, concerning his/her discharge plans (living environment). The assessment process, completed within the first 72 hours, also incorporates the patient's discharge plans.

2. Completion of the full bio-psychosocial assessment provides the initial information from which the treatment team begins to consider the appropriate level of care for the patient following discharge from inpatient treatment. Each individual's full set of circumstances is taken into consideration from the initial assessment and throughout treatment. Recommendations for appropriate discharge plans are based upon:
    a. Patient's living environment
    b. Active drug use in the home or neighborhood
    c. Patient's financial resources
    d. Patient's family support
    e. Access to continuing treatment facilities
    f. Patient's ability to reach therapeutic goals and objectives and demonstrate commitment to the recovery process

g. Patient's perception(s) of his/her continuing care needs

h. Patient's responsibilities toward children

i. Patient's legal status and court influences regarding continuing care

j. Patient's physical or mental health status

k. Patient's relapse history and/or potential

3. During the assessment phase, the primary counselor and nurse begin discussing, with the patient, his/her needs at discharge. The primary counselor will prepare a treatment plan during the assessment phase regarding continuing care to assist the patient in making a healthy decision for ongoing treatment after discharge from Addiction Recovery Inc. Treatment Center.

4. The primary counselor continues to assess the safety of the home environment through contact with the patient and his/her family members. This information is shared with the treatment team to assist in the discharge decision-making process.

5. Readiness for discharge is based upon integrating all of the above information through the treatment team review process.

PROCEDURES FOR DISCHARGE REFERRALS:

1. Discharge referrals for continuing chemical dependency treatment are made based upon the individual circumstances of the client, recommendation of the treatment team and willingness of the patient to follow those recommendations. Referral Agreements will be made with those outside agencies that agree to do so.

2. As soon as an appropriate level of care is determined (outpatient, IOP, 12-step fellowships, mental health counseling and family counseling) and agreed upon by the patient, the primary counselor begins the process of making a referral.

3. Consents to the referral agency are obtained both to release and obtain information prior to giving the agency any information about the patient.

4. The primary counselor telephones the agency to determine if there is a treatment slot and whether the patient may be eligible, based upon available information.

5. The primary counselor notifies the Medical Records Technician to insure required documents (agency specific) are forwarded as soon as possible. This is accompanied by a Referral Form. These may include but are not limited to:

   a. Consent to release information

   b. Screening Form

   c. All Assessment Forms

d. History and Physical

e. All laboratory reports including Urine Drug Screens

f. Treatment Plans

g. Progress Notes

h. Psychiatric Evaluation

i. Medication Records
j. TB Test Results
k. Discharge Instruction Sheet which is completed for all clients whether they chose to sign and take them with them no matter what the type of discharge.

6. All attempts are made to have the initial appointment for continuing care occur prior to the patient's actual discharge from Addiction Recovery Inc.. The purpose is to help insure appropriate linkage. However, when that is not possible due to distance and time schedules, the primary counselor attempts to schedule the patient's initial appointment as soon as possible after discharge.
7. All attempts are made to help the client/patient obtain personal transportation to initial continuing care appointments. However, in some instances (when distance is not a concern), Addiction Recovery Inc. will provide transportation for appointments in the Annapolis, Glen Burnie area. In the event a patient requires transportation, a request is made on the Leave of Absence form indicating that transportation is needed. If scheduling permits, the patient may be transported to and from an interview for a halfway house or an initial intake appointment for outpatient counseling by the Addiction Recovery Inc. staff.
8. In the event the patient requires a mental health referral at discharge, in addition to the chemical dependency referral, all attempts are made to facilitate an initial appointment by the nurse prior to or as soon after discharge as possible.
9. Individuals requiring medical or dental referrals will receive information from the Nurse prior to discharge. Appointments may be made prior to discharge based upon the nature of the medical referral.
10. All discharge referrals are documented in a progress note, the patient discharge instruction sheet, and indicated in the discharge summary, and reported at the Daily Clinical Team Meeting.
11. If family members request assistance with understanding discharge referrals, the primary counselor or nurse will meet with family members prior to discharge to explain the nature of the referral, with the consent of the patient.
12. All persons who are referred from OTF must be preapproved for ongoing outpatient counseling. The counselor is responsible for contacting the Health Department for approval for ongoing treatment.

TYPES OF DISCHARGE:

Addiction Recovery Inc. Discharge Criteria provides the following types of discharge:

a. **Successful Discharge**: The patient demonstrates that his/her physical, emotional, and behavioral problems have diminished in acuity or stabilized. He/she demonstrates awareness of addiction as a problem and a commitment to recovery as shown by achieving treatment plan objectives. He/she has demonstrated the capability to follow direction and has developed a specific continuing care plan. This corresponds to the Completed Treatment Plan-Referred.

b. **Therapeutic/Medical Discharge:** The patient demonstrates behavior, which interferes with his/her ability to benefit from inpatient chemical dependency treatment as a result of physical, emotional, or psychiatric condition, medical condition or complications. This behavior has resulted in the patient's inability to comply with or to benefit from nursing or medical direction or to perform activities both of daily living and therapeutic tasks necessary to receive benefit from the Addiction Recovery Inc. system. The patient is then referred to another caregiver or level of care whose protocol more closely meets his/her needs. This corresponds to the Did Not Complete Treatment Plan-Referred.

c. **Administrative/Staff Discharge:** The patient's repeated failure to comply within the program requirements the patient's inability to interact within the boundaries and requirements of this program are evident in his/her daily behavior. Therapeutic interventions have not brought about change. The patient is given referral information for alternative placement. The patient is also staff discharged whenever he/she violates those major rules warranting immediate discharge. This corresponds to the Non-Compliance/Administrative Discharge

d. **Against Medical Advice:** The patient has chosen to leave against the advice of the medical and clinical staff. The patient is given referral information in the event he/she chooses to enter treatment at another level of care or at a later date. Patient's Emergency contact is notified, and patient will not be provided with transportation.

e. **Other:** Patient is discharged if he/she has been incarcerated or has died.

PROCEDURES FOR REGULAR, THERAPEUTIC, OR STAFF DISCHARGE:

1. The patient has been assessed as meeting one of the above conditions by the therapeutic team. The primarycounselor and nurse inform the patient of his/her anticipated discharge date and finalize the schedule with the patient for any remaining concerns.

2. The Primary counselor provides the patient with a "Patient Plan for Continuing Recovery" at least 24-48 hours. The patient is instructed to complete the plan and bring it either to group and/or an individual session with the Counselor to review and discuss the feasibility of such plans. If the Counselor believes the patient lacks adequate, personal recovery plans, the patient is encouraged to revise his/her plans as appropriate and may be recommended for continued stay until such plans are adequate.

3. Twenty-four hours prior to discharge, the patient receives a discharge packet from the Primary counselor, which consists of the Addiction Recovery Inc. Discharge Instructions Sheet and Discharge Questionnaire. The patient is instructed to complete the Discharge Questionnaire and turn it in to the Administrative Office at check-out. The patient is instructed to complete all steps on the Check-Out Sheet prior to actual discharge including:

4. Staff Nurse completes the Nursing Discharge providing any final teaching, written prescriptions, recommendations or printed material helpful to the patient. The Nursing Discharge is signed and a copy given to the patient. The primary counselor makes a final entry into the Progress Note. The Medical Director is consulted to determine which prescriptions the patient may need at discharge. Medications and prescriptions are given to the patient on the actual day of discharge. Medication Kardexes are copied and given to the client upon request only made by the client.

b. The Primary counselor completes a final review with the patient, confirming continuing care plans and referrals for continuing treatment (appointment times, dates, etc.). The Counselor writes post-discharge instructions including appointment times, places and phone numbers of contact person(s) on the bottom of the Addiction Recovery Inc. Discharge Sheet. The Counselor completes a final progress note, indicating the status of the patient at discharge and referrals given. The Counselor informs the Administrative Office of the pending discharge.

c. Discharge Instruction Sheets are completed for all clients whether they chose to sign and take them with them no matter what the type of discharge.

4. On the morning of discharge, the patient is required to meet with the Direct

Care Personnel and complete the following actions:

a. Room inspection with Maintenance Staff.

b. Direct Care Personnel (Treatment Aide/TA) return any personal

belongings that have been stored during the patient's stay.

c. The TA provides the patient with his/her luggage.

d. The TA signs off on the check out sheet, indicating any items not returned

for which the patient will be financially responsible and indicates condition

of the patient's room and any damages for which he/she may be charge.

e. The TA instructs the patient to complete all tasks on the Check-Out Sheet

and to meet with the Administrative Office staff before leaving.

5. The patient is instructed to meet with the Administrative Office (last, after completing all other check-out) to complete financial paperwork and signs the check-out Sheet. The Front Office staff provides the patient with billing information and collects the Patient's Check-Out Sheet.

6. On the morning of discharge, the patient is presented with a marble and a certificate of completion during Community as a symbol of achievement and success. The patient/client is also provided a discharge letter by the primary counselor indicating the number of days of treatment and the recommendations for continuing care.

7. Immediately prior to leaving the facility, the patient is directed to return to the Nursing station.

The Nurse gives the patient any personal medication unfinished at the day of discharge, with instructions to complete. The Nurse returns any personal medications brought from home.

8. On the morning of discharge, the primary counselor presents the Discharge Criteria Form to the multidisciplinary team for review and final approval. The primary counselor, nurse and Director of Treatment sign the form indicating they have reviewed and agree with the type of discharge planned for the patient. The form is returned to the patient chart for permanent record.

PROCEDURES FOR DISCHARGE AGAINST MEDICAL ADVICE:

1. Any time a patient expresses to the staff a desire to leave treatment against medical advice, the patient's Counselor or On-Call Counselor is immediately notified. The Counselor will provide instruction to implement the AMA treatment plan in an attempt to keep the patient in treatment. The Counselor, Nurse, or manager may meet individually with the patient to attempt to help the patient change his/her decision. When all efforts on the part of the clinical staff have failed, the AMA discharge procedures are implemented.

a. Patients under care of the psychiatrist and/or prescription medication are asked to wait until orders for medications and mental health referrals can be obtained. Refusal to do so is documented.

c. Patients with suicidal ideation or homicidal ideation are not to be given any medication without a doctor's order. The risks related to abrupt discontinuation of medication are to be explained to patient and fully documented. Assessment and possible emergency/involuntary intervention may be needed.

2. The patient is asked to sign the AMA Release Form. However, an AMA form will be filled out by nursing whether the client signs the form or not, and the client's emergency contact will be notified.

3. The primary counselor, Nurse or TA notifies the Administrative Staff of the patient's decision to leave (immediately if during a weekday or the first thing in the morning if the discharge is after business hours).

4. The patient is provided with a discharge packet and asked to complete the necessary check-out procedures as listed for a regular discharge, prior to leaving the facility.

5. The patient is asked to meet with the Nurse to complete the nursing discharge paperwork. Patient may return in 24 hours to pick up Medications, prescriptions.

6. Patient's emergency contact is notified telephonically.

7. The patient is asked to meet with the Administrative Staff to complete financial obligations as outlined in a regular discharge.

8. Group and/or community good-byes are held at the discretion of the Treatment Team in consultation with the Director of Treatment and/or Director of Nursing.

9. The primary counselor reviews the chart for legal prohibitions to discharge and notifies, by telephone, any required legal agents of the patient's decision to leave treatment (courts, probation, etc.).

10. The primary counselor and Nurse review the chart to determine if any warning should be provided to any person(s) that may be in harm's way as a result of the patient's leaving against medical advice (Tarasoff), consults if possible with his/her clinical supervisor and carries out the notification to the person(s) in danger. The patient is not informed of this action. The Counselor or Nurse documents this action in a progress note.

11. All actions related to the AMA process, including individual sessions with the patient, the implementation of an AMA treatment plan, telephone calls, and efforts to keep the patient in treatment are documented in a progress note. This includes any refusals on the part of the patient to accept referrals to other agencies or to participate in the discharge process.

12. The primary counselor provides the patient with an alternative treatment referral and informs the patient it is his/her responsibility to contact that agency. He/she is asked to sign consent to release information to that agency to facilitate the referral. Refusal on the part of the patient is documented in a progress note.

13. In the event the patient chooses to leave AMA at a time when a primary counselor is not in the facility, the TA informs the nurse on duty. The on-call counselor or the Director of Treatment is then contacted. The patient signs the AMA release and other paper work is completed on the following business day, indicating that the patient did not complete the discharge process due to leaving AMA at a time when the case manger was not available. Patients leaving AMA are asked to complete discharge questionnaires.

PROCEDURES FOR PATIENTS WHO ARE AWAY WITHOUT LEAVE (AWOL):

1. Any patient AWOL shall be reported to the primary counselor, Nurse, or on-call primary counselor immediately by the on-duty staff person.

2. In the event a patient has gone AWOL and not completed any AMA forms, met with the Primary counselor, etc., the on-duty staff person shall document all noted behavior of the patient as soon as the AWOL is discovered:

a. Treatment Aides and/or Associate Counselors shall document all behaviors in the Behavior Book which to be shared with the clinical staff as soon as possible.

b. Primary counselor and nurses shall document in a patient progress note as soon as possible.

3. The Primary counselor (on duty or on call) is responsible for notifying legal authorities as outlined in the AMA discharge.

4. If the event occurs during regular working hours on a weekend, the on-duty weekend Nurse and/or Counselor is requested to discuss these actions with the on-call Counselor or Director of Treatment. If it is necessary to provide a warning and the Nurse has been unable to contact the On-Call Counselor in a very timely fashion, the Nurse is requested to discuss this with her clinical supervisor. Unseemly delays in seeking consultation must not be taken if a warning must be made.
Documentation supporting the violations of confidentiality and the warning must be specific as to the rationale and have supporting information in the clinical record. Staff is to follow guidelines in the Emergency Policy and Procedure related to Tarasoff. The psychiatrist is to be notified if the patient has been in withdrawal and/or taking medication for a mental health condition.

5. If the event occurs on a weekend, notification of legal authorities, WITH THE EXCEPTION OF DETENTION CENTERS IF THE PATIENT WAS TO BE RETURNED FOLLOWING DISCHARGE, will be made Monday morning. If the Detention Center must be notified, the on-call primary counselor will provide that service immediately after the AWOL is noticed (or the Nurse in the absence of a Counselor).

6. Documentation of the event(s) on a weekend is the responsibility of the Saturday primary counselor and weekend nurse on duty.

CLIENTS WITH A PRIMARY DIAGNOSIS OF OPIOID DEPENDANCE

1. Clients who have a primary diagnosis of opiate dependence are given referral information and telephone numbers on the discharge instructions to access various types of opioid maintenance therapy programs.

WOMEN WITH DEPENDENT CHILDREN

1. Women with dependent children are given linkages on the discharge instructions which include but are not limited to :

a. Case management
b. Transportation needs
c. Legal needs
d. Assistance with accessing insurance
e. Education needs
f. Housing needs
g. Physical health
h. Behavioral health
i. Prenatal Care and other health services
j. Therapeutic daycare for children
k. Head Start
l. Trauma Informed Care service

PROCEDURES FOR DISCHARGE CLOSURE OF THE ELCTRONIC RECORD:

1. All paper documents (medical records from hospital, urine results, medication Kardexes etc.) are scanned into the record by the Medical Records Technician or Nursing Assistant.

2. The Front office changes the client electronic record for ACTIVE to DISCHARGED.

Appendix K

Transfer and Referral Agreements

Memorandum of Understanding

This agreement dated 20 day of July, 2018, made between **Hope House Recovery Center** and **A+ Counseling Center** to develop a framework for referrals, better communication, coordination of care and the safe transition of care between the two agencies to streamline the clinical workflow and improve the patient experience, as well as optimizing client outcomes.

About Hope House Treatment Centers
Hope House Treatment Centers has provided intensive residential and outpatient substance abuse treatment adults and adolescents. Hope House is located in Crownsville and Laurel Maryland.

About A+ Counseling Center:
A+ Counseling Center provides intensive outpatient substance abuse treatment, comprehensive clinical assessments, DUI/DWI education, job readiness training, family counseling, therapeutic individual/group counseling, and recovery coaching in the Maryland.

SCOPE OF WORK

Hope House Treatment Center and A+ Counseling Center hereby agree to collaborate via a two-way referral agreement as for our prospective clients to receive maximum benefit between the two organizations. Hope House Treatment Center and A+ Counseling Center shall agree to adhere to all State of Maryland DMH BHA, and HIPPA guidelines and respective licensure regulations ensuring the confidentiality of patient and/or service recipient data and files, and information sharing. In addition, upon referral of client between the parties, each agree to maintain separate patient and/or service recipient authorizations, billing, records and receipts.

I have read and agreed to the MOU terms and conditions:

HOPE HOUSE TREATMENT CENTER

Peter D'Souza, Executive Director
429 Main Street
Laurel, Maryland 20707
Telephone: (301) 490-5551

A+ COUNSELING CENTER

Katrina Wilkins-Jackson, CEO
10903 Indian Head Hwy., Suite 504
For Washington, Maryland 20744
Telephone: (240) 766-4194

QCI Behavioral Health Consulting Group, LLC
dba
QCI BEHAVIORAL HEALTH, LLC

9475 Lottsford Road, Suite 250
Largo, Maryland 20774

Phone: 301-636-6504
Fax: 301-636-3609

Memorandum of Understanding

Hope House Treatment Center
429 Main Street
Laurel, Maryland 20707
Peter D'Souza, Executive Director
James Goines, Director of Treatment

and

QCI Behavioral Health
9475 Lottsford Road, Suite 250
Largo, Maryland 20774
Millie Richmond, CEO

THIS MEMORANDUM OF UNDERSTANDING
Is made this 17th day of July, 2018,
by and between
Hope House Treatment Centers and QCI Behavioral Health

The partners entering into this Memorandum of Understanding have agreed to form collaborative services as given in the following Articles and clauses:

Article I) Purpose and Scope:

To identify substance abusing patients and make referral for mental health assessment, psychiatric diagnostic evaluation and other needed and required treatment services as indicated by assessment and evaluation.

Article II) Background:

QCI Behavioral Health has identified a need for appropriate patients/consumers, to be involved with Hope House Treatment Center.

QCI Behavioral Health provides ongoing Mental Health treatment services, including Mobile Treatment Services (MTS) and Outpatient Mental Health Clinic services. Services include diagnostic intake and assessment, psychiatric evaluation, MTS team services in the patient's own environment, including continuing mental health and medication management, therapy, nursing, and case management, with the overall goal toward independent living, and healthy, socially successful lives within the community, those who are being provided Behavioral Health services have the overall goal to be guided toward Abstinence, and hopefully, stabilization are the goals of Hope House Treatment Center, focused on enhancing the expectation for long term sobriety.

Article III) Roles and Responsibilities of Party A:

Hope House Treatment Center is licensed and certified by the State of Maryland as a residential and outpatient alcohol and drug treatment facility for adult men and women over the age of 18. Hope House is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Hope House Treatment

Center accepts most major medical insurances, Maryland Medicaid, and private pay. Hope House will provide inpatient treatment services pending completion of initial screening and medically approval for inpatient level of care.

Article iV) Roles and Responsibilities of Party B:

QCI Behavioral Health Consulting Group is licensed and certified by the State of Maryland to provide Mobile Treatment Services (MTS) and Outpatient Mental Health Clinic (OMHC). QCI Behavioral Health is also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide these services. QCI will refer the patients/consumers for whom the focused in-patient substance abuse treatment services provided by Hope House Treatment Center. Although this is a collaborative effort between the parties named above, Hope House is not under contract with QCI Behavioral Health; and to that extent, QCI Behavioral Health remains its own entity and is not obligated to make any payment to Hope House Treatment Center, as Hope House is not employed by QCI Behavioral Health.

Article V) Issues of Mutual Understanding:

Hope House is a substance abuse treatment provider and QCI Behavioral Health is assisting individuals who have dual diagnoses for mental illness and chemical dependency who have entered into their programs. These boundaries are clear to staff and potential participants in the collaboration. Consents to obtain and release information must be obtained for each referred individual to facilitate ongoing and necessary communication as for treatment.

Article VI) Compensation Details:

Hope House Treatment Center and QCI Behavioral Health each will bill and be paid through the appropriate licensed and certified programs named above.

Article VII) Miscellaneous Details: N/A

Article VIII) Term of Agreement:

Hope House and QCI Behavioral Health agree to the terms as stated in this Memorandum of Understanding which will continue in full force and effect from this date forward.

Article IX) Effective Date and Signatures:

Party A: Hope House Treatment Center:

MA, CAC-AD

Date: 7-17-18

James A. Goines, Director of Treatment

Party B: QCI Behavioral Health:

Date: 07/17/2018

Millie Richmond, MA, Chief Executive Officer

Hope House

Memorandum of Understanding

Between

Hope House Treatment Centers
429 Main Street, Laurel, Maryland 20707
Peter D'Souza, Executive Director / James Goines, Director of Treatment

and

Precision Recovery
14201 Park Center Dr #410
Laurel, MD 20707
Dr. Jason Litt, MD

This Memorandum of Understanding
Is made this 18th day of July 2018 by and between
Hope House Treatment Center and Precision Recovery

We, Hope House Treatment Center and Precision Recovery, have come together to collaborative services as given in the following articles and clauses:

Article I) Purpose and Scope:

To identify substance abusing patients and make referral for assessment, and other treatment services, as necessary. To identify consumers/customers in need of Medication Assisted Treatment and pain management issues.

Article II) Background:

Precision Recovery has identified a need for consumers/customers to be involved with Hope House Treatment Centers.

1

Article III) Roles and Responsibilities of Party A:

Hope House Treatment Center is licensed and certified by the State of Maryland as a residential and outpatient alcohol and drug treatment facility for adult men and women over the age of 18. Hope House is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Hope House Treatment Center accepts most major medical insurances, Maryland Medicaid, and private pay. Hope House will provide inpatient treatment services pending completion of initial screening and medically approved for inpatient level of care.

Article IV) Roles and Responsibilities of Party B:

Precision Recovery will refer the consumers that could benefit from the substance abuse treatment services provided by Hope House Treatment Center. Although this is a collaborative effort between the parties named above, Hope House is not under contract with Precision Recovery. To that extent, Precision Recovery remains its own entity and is not obligated to make any payment to Hope House Treatment Center, as Hope House is not employed by Precision Recovery.

Article V) Issues of Mutual Understanding:

Hope House is a substance abuse treatment provider and Precision Recovery are assisting individuals who have been diagnosed with Chemical Dependency Disorder. These boundaries are clear to staff and potential participants in the collaboration. Consents to obtain and release information must be obtained for each referral in order to communicate regarding their individual circumstances.

Article VI) Compensation Details: See information above regarding insurance reimbursement.

Article VII) Miscellaneous Details: N/A

Article VIII) Term of Agreement

Article IX) Effective Date and Signatures

(Party A) MA, CAC-AD Date 7/18/18

James Goines, MA, CAC-AD

Director of Treatment

(Party B) Date 7/18/18

Dr. Jason Litt, MD

2

Hope House

Memorandum of Understanding

Between

Hope House Treatment Center s
429 Main Street, Laurel, Maryland 20707
Peter D'Souza, Executive Director / James Goines, Director of Treatment

and

University of Maryland
Laurel Regional Hospital
7300 Van Dusen Road
Laurel, Maryland 20707

We, Hope House Treatment Center and Laurel Regional Hospital, have come together to collaborate and to make an agreement for Memorandum of Understanding. The partners entering the MOU have agreed to form collaboration and so agree to the following articles and clauses:

Article I) Purpose and Scope: To identify substance abusing patients and make referral for assessment, and other treatment services, as necessary.

Article Ii) Background: Laurel Regional Hospital has identified a need for

Article III) Roles and Responsibilities of Party A: Hope House Treatment Center is licensed and certified by the State of Maryland as a residential and outpatient alcohol and drug treatment facility for adult men and women over the age of 18. Hope House is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Hope House Treatment Center accepts most major medical insurances, Maryland Medicaid, and private pay. Hope House will provide inpatient treatment services pending completion of initial screening and medically approved for inpatient level of care.

1

Article IV) Roles and Responsibilities of Party B: Laurel Regional Hospital will refer the consumers that could benefit from the substance abuse treatment services provided by Hope House Treatment Center. Although this is a collaborative effort between the parties named above, Hope House is not under contract with Laurel Regional Hospital. To that extent, Laurel Regional Hospital remains its own entity and is not obligated to make any payment to Hope House Treatment Center, as Hope House is not employed by University of Maryland, Laurel Regional Hospital.

Article V) Issues of Mutual Understanding: Hope House is a substance abuse treatment provider and Laurel Regional Hospital Services is assisting individuals who have been diagnosed with Chemical Dependency that present in the Emergency Room. These boundaries are clear to staff and potential participants in the collaboration. Consents to obtain and release information must be obtained for each referral in order to communicate regarding their individual circumstances.

Article VI) Compensation Details: See information above regarding insurance reimbursement.

Article VII) Miscellaneous Details: N/A

Article VIII) Term of Agreement

Article IX) Effective Date and Signatures

(Party A) _____ Date 6/27/18

James Goines, MA, CAC-AD

Director of Treatment

(Party B) _____ Date _____

Dr. Trudy Hall, MD, Interim President, VPMA

BEHAVIORAL HEALTH ADMINISTRATION (BHA)

AGREEMENT TO COOPERATE
(REQUIREMENT UNDER COMAR 10.63.01.05)

Before applying for licensure under Subtitle 10.63 - *Community-Based Behavioral Health Programs and Services*, behavioral health programs in Maryland must enter into an Agreement to Cooperate with the CSA, LAA, or LBHA in each of the relevant counties or Baltimore City in which the program operates. Agreements are required when submitting an initial application, renewal application, or when a change to a program's license is requested (e.g., change in service array or locations). Please note that separate agreements are not required per site, unless there is a change to the program's existing license, such as adding a new location.

Program Information

Program Name*: **Addiction Recovery, Inc. dba Hope House Treatment Centers**
Primary Program Address: **429 Main Street, Laurel, MD 20707**
Primary Contact Name: **Peter D'Souza**
Primary Contact Phone: **410-923-6700 x 103**
Primary Contact Email: **pdsouza@hopehousemd.org**

Local Behavioral Health Authority Information

Local Jurisdiction: **Behavioral Health Services Prince George's County**

Primary Contact Name: **L. Christina Waddler**
Primary Contact Phone: **301-856-9500**
Primary Contact Email: **lcwaddler@co.pg.md.us**

Type of Program

Non-Accredited Program Types	
☒ DUI Education	☒ Substance-Related Disorder Assessment and Referral
☒ Early Intervention Level 0.5	

Accredited Program Types	
☐ Group Homes for Adults with Mental Illness	☐ Psychiatric Rehabilitation Program for Minors (PRP-M)
☐ Integrated Behavioral Health	☐ Residential Crisis Services (RCS)
☒ Intensive Outpatient Treatment Level 2.1	☐ Residential: Low Intensity Level 3.1
☐ Mobile Treatment Services (MTS)	☒ Residential: Medium Intensity Level 3.3
☐ Outpatient Mental Health Center (OMHC)	☐ Residential: High Intensity Level 3.5
☒ Outpatient Treatment Level 1	☐ Residential: Intensive Level 3.7
☒ Partial Hospitalization Treatment Level 2.5	☐ Residential Rehabilitation Program (RRP)
☐ Psychiatric Day Treatment Program (PDTP)	☐ Respite Care Services (RPCS)
☐ Psychiatric Rehabilitation Program for Adults (PRP-A)	☐ Supported Employment Program (SEP)

Accredited Services	
☐ **Opioid Treatment**	☐ **Withdrawal Management**

DHMH #4781 (September 21, 2016)

* Program name should match the corporate/business name included on the application for licensure.
As required under COMAR 10.63.01.05, Hope House Treatment Centers enters into the following agreement with Prince George's County Local Behavioral Health Authority to provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including complaint investigation and the transition of services if the program closes.

Additional activities identified by the program and local authority will include (optional):
(Please note that the agreement may not include a provision to prohibit a program from offering services at any location.)

Click here to enter text.

Behavioral Health Program

P'Souza
Signature

6/5/2018
Date

Peter D'Souza
Print Name

Local Behavioral Health Authority

L. Christina Waddler
Signature

June 6, 2018
Date

L. Christina Waddler
Print Name

Regulatory Authority

COMAR 10.63.01.02B(5)

B. Terms Defined.
(5) "Agreement to cooperate" means a written agreement between the program and a core service agency, local addictions authority, or local behavioral health authority that provides for coordination and cooperation in carrying out behavioral health activities in a given jurisdiction.

COMAR 10.63.01.05E

E. Agreement to Cooperate.
(1) Before applying for licensure, a program shall enter into an agreement to cooperate with the CSA, LAA, or LBHA that operates in the relevant county or Baltimore City.
(2) The agreement to cooperate shall provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including but not limited to facilitating:
(a) A complaint investigation; and
(b) The transition of services if the program closes.
(3) The agreement to cooperate may not include a provision that authorizes the CSA, LAA, or LBHA to prohibit a program from offering services at any location.

BEHAVIORAL HEALTH ADMINISTRATION (BHA)

AGREEMENT TO COOPERATE

(REQUIREMENT UNDER COMAR 10.63.01.05)

Before applying for licensure under Subtitle 10.63 - *Community-Based Behavioral Health Programs and Services*, behavioral health programs in Maryland must enter into an Agreement to Cooperate with the CSA, LAA, or LBHA in each of the relevant counties or Baltimore City in which the program operates. Agreements are required when submitting an initial application, renewal application, or when a change to a program's license is requested (e.g., change in service array or locations). Please note that separate agreements are not required per site, unless there is a change to the program's existing license, such as adding a new location.

Program Information

Program Name*: **Addiction Recovery, Inc. dba Hope House Treatment Centers**
Primary Program Address: **419 Main Street, Laurel, MD 20707**
Primary Contact Name: **Peter D'Souza**
Primary Contact Phone: **410-923-6700 x 103**
Primary Contact Email: **pdsouza@hopehousemd.org**

Local Behavioral Health Authority Information

Local Jurisdiction: **Behavioral Health Services Prince George's County**

Primary Contact Name: **L. Christina Waddler**
Primary Contact Phone: **301-856-9500**
Primary Contact Email: **lcwaddler@co.pg.md.us**

Type of Program

Non-Accredited Program Types	
☐ DUI Education	☒ Substance-Related Disorder Assessment and Referral
☐ Early Intervention Level 0.5	

Accredited Program Types	
☐ Group Homes for Adults with Mental Illness	☐ Psychiatric Rehabilitation Program for Minors (PRP-M)
☐ Integrated Behavioral Health	☐ Residential Crisis Services (RCS)
☒ Intensive Outpatient Treatment Level 2.1	☐ Residential: Low Intensity Level 3.1
☐ Mobile Treatment Services (MTS)	☒ Residential: Medium Intensity Level 3.3
☐ Outpatient Mental Health Center (OMHC)	☐ Residential: High Intensity Level 3.5
☒ Outpatient Treatment Level 1	☒ Residential: Intensive Level 3.7
☒ Partial Hospitalization Treatment Level 2.5	☐ Residential Rehabilitation Program (RRP)
☐ Psychiatric Day Treatment Program (PDTP)	☐ Respite Care Services (RPCS)
☐ Psychiatric Rehabilitation Program for Adults (PRP-A)	☐ Supported Employment Program (SEP)

Accredited Services	
☐ **Opioid Treatment**	☒ **Withdrawal Management**

DHMH #4781 (September 21, 2016)

* Program name should match the corporate/business name included on the application for licensure.
As required under COMAR 10.63.01.05, Hope House Treatment Centers enters into the following agreement with Prince George's County Local Behavioral Health Authority to provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including complaint investigation and the transition of services if the program closes.

Additional activities identified by the program and local authority will include (optional):
(Please note that the agreement may not include a provision to prohibit a program from offering services at any location.)

Click here to enter text.

Behavioral Health Program

P'Souza
Signature

6/5/2018
Date

Peter D'Souza
Print Name

Local Behavioral Health Authority

L. Christina Waddler
Signature

June 6, 2018
Date

L. Christina Waddler
Print Name

Regulatory Authority

COMAR 10.63.01.02B(5)

B. Terms Defined.
(5) "Agreement to cooperate" means a written agreement between the program and a core service agency, local addictions authority, or local behavioral health authority that provides for coordination and cooperation in carrying out behavioral health activities in a given jurisdiction.

COMAR 10.63.01.05E

E. Agreement to Cooperate.
(1) Before applying for licensure, a program shall enter into an agreement to cooperate with the CSA, LAA, or LBHA that operates in the relevant county or Baltimore City.
(2) The agreement to cooperate shall provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including but not limited to facilitating:
(a) A complaint investigation; and
(b) The transition of services if the program closes.
(3) The agreement to cooperate may not include a provision that authorizes the CSA, LAA, or LBHA to prohibit a program from offering services at any location.

Hope House
Treatment Center

Memorandum of Understanding

Between

Hope House Treatment Center
429 Main Street, Laurel, Maryland 20707
Peter D'Souza, Executive Director

And

Patrons for Peace Project, Inc. Community Non Profit
329 Prince George Street
Laurel, Maryland, 20707

We, Hope House Treatment Center and Patrons for Peace Project, Inc., have come together to collaborate and to make an agreement for Memorandum of Understanding. The partners entering the MOU have agreed to form a collaboration and so agree to the following articles and clauses:

Article I) Purpose and Scope: To identify substance abusing patients and make referral for assessment, detoxification and other treatment services, as necessary.

Article II) Background: Patrons for Peace has identified a need for some of the consumers/customers, to be involved with Hope House Treatment Center. Ideally, those who are being provided chemical dependency services have the overall goal to be guided toward independent living, healthy, and socially successful lives. Abstinence, and hopefully, long-term recovery is the goal of Hope House Treatment Center, which would improve the chances for successful living and long-term sobriety.

Article III) Roles and Responsibilities of Party A: Hope House Treatment Center is licensed and certified by the State of Maryland as a residential and outpatient alcohol and drug treatment facility for adult men and women over the age of 18. Hope House is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Hope House Treatment Center accepts most major medical insurances, Maryland Medicaid, and private pay. Hope House will provide inpatient treatment services pending completion of initial screening and medically approved for inpatient level of care.

Article IV) Roles and Responsibilities of Party B: Patrons for Peace Project will refer the consumers that could benefit from the substance abuse treatment services provided by Hope House Treatment Center. Although this is a collaborative effort between the parties named above, Hope House is not under contract with Patrons for Peace Project, Inc.. To that extent, Patrons for Peace Project remains it's own entity and is not obligated to make any payment to Hope House Treatment Center, as Hope House is not employed by Patrons for Peace Project, Inc..

Article V) Issues of Mutual Understanding: Hope House is a substance abuse treatment provider and Patrons for Peace a Community Non-Profit assisting individuals who are drug and alcohol dependent, indigent, homeless, unemployed and lack resources to sustain with necessities of life. Those boundaries are clear to staff and potential participants in the collaboration. Consents to obtain and release information must be obtained for each referral in order to communicate regarding their individual circumstances.

Article VI) Compensation Details: See information above regarding insurance reimbursement.

Article VII) Miscellaneous Details: N/A

Article VIII) Term of Agreement

Article IX) Effecti[illegible]tures

(Party A) _____ Date 1/4/18

Peter D'Souza, Executive Director

(Party B) _____ Date 1/4/18

Ruth K. Walls, MS, MSN, RN

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MOU have agreed

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ded toward
long-term recovery
ıccessful living and

Hope House
Treatment Center

Memorandum of Understanding

Between

Hope House Treatment Center
429 Main Street, Laurel, Maryland 20707
Peter D'Souza, Executive Director

And

Capital Diagnostics ɯc
14201 Park Center Dr. Suite 407
Laurel, Maryland, 20707
(301) 498-0340

We, Hope House Treatment Center and Capital Diagnostics, have come together to collaborate and to make an agreement for Memorandum of Understanding. The partners entering the MOU have agreed to form a collaboration and so agree to the following articles and clauses:

Article i) Purpose and Scope: To identify substance abusing patients and make referral for assessment, Suboxone Program, Vivitrol Injection, detoxification and other treatment services, as necessary.

Article II) Background: Capital Diagnostics ɯc has identified a need for some of the consumers/customers, to be involved with Hope House Treatment Center. Ideally, those who are being provided treatment for chemical dependence services have the overall goal to be guided toward independent living, healthy, and socially successful lives. Abstinence, and hopefully, long-term recovery is the goal of Hope House Treatment Center, which would improve the chances for successful living and long-term sobriety.

Article III) Roles and Responsibilities of Party A: Hope House Treatment Center is licensed and certified by the State of Maryland as a residential and outpatient alcohol and drug treatment facility for adult men and women over the age of 18. Hope House is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Hope House Treatment Center accepts most major medical insurances, Maryland Medicaid, and private pay. Hope House will provide inpatient treatment services pending completion of initial screening and medically approved for inpatient level of care.

Article IV) Roles and Responsibilities of Party B: Capital Diagnostics LLC will refer the consumers that could benefit from the substance abuse treatment services provided by Hope House Treatment Center. Although this is a collaborative effort between the parties named above, Hope House is not under contract with Capital Diagnostics. To that extent, Capital Diagnostics LLC remains its own entity and is not obligated to make any payment to Hope House Treatment Center, as Hope House is not employed by Capital Diagnostics.

Article V) Issues of Mutual Understanding: Hope House is a substance abuse treatment provider and Capital Diagnostics LLC, assisting individuals who are drug and alcohol dependent, indigent, homeless, unemployed and lack resources to sustain with necessities of life. Those boundaries are clear to staff and potential participants in the collaboration. Consents to obtain and release information must be obtained for each referral in order to communicate regarding their individual circumstances.

Article VI) Compensation Details: See information above regarding insurance reimbursement.

Article VII) Miscellaneous Details: N/A

Article VIII) Term of Agreement

Article IX) Effective Date and Signatures

(Party A) _____ Date 1/4/18

Peter D'Souza, Executive Director

(Party B) Donna Boatman Date 1-4-2017

Donna Boatman, Director of Pain Management

Appendix L

Sources of Referral

Sources of Referral

"More than 80% of the patients that we serve are on Medicaid and are considered indigent or gray area population."

Average percentage over the last 4 years: 82.31%

2018 Data

Income Level	Patients Served	%
$0-$999	488	81%
$1,000-$4,999	16	2.65%
$10,000-$19,999	29	4.81%
$100,000-$119,999	4	0.66%
$120,000-$129,999	3	0.50%
$150,000-$159,999	1	0.17%
$160,000-$169,999	1	0.17%
$20,000-$29,999	15	2.49%
$30,000-$39,999	11	1.82%
$40,000-$49,999	3	0.50%
$5,000-$9,999	8	1.33%
$50,000-$59,999	8	1.33%
$70,000-$79,999	2	0.33%
$80,000-$89,999	1	0.17%
$90,000-$99,999	2	0.33%
Declined to Answer	11	1.82%
Grand Total	**603**	

2016 Data

Income Level	Patients Served	%
$0-$999	706	70.46%
$1,000-$4,999	6	0.60%
$10,000-$19,999	39	3.89%
$100,000-$119,999	6	0.60%
$130,000-$139,999	2	0.20%
$150,000-$159,999	3	0.30%
$160,000-$169,999	4	0.40%
$20,000-$29,999	64	6.39%
$30,000-$39,999	41	4.09%
$40,000-$49,999	25	2.50%
$5,000-$9,999	12	1.20%
$50,000-$59,999	22	2.20%
$60,000-$69,999	18	1.80%
$70,000-$79,999	9	0.90%
$80,000-$89,999	5	0.50%
$90,000-$99,999	3	0.30%
Declined to Answer	37	3.69%
Grand Total	**1002**	

2017 Data

Income Level	Patients Served	%
$0-$999	796	78.66%
$1,000-$4,999	17	1.68%
$10,000-$19,999	39	3.85%
$100,000-$119,999	6	0.59%
$130,000-$139,999	1	0.10%
$140,000-$149,999		0.00%
$150,000-$159,999	1	0.10%
$160,000-$169,999	5	0.49%
$20,000-$29,999	42	4.15%
$30,000-$39,999	21	2.08%
$40,000-$49,999	20	1.98%
$5,000-$9,999	3	0.30%
$50,000-$59,999	8	0.79%
$60,000-$69,999	7	0.69%
$70,000-$79,999	4	0.40%
Declined to Answer	42	4.15%
Grand Total	**1012**	

2015 Data

Income Level	Patients Served	%
$0-$999	712	70.50%
$1,000-$4,999	13	1.29%
$10,000-$19,999	62	6.14%
$100,000-$119,999	2	0.20%
$120,000-$129,999	2	0.20%
$130,000-$139,999	1	0.10%
$140,000-$149,999	2	0.20%
$160,000-$169,999	1	0.10%
$20,000-$29,999	38	3.76%
$30,000-$39,999	34	3.37%
$40,000-$49,999	29	2.87%
$5,000-$9,999	9	0.89%
$50,000-$59,999	26	2.57%
$60,000-$69,999	8	0.79%
$70,000-$79,999	9	0.89%
$80,000-$89,999	3	0.30%
$90,000-$99,999	4	0.40%
Declined to Answer	55	5.45%
Grand Total	**1010**	

Appendix M

Staff Training

ACCREDITATION NOW!
Assisting with Obtaining and Maintaining CARF Accreditation

Welcome, Damika Weems

Settings Help Log Out

Training Category

The CARF Behavioral Health, Children and Youth Services, and Opioid Treatment Program accreditation standards require that organization have initial (upon orientation) and recurring training for ALL employees in at least eight distinct areas. These areas are: Person-Centered Planning, Workplace Violence Prevention, Confidentiality, Cultural Competency, Personal Conduct, Customer Service, Rights and Responsibilities and Unique Needs of Persons Served. All other program areas accredited by CARF (Medical Rehabilitation, Employment and Community Services, and Adult Day Services) also benefit from trainings in these areas, and to some degree all CARF accredited programs are required to have a knowledgeable staff regarding these noted areas of training.

For programs that are required to provide initial and recurring training in these areas, it is usually the practice to provide employees an orientation that would include reviewing the conduct/ethical policy, reviewing the confidentiality policies, a review of the cultural competency plan, and so on. With this type of orientation documented in a personnel file, it would qualify as meeting the standard for "initial" training. With the Accreditation Now trainings listed below, your organization can have some flexibility in when and how you want to provide the required initial and recurring training. You may want to have all employees review your policies, procedures, and plans in the required areas annually to meet the initial and recurring training and use the Accreditation Now training as "add-on" training, or you may want to use Accreditation Now training as your basic training in the required areas.

All trainings, when completed in a manner that indicates mastery, include a certificate of completion that may be provided to the employees and/or placed in an employee's personnel file for training documentation. In addition, your organization's administrator of the Accreditation Now website has access to a complete database of participants in the training, which can be used to document adherence to the training standard during a CARF survey.

You may only attempt any given test once per day.

If there isn't a Start Training link for you to click to take a training, you have either;

1) Already passed the test and cannot take it again; -or-

2) Attempted and did not pass the test today; -or-

3) The training is not scheduled by your Administrator.

Training Number ▾ Ascending ▾ Refresh

DATE TAKEN	PASSED	TRAINING	DUE DATE	START
N/A	N/A	Health and Safety-Medical Emergencies	07/31/2018	Start Training
N/A	N/A	ARI - Contributing Factors or Causes of Threatening Behaviors and Non-violent practices	07/31/2018	Start Training
N/A	N/A	Health and Safety- Reducing Physical Risks	07/31/2018	Start Training
N/A	N/A	Health and Safety -Building Evacuation	07/31/2018	Start Training
N/A	N/A	Health and Safety- Natural Disasters	07/31/2018	Start Training
N/A	N/A	Health and Safety -Bomb Disasters	07/31/2018	Start Training
N/A	N/A	Health and Safety-Blood Borne Pathogens - NURSING AND HOUSEKEEPING ONLY	07/31/2018	Start Training
N/A	N/A	Active Shooter	11/30/2018	Start Training
N/A	N/A	ARI-Identification of Unsafe Environmental/Hazardous materials	07/31/2018	Start Training

N/A	N/A	ARI-Therapeutic Boundaries	07/31/2018	Start Training
N/A	N/A	ARI- Wellness of Patients served	07/31/2018	Start Training
N/A	N/A	ARI-Transportation Safety	07/31/2018	Start Training
N/A	N/A	ARI-Reporting of Suspected Abuse/Neglect	07/31/2018	Start Training
N/A	N/A	ARI-Fiscal Policies and Procedures	07/31/2018	Start Training
N/A	N/A	ARI - Rights of Personnel	07/31/2018	Start Training
N/A	N/A	Health and Safety -Fire Disasters	07/31/2018	Start Training
N/A	N/A	Health and Safety - Loss of Utility	07/31/2018	Start Training
N/A	N/A	ARI- People-First Language	07/31/2018	Start Training
N/A	N/A	ARI - Medication Mgmt/Error Prevetion and Reporting(LICENSED NURSES ONLY)	07/31/2018	Start Training
N/A	N/A	Health and Safety - Active Shooter	07/31/2018	Start Training
N/A	N/A	Wellness of Patients Served	11/30/2018	Start Training
N/A	N/A	Fiscal Policies and Procedures	11/30/2018	Start Training
N/A	N/A	Rights of Personnel	11/30/2018	Start Training
N/A	N/A	Reducing Physical Risks	11/30/2018	Start Training
N/A	N/A	CARF - Series 1: Confidentiality	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Cultural Competency	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Customer Service	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Person Centered Planning	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Personal Conduct	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Rights and Responsibilities	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Unique Needs Of Persons Served	07/31/2018	Start Training
N/A	N/A	CARF - Series 1: Workplace Violence Prevention	07/31/2018	Start Training
N/A	N/A	CARF - Infection Control In The Human Service Environment	07/31/2018	Start Training
N/A	N/A	CARF - Critical Incident Reporting	07/31/2018	Start Training
N/A	N/A	CARF - Corporate Compliancy	07/31/2018	Start Training

Appendix N

Personnel Manual

ADDICTION RECOVERY INC. POLICY & PROCEDURE

HUMAN RESOURCE MANAGEMENT

PURPOSE: Addiction Recovery, Inc. Human Resource Management Policies and Procedures are designed to insure the qualifications and competencies of all staff members. To provide insure adequate staff coverage consistent with plans for staffing patterns, we encourage staff development and learning, and provide an atmosphere that promotes the objectives of Addiction Recovery, Inc. through the provision of standard practices with employees consistent with all Federal and State employment requirements.

The Human Resource Management Policies are not to be viewed independent of other overlapping policies, which include Staff Development Policies; Clinical Privileging and Credentialing Policies, Improving Organizational Performance and Leadership sections.

POLICIES AND PROCEDURES:

The organization of the staff into separate departments and specialties permits each Department Head to determine both the type and number of staff members, including their qualifications and competencies, needed to fulfill the organization's mission of providing comprehensive chemical dependency treatment.

The Addiction Recovery Inc. Organizational Chart outlines the following departments: Administrative, Counseling, Nursing, and Direct Care, as well as sub-departments such as Food Service, and Housekeeping. Each department head has the responsibility of defining the staff coverage and competencies required to fulfill the Addiction Recovery, Inc.'s Mission.

All department heads annually review position descriptions and anticipated job responsibilities to determine the educational level, applicable licensure and certification within the laws, as well as the need to upgrade positions due to a changing client population.

Minimum staffing patterns for each department include the following positions and ratios:

ADMINISTRATIVE:

Executive Director

Director of Operations

Three Front Office Staff

One Director of Finance and one assistant to the Director of Finance

One HR/Electronic Billing Specialist and one assistant to HR/Electronic billing and 1 assistants to electronic billing

Facility Maintenance Coordinator
Two Housekeepers

COUNSELING:

Director of Treatment – Master's Level, CPC-AD or Licensed

Minimum of one counselor/CM or ADT to every 8 patients/clients for Detox, ICF,

Rehab/Residential and one counselor to every 15 patients for Ambulatory Detox a PHP and

IOP levels of care Counselors must be certified through the State Board of Professional

DOT and Evening/Weekend Supervisor -on-call, 24 hours/day, 7 days/week

NURSING:

Director of Nursing – Minimum RN license.

One RN for 8 hours on duty daily. The other 16 hours performed by LPN or RN.

Two Charge Nurses who works 40 hours/week. Hours are staggered to accommodate

training and outages.

One LPN or RN on duty daily from 11:00 PM – 7:00 AM

Charge Nurse or DON on-call, 24 hours/day, 7 days/week, as required.

2 UR nurses

2 Nursing Assistants

DIRECT CARE:

A minimum of two Direct Care Personnel on duty with a nurse from the hours of 3:00 PM through 11:00 PM and on all holidays.

From the hours of 11:00 PM - 7:00 AM, one Direct Care staff is required.

FOOD SERVICE:

Food Service Manager 40 hours per week.

Minimum one cook available for 2 meals per day, 7 days per week

STAFF COMPETENCIES

Upon hire, each staff member undergoes a general organizational orientation with specific training as outlined on the orientation form. In addition, departmental specific orientation/initial competency tasks are outlined based upon job function. Completed training test (general and department specific) are maintained in each employee's personnel file.

Verification of clinical competence and the ability to perform clinical responsibilities is required upon hire of all clinical staff through references from prior clinical supervisors and individuals who can attest to the clinical competence of the individual through direct supervision and observation of their work. State Certification or eligibility for such with pursuit in progress is required as further evidence of competence and appropriate training and experience for counselors. Licensure is required for Nurses.

Nursing and counseling licenses are initially verified on line by the HR employee and then annually by the Department director.

The Human Resource Director will verify all prospective staff member's credentials on line for licensed staff, and those with higher degrees asked to bring with them, a sealed envelope containing transcripts directly from the institution where the individuals obtained the degree and their current license(s). All employee records are kept locked in the HR office. This is done prior to the individual's employment by Addiction Recovery Inc.

The competency of all staff members is evaluated annually through a required performance evaluation. Each position description outlines performance expectations as job functions against which each employee is evaluated.

Staff members who are licensed or certified are required to maintain current licensure and to submit current licensure and certification in accordance with credentialing policies and

procedures. Training and education required to maintain certification and licensure in addition as set forth by the Board of Professional Counselors and State Nursing Board underneath DHMH regulations.

The availability of in-services and reading materials is to provide ongoing educational experiences and training materials to maintain and improve staff competence.

Clinical supervisors meet regularly with staff, as to insure the competence of those individuals who are not independent practitioners. Supervision may occur through the supervisor's participation in daily treatment team meeting, organizational staff meetings, side by side sessions with persons served, or 1:1 meetings between the supervisor and the personnel. Areas to be evaluated include but are not limited to: (1) The appropriateness of the treatment/service intervention selected relative to the specific needs of the person served. (2) Accuracy of the employee's assessment and referral skill and (3) Treatment service/ effectiveness as reflected by the person served meeting his/her individual goal. The supervisor also evaluates staff and identifies on-going documentation issues through on-going compliance reviews.

MANDATED TESTING

All employees will have a criminal background check done prior to employment. Also annually employees are required to complete an annual criminal record statement form indicating there have had no felony charges within the last 360 days. Pre-employment urine drug testing is also required.

COMPETENCIES OF CLINICAL DEPARTMENT HEADS

The Director of Treatment and Director of Nursing are the individuals responsible for developing treatment-planning services, diagnostic summaries and treatment approaches. Through job requirements as outlined in job descriptions and minimum requirements. Each of these individuals must have knowledge in the natural history of dependence, biopsychosocial influences and effects, and full

knowledge of the range of treatment individuals needs. They are required to be knowledgeable of community resources to assist clients in accessing care beyond the scope of Addiction Recovery, Inc. and are expected to continue to network with those resources as appropriate to enhance working relationships. These two individuals also have administrative responsibilities upon which they are evaluated but must, at least, possess the clinical competence to obtain and remain in a supervisory capacity. Each must be licensed by the respective State Licensing Boards to further document scope of practice, training, and experience required for supervisory positions.

COMPETENCIES OF INDEPENDENT PRACTITIONERS

Addiction Recovery Inc. policies on clinical privileging fully outline methods and processes designed to assess competency of licensed, independent practitioners who serve in a consultant and/or supervisory position, such as the Medical Director. This process includes:

Review of all relevant licensure with primary verification from the American Medical Association, State Board of Nursing, State Board of Social Work Examiners (as appropriate), and (when the mechanism is available) the State Board of Professional Counselors and Therapists.

All independent practitioners are required to submit current licensure and certifications as required and to document receipt of relevant training or experience for initial clinical privileging and re-privileging.

DENIAL OF CREDENTIALING OR CLINICAL PRIVILEGING

The Addiction Recovery, Inc. Credentialing and Clinical Privileging Policies fully outline the appeal process for independent practitioners who may receive adverse decisions regarding initial granting or renewing of any clinical responsibilities.

CONTRACTED INDIVIDUALS

Addiction Recovery, Inc. may chose to contract some positions with individuals. Those individuals are contracted for a specific service and receive written job descriptions and expectations of performance. The Addiction Recovery, Inc. leadership reviews all contracted personnel annually to assure they conform to current CARF standards applicable to the services they provide.

STAFF REQUESTS TO BE EXCUSED FROM AN ASPECT OF CARE

Such requests are fully outlined in the Employee Personnel Handbook, which follows.

The Addiction Recovery, Inc. Employee Personnel Handbook fully outlines all human resource activities and functions and provides a reference for all employees regarding both their responsibility to the organization and Addiction Recovery, Inc. responsibility to the employee.

Unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the workplace. If an employee is the subject of a drug-related investigation by Addiction Recovery, Inc. or by a law enforcement agency, the employee may be suspended pending completion of the investigation. As a condition of employment under the grant, the employee will:

1.) Abide by the terms of the statement; and
2.) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction.

Addiction Recovery, Inc. will notify the Addictions Coordinator of Anne Arundel County "within 30 calendar days" of receiving notice under paragraph (d)(2) with respect to any employee who is so convicted:

1.) Taking appropriate action against such an employee, up to and including termination consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
2.) Requiring such employee to participate satisfactorily in a drug assistance or rehabilitation program approved for such purpose by a Federal, State or Local Health Agency, law enforcement or other appreciate agency.

DRUG TESTING POLICY

1. POLICY

1.1 Addiction Recovery, Inc. has a vital interest in maintaining a safe, healthy, and efficient working environment. Being under the influence of a drug or alcohol on the job poses serious safety and health risks to the user and to all those who work with the user. The use, sale,

purchase, transfer, or possession of an illegal drug in the workplace, and the use, possession, or being under the influence of alcohol also poses unacceptable risks for safe, healthy, and efficient operations.

1.2 Addiction Recovery, Inc. has the right and obligation to maintain a safe, healthy, and efficient workplace for all of its employees, and to protect the organization's property, information, equipment, operations and reputation.

1.3 Addiction Recovery, Inc. recognizes its obligations to its affiliates for the provision of services that are free of the influence of illegal drugs and alcohol, and will endeavor through this policy to provide drug-and alcohol-free services.

1.4 Addiction Recovery, Inc. further expresses its intent through this policy to comply with federal and state rules, regulations or laws that relate to the maintenance of a workplace free from illegal drugs and alcohol.

1.5 As a condition of employment, all employees are required to abide by the terms of this policy and to notify Addiction Recovery, Inc. Personnel management of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction.

2. PURPOSE

2.1 This policy outlines the goals and objectives of Addiction Recovery, Inc. drug and alcohol testing policies and provides guidance to supervisors and employees concerning their responsibilities for carrying out the program.

3. SCOPE

3.1 This policy applies to all departments, all employees and all job applicants. The term employee includes contracted employees. In the case that an employee is being supervised by a professional board such as Maryland Board of Nursing, The Maryland State Board of professional counselors and therapist rehabilitation committee, applicants must consent Addiction Recovery, Inc. to obtain and disclose test result. Failure to do so may result in discharge. Addiction Recovery, Inc. abides/complies with the Maryland Board Rehabilitation Committee and other Maryland State rehabilitation committees in providing our patients with acceptable standards of treatment. Addiction Recovery, Inc. is aware that all information about the participants in these particular programs is confidential.

4. DEFINITIONS

4.1 **Alcohol** means any beverage that contains ethyl alcohol (ethanol), including but not limited to beer, wine and distilled spirits.

4.2 **Company premises or company facilities** means all property of Addiction Recovery, Inc. including, but not limited to, the offices, facilities and surrounding areas on [EMPLOYER]-owned or -leased property, parking lots, and storage areas. The term also includes Addiction Recovery, Inc.-owned or -leased vehicles and equipment wherever located.

4.3 **Contraband** means any article, the possession of which on Addiction Recovery, Inc. premises or while on Addiction Recovery, Inc. business, causes an employee to be in violation of Addiction Recovery, Inc. work rule or law. Contraband includes illegal drugs and alcoholic beverages, drug paraphernalia, lethal weapons, firearms, explosives, incendiaries, stolen property, counterfeit money, untaxed whiskey, and pornographic materials.

4.4 **Drug testing** means the scientific analysis of urine, blood, breath, saliva, hair, tissue, and other specimens of the human body for the purpose of detecting a drug or alcohol.

4.5 **Illegal drug,** means any drug which is not legally obtainable; any drug which is legally obtainable but has not been legally obtained; any prescribed drug not legally obtained; any prescribed drug not being used for the prescribed purpose; any over-the-counter drug being used at a dosage level other than recommended by the manufacturer or being used for a purpose other than intended by the manufacturer; and any drug being used for a purpose not in accordance with bona fide medical therapy. Examples of illegal drugs are cannabis substances, such as marijuana and hashish, cocaine, heroin, methamphetamine, phencyclidine (PCP), and so-called designer drugs and look-alike drugs.

4.6 **Legal drug** means any prescribed drug or over-the-counter drug that has been legally obtained and is being used for the purpose for which prescribed or manufactured.

4.7 **Reasonable belief** means a belief based on objective facts sufficient to lead a prudent person to conclude that a particular employee is unable to satisfactorily perform his or her job duties due to drug or alcohol impairment. Such inability to perform may include, but not be limited to, decreases in the quality or quantity of the employee's productivity, judgment, reasoning, concentration and psychomotor control, and marked changes in behavior. Accidents, deviations from safe working practices and erratic conduct indicative of impairment are examples of "reasonable belief" situations.

4.8 **Under the influence** means a condition in which a person is affected by a drug or by alcohol in any detectable manner. The symptoms of influence are not confined to those consistent with misbehavior, nor to obvious impairment of physical or mental ability, such as slurred speech or difficulty in maintaining balance. A determination of being under the influence can be established by a professional opinion, a scientifically valid test, such as urinalysis or blood analysis and in some cases by the opinion of a layperson.

5. EDUCATION

5.1 Supervisors and other management personnel are to be trained in:

a. detecting the signs and behavior of employees whom may be using drugs or alcohol in violation of this policy;

b. intervening in situations that may involve violations of this policy;

c. recognizing the above activities as a direct job responsibility.

5.2 Employees are to be informed of:

a. the health and safety dangers associated with drug and alcohol use;

b. the provisions of this policy.

6. PROHIBITED ACTIVITIES

6.1 Legal Drugs

a. The undisclosed use of any legal drug by any employee while performing Addiction Recovery, Inc. business or while on Addiction Recovery, Inc. premises is prohibited. However, an employee may continue to work even though using a legal drug if Addiction Recovery, Inc. Personnel management has determined, after consulting with Addiction Recovery, Inc.'s health and/or human resources officials, that such use does not pose a threat to safety and that the using employee's job performance is not significantly affected. Otherwise, the employee may be required to take leave of absence or comply with other appropriate action as determined by Addiction Recovery, Inc. Executive Committee management.

b. An employee whose medical therapy requires the use of a legal drug must report such use to his or her supervisor prior to the performance of Addiction Recovery, Inc. business. The supervisor who is so informed will contact Addiction Recovery, Inc. designated human resources officials for guidance.

b. Addiction Recovery, Inc. at all times reserves the right to judge the effect that a legal drug may have on job performance and to restrict the using employee's work activity or presence at the workplace accordingly.

6.2 Illegal Drugs and Alcohol

a. The use, sale, purchase, transfers, or possession of an illegal drug or of alcohol by any employee while on Addiction Recovery, Inc. premises or while performing Addiction Recovery, Inc. business is prohibited.

7. DISCIPLINE

7.1 Any employee who possesses, distributes, sells, attempts to sell, or transfers illegal drugs on Addiction Recovery, Inc. premises or while on Addiction Recovery, Inc. business will be discharged.

7.2 Any employee who is found to be in possession of or under the influence of alcohol in violation of this policy will be subject to discipline up to and including discharge.

7.3 Any employee who is found to be in possession of contraband in violation of this policy will be subject to discipline up to and including discharge.

7.4 Any employee who is found through drug or alcohol testing to have in his or her body a detectable amount of an illegal drug or of alcohol will be discharged.

8. DRUG AND ALCOHOL TESTING OF EMPLOYEES

8.1 Addiction Recovery, Inc. will notify employees of this policy by:

a. Providing to each employee a copy of the policy, and obtaining a written acknowledgement from each employee that the policy has been received and read.

b. Announcing the policy in various written communications and making presentations at employee meetings.

8.2 Addiction Recovery, Inc. may perform drug or alcohol testing:

a. Of any employee who manifests "reasonable belief" behavior.

b. Of any employee who is involved in an accident that results or could result in the filing of a Workers' Compensation claim.

c. On a random basis of any employee. All random urine drug testing is conducted by Friends Medical Lab and the employee must go directly from work if notified by HR or before reporting to work when notified by HR, All employee selections for testing is conducted by Friends medical Laboratory as well as specimen collection and testing.

d. Of any employee who is subject to drug or alcohol testing pursuant to federal or state rules, regulations or laws.

8.3 An employee's consent to submit to drug or alcohol testing is required as a condition of employment and the employee's refusal to consent may result in disciplinary action, including discharge, for a first refusal or any subsequent refusal.

8.4 An employee who is tested in a "reasonable belief" situation may be suspended pending receipt of written test results and whatever inquiries may be required.

9. APPEAL OF A DRUG OR ALCOHOL TEST RESULT

9.1 An applicant or employee whose drug or alcohol test reported positive would be offered the opportunity of a meeting to offer an explanation. The purpose of the meeting will be to determine if there is any reason that a positive finding could have resulted from some cause other than drug or alcohol use. Addiction Recovery, Inc., through its health and/or human resource officials, will judge whether an offered explanation merits further inquiry.

9.2 An employee whose drug or alcohol test is reported positive will be offered the opportunity to:

Obtain and independently test, at the employee's expense (you only have 72 hours to do so), the remaining portion of the urine specimen that yielded the positive result;

b. b. Obtain the written test result from ADP Select Services medical review officer (MRO): Dr. John G. Cametas, Pembrooke Occupational Health, Inc., 2301 N. Parham Road, Suite 5, Richmond, VA 23229 1-888-382-2281. and submit it to an independent medical review at the employee's expense.

9.3 The employee may use Addiction Recovery, Inc. medical benefits, to the extent that coverage may apply, for meeting the costs of 10.2 (a) and (b);

9.4 During the period of an appeal and any resulting inquiries, the pre-employment selection process for an applicant will be placed on hold, and the employment status of an employee may be suspended. An employee who is suspended pending appeal will be permitted to use any available annual leave in order to remain in an active pay status. If the employee has no annual leave or chooses not to use it, the suspension will be without pay.

10. REHABILITATION AND EMPLOYEE ASSISTANCE PROGRAM

10.1 Rehabilitation assistance in lieu of discharge may be offered:

a. To any employee, who has requested rehabilitation assistance, provided the employee has not violated the drug free workplace policy.

10.2 Rehabilitation assistance given by Addiction Recovery, Inc. will be:

a. Limited to those medical benefits that may be available in the employee's medical benefits plan.

b. Referral to contracted EAP program.

c. Obtained by the employee during times that will not conflict with the employee's work time, except that the employee may use any available sick leave or annual leave to be absent from the job with pay.

10.3 Addiction Recovery, Inc. will provide to any employee, upon request and at no cost to the employee, information concerning local resources that are available for the treatment of drug and alcohol related problems.

11. INSPECTIONS AND SEARCHES

11.1 Addiction Recovery, Inc. may conduct unannounced general inspections and searches for drugs or alcohol on Addiction Recovery, Inc. premises or in Addiction Recovery, Inc. vehicles or equipment wherever located. Employees are expected to cooperate.

11.2 Search of an employee and his or her personal property may be made when there is reasonable belief to conclude that the employee is in violation of this policy.

11.3 An employee's verbal consent to a search is required as a condition of employment, and the employee's refusal to verbal consent may result in disciplinary action, including discharge, even for a first refusal.

11.4 Illegal drugs, drugs believed to be illegal, and drug paraphernalia found on Addiction Recovery, Inc. property will be turned over to the appropriate law enforcement agency and the full cooperation given to any subsequent investigation. Substances that cannot be identified as an illegal drug by a layman's examination will be turned over to a forensic laboratory for scientific analysis.

11.5 Other forms of contraband, such as firearms, explosives, and lethal weapons, will be subject to seizure during an inspection or search. An employee who is found to possess contraband on Addiction Recovery, Inc. property or while on Addiction Recovery, Inc. business will be subject to discipline up to and including discharge.

11.6 If an employee is the subject of a drug-related investigation by Addiction Recovery, Inc. or by a law enforcement agency, the employee may be suspended pending completion of the investigation.

12. CONFIDENTIALITY

12.1 All information relating to drug or alcohol testing or the identification of persons as users of drugs and alcohol will be protected by Addiction Recovery, Inc. as confidential

unless otherwise required by law, overriding public health and safety concerns, or authorized in writing by the persons in question.

Appendix O

Infection Control

ADDICTION RECOVERY, INC.

POLICIES AND PROCEDURES RELATED TO INFECTION CONTROL

PURPOSE: Prevention and control of infections. The goal is to identify, treat and prevent/reduce the spread of nosocomial infections through observation, identification, education and medical and environmental intervention. In addition, the potential to reduce transmission of infections in the patient's home community exists through early identification, education and treatment for infections.

Persons presenting for inpatient admission with a known, untreated, infectious disease, in which the patient's needs exceed Addiction Recovery Inc. capabilities to provide care, or, in which the course and treatment would preclude his participation in this program of chemical dependency treatment, will be referred to an appropriate facility for care.

Persons diagnosed with infections while a patient in Addiction Recovery Inc. are continued in treatment unless their physical health needs exceed Addiction Recovery Inc. ability to provide care, and then appropriate referrals are made.

Persons with infections and unable/unwilling to comply with infection control procedures to prevent transmission to peers or staff will not be admitted and will be discharged (with referrals and recommendations) if in treatment.

The overall intent is to prevent the transmission of infectious organisms from a host (person with an infection) to a source (person without the infection)..

PROCEDURES:

The Director of Nursing, in conjunction with the Medical Director, is responsible for the management of infection surveillance, prevention and control.

Staff within all departments are in-serviced upon hire about their responsibility related to Infection Control procedures in Addiction Recovery Inc..

a) Tuberculosis Infection/Disease

b) Hand washing

f) Discipline specific procedures and protocols are taught.

g) Kitchen/dietary teaching is the responsibility of the Food Service Manager.

Primary prevention: the process of reducing the exposure risk and/or altering susceptibility to infection includes the following.

1. Patient education during orientation to report suspicion of illness or open cuts/sores.

2. Personal hygiene supplies provided to patients in need.

3. Patient education groups: STDs and HIV disease.

a) Education includes a variety of handouts for patients to review after group.

b) Group education by nursing is available upon patient request for specific illnesses; i.e., community living with viral hepatitis, HIV.

4. Housekeeping duties performed by housekeeping staff, patients/clients and supervised by Treatment Aides

a) Unit cleaning at discharge.

b) Laundry at discharge

c) Kitchen sanitation protocols

5. Annual Flu Vaccine offered to all staff depending upon the availability of vaccine provided by AACo. Health Department. Vaccine and educational leaflets as well as signed consent slips are provided annually.

6. Universal Precautions.

7. Transmission Precautions:

a) Contact precautions: Gloves are worn by staff. Patients are taught about the risk of allowing others to touch an infected area. If the individual is able to maintain appropriate safeguards (as confirmed by direct staff observation) and/or a private room is available, the individual will remain in treatment. If it is deemed necessary that protective clothing be worn over street clothes when working with the patient, the patient will be discharged with appropriate referrals.

b) Airborne precautions: Infections spread through airborne distribution will require discharge and hospitalization.

c) Droplet precautions: Patients are taught to sneeze into the elbow area while facing away from others, not to share food or other items used by mouth, and are given Kleenex tissues.

Secondary Prevention: Early detection and prompt treatment of disease.

1. Identification of infections occurs through:

a) PPD screening for TB infection on :

(1) Employees at time of hire and annually thereafter.

(2) Patients at time of admission. PPD Protocol

Patients diagnosed with active disease are immediately transferred to the nearest hospital via ambulance for treatment. Evidence of three negative cultures for tubercle bacillus must be provided before patients are permitted back into treatment at Addiction Recovery Inc. Patients must agree to continue pharmacological treatment as ordered.

b) Patient interviews and assessments.

c) Review of current medical records from referring agencies

d) Physical assessments

e) Laboratory findings

(1) Admission screens:

Urinalysis dipstix

Comprehensive Metabolic Panel (if ordered)

Complete Blood Count (if ordered)

Gonorrhea/chylamydia (if ordered)

f) Voluntary, anonymous or confidential HIV testing available (in house) to patients.

2. Control of infections occurs through:

a) Treatment/protocols

b) Universal Standards.

c) Infectious waste management

d) Education r/t transmission for patients, 1:1 and Didactics

e) Disinfection/cleaning.

f) Immunization for staff limited to annual influenza and hepatitis B if clinically indicated.

g) Discharge and referral of patients with infectious diseases and who are not compliant with medical/nursing direction related to prevention of transmission.

Tertiary Prevention: Limiting disability in cases where infection has occurred and facilitating rehabilitation where possible.

Limitation of disability consists of attempting to prevent further losses and to help the individual effectively utilize remaining capabilities. This will include all those activities previously listed as well as referral to private and community agencies for additional case management. Examples include persons with HIV/AIDS, chronic hepatitis and/or any other infections not resolved at the time of discharge.

EMPLOYEE HEALTH

Employee health activities are limited and conducted and/or supervised by the Director of Nursing in cooperation with the Medical Director.

1. PPD screening. Known converters are not retested during annual Mantoux test periods and are advised not to have this test repeated during future health evaluations. Converters must provide radiological proof of the absence of active disease every 10 years.

Records are kept of the testing and results of employee tests at the time of hire and annually thereafter. These are in Human Resources personnel file.

Persons reporting previous conversion are required to submit medical proof of evaluation and disposition.

a) Employees positive according to the PPD protocol are referred to their private health care provider or the Anne Arundel County Health Department Chest Clinic for full assessment.

b) Employees being treated for TB exposure and not having active disease have no work restrictions but are required to complete the course of antimicrobial prophylaxis as ordered. Proof of this will be filed in the employees HR file.

c) Employees being treated for TB disease are restricted from working until no evidence of active disease exists as demonstrated by 3 negative sputum cultures. Proof of this will be filed in the employees HR file.

***Employees have the ethical obligation to comply with Infection Control policies to reduce the risk of the transmission of infection to patients/clients as well as peers.

1. All staff are referred to their private physician for evaluation and treatment of known or suspected illnesses/infections.
2. All employees are asked not to report to work with temperature elevations of 100 degrees or above
3. All employees are asked not to return to work until afebrile for at least 24 hours and longer depending on the medical diagnosis.
4. Employees assessed while at work to be at risk of transmitting infection to patients/clients may be asked to leave the facility and obtain medical evaluation and clearance to return to work. Supervisors are advised that the individual was sent home and requested to see a physician.

BLOODBORNE DISEASES

Viral hepatitis B and C and HIV disease are of special concern to the population served at Addiction Recovery Inc.

Staff is advised that the exposure risk to HBV, HCV and HIV in the workplace is possible but the application of routine infection control procedures reduces risk. Universal Precautions are required at all times. Exposure is possible through accidents and injuries. The protocol for Exposure Incidents is described in the Exposure Control Plan.

HIV/AIDS

1. HIV testing is not completed as part of the admission process on patients admitted to Addiction Recovery Inc., but information is collected admission.
3. All persons assessed at risk are offered options for testing while in treatment on-site by Addiction Recovery Inc. nurses or receive a referral at discharge. Patients may also refuse HIV testing at any time.

SURVEILLANCE: Collection and analysis of data in order to identify methods of transmission so that risk may be reduced or eliminated.

1. Information regarding past and current infections are collected during a patient's treatment stay on the Past Medications/Fagerstrom test/Infection Control form.

2. This information is then downloaded into an Excel spreadsheet monthly for aggregation. This information the is compiled to look at:

a) clusters of infections

b) suspected modes of transmission

c) suspected source of the infection

d) seasonal trends

e) determination of whether the infection was community acquired (defined by it being present or incubating at the time of admission, or the individual was exposed prior to or at the time of admission, or on a leave of absence, including those which are chronic, recurrent or the result of noncompliance with medical therapy.

Following analysis of aggregated data, the Director of Nursing will report the findings at the quarterly CQI meetings.

1. Findings are applied to current Addiction Recovery Inc. Infection Control practices to determine if change is appropriate and necessary to reduce or eliminate transmission and reduce the rate of nosocomial infections.

2. Recommendations for change are implemented in a timely manner.

Appendix P

Blood Borne Pathogens Training

Health and Safety - Blood Borne Pathogens
(Nursing and Housekeeping Only)

Introduction

Our image of blood borne diseases has sharpened in recent years due to research and technological advances. Most is known about the transmission, prevention, and treatment of disease such as hepatitis B, hepatitis C and HIV (Human Immunodeficiency Virus) infection.

Research shows that safety precautions such as handling all blood and body fluids as though infectious, disposing of sharps properly, and using sharps safety devices have decreased the numbers of exposures to blood borne pathogens. However, some healthcare workers still fail to use safety measures. Healthcare workers most often become exposed to hepatitis B, hepatitis C, and HIV through accidental need sticks. Let us take a closer look at the blood borne pathogens putting you at greatest risk on the job: hepatitis B virus, hepatitis C virus and HIV.

Hepatitis B Virus

Hepatitis B virus (HBV) causes serious liver disease. About half the people infected with hepatitis B have no symptoms. Those with symptoms may experience jaundice, fatigue, abdominal pain, loss of appetite, occasional nausea or vomiting. Most people infected with HBV recover and clear the infection. However, about 10% become chronically infected. The hepatitis B virus poses a greater risk to healthcare workers than with hepatitis C or HIV, since it is more easily transmitted. Fortunately, the hepatitis B vaccine can prevent the disease.

Hepatitis C Virus

Hepatitis C virus (HCV) causes a serious liver disease known as hepatitis C. This liver disease may cause symptoms similar to hepatitis B. However, there are important differences between hepatitis B and hepatitis C. While 85 percent of people with HCV have chronic infections, only 10 percent of those infected with HBV are chronically infected. People chronically infected with hepatitis C may have no symptoms for up to 30 years, yet during this time, the infection may be slowly damaging the liver. Hepatitis C is the leading indicator for liver transplants. Every year, up to 10,000 people die from HCV related chronic liver disease. There is no vaccine to prevent HCV. However, newly approved antiviral drugs have been effective in some people who have contracted the infection.

HIV

HIV attacks the immune system and causes it to break down. The clinical picture of HIV infection differs widely from person to person. A number of those infected remain apparently healthy for many years. The infected person becomes seriously ill when the immune system loses its ability to fight infections. Some infected people go to develop AIDS. The number of HIV-infected people who develop serious illness and who die from AIDS has decreased, thanks to the success of recent treatments. People with HIV now live longer and healthier lives. There is no preventative vaccine against HIV.

Transmission

Hepatitis B, hepatitis C, and HIV spread most easily through contact with blood. They also spread through contact with other potentially infectious materials, or OPIM, including semen and vaginal secretions as well as any other bodily fluid or tissue containing visible blood.

In our society, blood borne viruses are most commonly transmitted through sharing needles to inject drugs, by having unprotected sexual intercourse with an infected person, or passed from mother to unborn child before or during birth.

Focus on exposures at work

At work, you can be exposed to blood borne pathogens if:

- **contaminated sharp punctures your skin**
- **Blood or OPIM splash your broken skin or mucous membranes of your eyes, nose, or mouth.**

According to research, needle stick injuries cause 80% of exposures to healthcare workers. The Occupational Safety and Health Administration (OSHA) reports most needle stick injuries occur when disposing of needles, including cleaning up after a procedure, giving medications, drawing blood, recapping needles or handling trash and dirty linens.

Safety Guidelines

A Safe Picture

Your facility's Exposure Control Plan (ECP) details blood borne pathogen safety measures, including a method of identifying and evaluating safety devices such as protective sharps. Your ECP is based on OSHA's Blood borne Pathogen Standard and CDC guidelines for healthcare personnel. Here is a snapshot of the safety precautions you should take.

Hepatitis B Vaccine

According to OSHA, immunization against hepatitis B virus has proven very effective. In 1985, 12,000 healthcare workers were infected with HBV on the job. By 1995, after immunizations were promoted, only 800 healthcare workers were infected at work and that is currently true. Today's vaccines are safe and very effective at protecting you from getting hepatitis B if the series is complete.

Standard Precautions

Standard precautions means treating blood, all bodily fluids, excretions and secretions (except sweat), plus non-intact skin and mucous membranes as though infected with blood borne or other pathogens. Standard precautions incorporate features of both Universal precautions and Body substance isolation practices to protect you against the risk of blood borne pathogens as well as pathogens from moist body substances. Remember: all body fluids pose a potential risk of infection.

Personal Protective Equipment

To follow Standard precautions you must use barrier protection, or personal protective equipment (PPE), when you anticipate touching blood, body fluids, secretions, excretions, and contaminated surfaces. PPE may include gloves, gown, lab coat, face shields, or masks and eye protection, resuscitation bags, pocket masks, or other ventilation devices. Some tasks require more PPE, some less and some none at all. The point is, you need to wear only as much equipment as is necessary. Read your Exposure control plan for details.

Gloves

Gloves are the most common type of PPE. Single-use, disposable gloves that are low protein and powder free are used for medical procedures, and heavy-duty utility gloves are used for some housekeeping duties. Gloves can be torn or punctured, so cover any hand cuts you may have before being gloved. They should fit snugly on your fingers and be pulled up as far over your wrists as possible.

Single-use, disposable gloves should be worn only once, then thrown away. Always change gloves between each patient. If a glove tears, punctures, leaks or becomes contaminated, remove it as soon as you can and discard. Never reuse gloves. Utility gloves may be cleaned or decontaminated and reused if not damaged. If they are damaged, throw them out.

Avoid touching the outside of contaminated gloves when removing them. Then, wash your hands.

Other PPE

Wear a mask and eye protection or a face shield to protect your eyes, nose and mouth during activities that may generate spatters of blood or OPIM

Wear PPE when resuscitating a patient. Emergency respiratory devices and pocket masks isolate you from contact with a patient's body fluids. Your facility will provide you with necessary PPE and train you to use it. Make sure PPE fits properly. Check it routinely for physical flaws or damage. Remove as soon as possible if blood or OPIM penetrates PPE. Always remove PPE before leaving the work area. Immediately dispose of used PPE or have it laundered or decontaminated according to your facility's policy. Always wash your hands after removing PPE.

Safe Work Practice Guidelines

Hand hygiene guidelines

Hand hygiene is your number one protection against infection, and it keeps you from infecting other people or objects. The CDC recommends decontaminating your hands with an approved alcohol anti-septic hand rub if hands are not visibly soiled. Apply the product to the palm of one hand the rub hands together covering all hand surfaces and fingers until hands are dry. Decontaminate your hands between all patient contacts to avoid transferring pathogens to other patients.

If hands are visibly soiled, you must still wash your hands with soap and water as soon as you can. Wash hands with soap and running water for at least 10-15 seconds. Rub vigorously over all surfaces, including the wrist. Rinse thoroughly. Then dry with a clean paper towel and discard. Now, using a clean paper towel, turn off the faucet. Use anti-microbial soaps only when indicated since they remove your skins natural protective defenses and may cause dryness.

More of the Picture on Safe Work Practice

You should never eat, drink, or smoke where you are likely to be exposed to blood or bodily fluids. Also, do not handle contact lenses, apply cosmetics, or lip balms where exposure is possible. Never keep food or drinks in places where blood or OPIM are present.

Transport specimens of blood or OPIM enclosed, leak-proof containers. Wear gloves and handle carefully.

Handle contaminated patient equipment with care. Do not let it touch your skin, mucous membranes, clothing, other patients, visitors, or items in the environment. Clean reusable equipment properly before using it on another patient. Discard single-use items appropriately.

Clean all blood and fluid spills promptly, according to your facility's policy. Keep work surfaces and protective coverings clean.

Handle contaminated laundry carefully to prevent exposure of clothing and skin. Wear gloves. Place in an appropriate container in the area where used. Deposit wet laundry in a leak-resistant container.

Never use your hands or feet to push down trash since it may contain sharps or OPIM. Instead, gently shake down waste containers. Carry waste bags by the top, away from your body.

Dispose of blood and other regulated medical waste in appropriately labeled, closable, leak-proof containers. Follow your states regulations, as specified in you ECP.

Be aware of fluorescent orange-red labels, red bags and containers, and warning signs. They warn you that the contents contain blood or OPIM.

Sharps Safety

You are at the greatest risk of exposure to blood borne pathogens when handling contaminated sharps. More than half a million sharps-related injuries occur each year, according to OSHA. Studies show that sharps safety devices may significantly reduce your risk of injury during procedures such as joining IV lines, drawing blood, injecting medications, and suturing during surgery. The FDA and OSHA now recommend use of breakage-resistant blood capillary tubes to decrease exposure.

Safety devices include needleless systems and engineered protective devices for needles and other sharps. Your ECP details sharps safety rules you should follow. Here are some general guidelines.

- **Use a safe-needle device or needleless system for withdrawal of body fluids, accessing a vein or artery, or administering medications or fluids.**
- **Use either a needleless system or a needle with an engineered sharps protection for any other procedure requiring needle devices, when available.**
- **Use non-needle sharps with engineered sharps protection when available.**
- **When using sharps, always follow effective, safe handling techniques to prevent injury.**
- **Never shear, break, bend, or recaps contaminated needles or sharps, except in cases when recapping is required by the procedure. Then, use a re-sheathing device or a one-handed scoop method.**
- **Never reuse disposable sharps.**
- **Do not pick up contaminated broken glass (also a sharp) with your hands. Instead, use a broom and dustpan, forceps, or tongs.**
- **Discard contaminated sharps immediately after use in an appropriate, puncture-resistant, color-coded container. Nearly one-third of all sharps injuries happen during disposal. The National Institute for Occupational Safety and Health (NIOSH) suggests this risk can be decreased by placing sharps containers within easy reach and slightly below eye level. Do not allow containers to overfill. Never reach into a container of contaminated sharps.**
- **Report all sharps injuries as directed in your ECP. Document sharps exposure incidents including date, time, and type of sharp used as well as effectiveness of any safety device used, and how the injury could have been prevented, if possible. This information, entered into the Sharps Injury Log, is used to judge the effectiveness of the current sharps safety devices.**

<u>What to do if exposed</u>

Immediately, wash the exposed skin area, needle sticks, and cuts with soap and water. Flush eyes and exposed mucous membranes with large amounts of clean water. Do not use caustic agents, such as bleach. Next, report the exposure to the designated person right away, so that post-exposure evaluation, counseling, and any necessary treatment can begin. Act quickly, because for some infections, treatment should start right away. If you are exposed, do not panic. Remember, most exposures do not lead to infection. To become infected, a large enough dose of the live virus must enter your bloodstream and overcome your body's defense system. To put it in perspective, here are the risks of contracting a blood borne infection after a sharps injury. Studies report the risk of acquiring hepatitis B if unvaccinated is between 6-30%, for hepatitis C its 1.8%, and for HIV the risk is approximately 0.3% or 1 in 300.

Summary

The risks of infection are real and should be taken seriously. You can protect yourself by using safe work practices. Research, better surveillance, preventative treatment, and advances in technology will continue to give us a sharper image of blood borne pathogens. The more we know about preventing the risks. The better we can protect ourselves."

Citation: *Blood borne Pathogens: A Sharper Image*. (2002). Virginia Beach, VA: Coastal Training Technologies.

Appendix Q

Outpatient Policy/Procedure

ADDICTION RECOVERY INC. PROGRAM DESCRIPTION FOR THE

OUT PATIENT LEVEL OF CARE

Mission

To provide high quality, comprehensive, integrated, holistic, patient-centered treatment for addiction and co-occurring mental illness in a caring and supportive environment that equips patients to achieve sobriety and pursue a fulfilling life in recovery.

Vision

To achieve status as the premier provider of addiction and mental health recovery treatment for patient, support and advocacy services for families, and as a positive change agent in the communities we serve.

Core Values

- Person Centered Approach: Our people are our greatest asset. Our programs and policies and procedures are designed to optimize the therapeutic experience of patient, family members, and professional staff, maximizing the dignity and respect shown to all.
- Maximum Extension of Reach: We seek to provide affordable, high quality services to the greatest number possible, not ignoring the most fragile, by pursuing aggressive expansion and cost management strategies.
- Continuous Improvement through Innovation and Best Practive:We are dedicated to incorporating innovative treatment and management practices to optimize the existing business model.

POPULATIONS SERVED:

Clients who are 18 years of age or older who have a current history of a co-occurring disorder and/or of alcohol and/or drug use indicating a need for treatment according to ASAM criteria. There also must be an absence of severe medical and/or psychiatric problems that would require a different level of care, intervention, or not impact their ability to engage in our treatment program.

SETTING: The setting for Out-Patient services is a freestanding substance abuse facility.

Hope House Crownsville	Hope House Laurel
26 Marbury Drive	419/429 Main Street
Crownsville MD 21032	Laurel MD 20707

HOURS AND DAYS AND FREQUENCY OF OPERATION:

Out-Patient services are provided at least 1-8hrs per week a week and have a licensed and or certified counseling, (LCPC, LCSW-C, CSC-AD, CAC-AD, ADT) and therapeutic intervention services available.

Individual sessions are provided as needed.

IOP: Monday, Wednesday, Friday 11:00am – 2:00pm; Tuesday, Wednesday, Thursday 5:00pm – 8:00pm
OP: Monday 5:30pm – 6:30pm; Thursday 11:00am – 12:00pm

Liver Transplant Group: Tuesday 10:00am – 11:00am

IOP/OP Cancellations: Weather events will run in accordance with county school closers.

Addiction Recovery Inc. emergencies will be communicated via phone and if a client has an emergency situation that deems an absence from group they should call 410-923-9700 ext 113 Barry Grant during normal business hours and if it is not during business hours to call 410-923-6700 or 911 for any medical/psychiatric emergencies.

PAYER SOURCES:

Payer Sources include but are not limited to: Insurance Companies, Medicaid, Other Public Funds, and Self Pay.

FEES:

Fees are assessed on the day of admission depending on the funding source of the individual's treatment stay. These may include but are not limited to: deductibles, co-pays, any other managed care related fee and facility fees. If the client is transitioned from another level of care, these fees are billed at the end of treatment. If a client loses their funding while attending program Addiction Recovery Inc. will offer self-pay rates and/or refer client to County Health Department for evaluation for funding.

REFERRAL SOURCES:

There is a myriad of ways to be referred to our Out-Patient program including but not limited to: Insurance Companies, Internet, Court System, EAP, DSS/CPS, Crisis Response, or Self-referral.

SPECIFIC SERVICES OFFERED:

Clients receive all services from Addiction Recovery Inc. employees and their independent contractor unless an emergent situation arises that requires transfer to another level of care.

PROGRAM DESCRIPTION AND SCOPE OF SERVICES:

Addiction Recovery Inc. offers short-term treatment for people who meet the ASAM criteria Out-Patient. Services for outpatient are provided 1-8hrs per week of therapeutic programming, dependent on contractual obligations with payers, and these services are funded by private insurance, County/State funding, or a self-pay option. Treatment is supervised by a qualified behavioral health practitioner that is on site during clinical hours. Admission to this level of care usually begins with a complete psychosocial assessment, including a mental health assessment when psychiatric problems are suspected if not already done in previous levels of care. The treatment component consists of group, as needed individual, and family counseling using ROSC, Motivational Interviewing, and the Matrix Model and other evidence based practices, health teaching, education about drugs and recovery, introduction to 12-step, self-help support groups, such as alumni, interactive peer support, introduction to web base services, psychiatric services as required and intervention/referral when physical problems are noted. The short-term component of treatment generally lasts from 30 to 90 days for Out-Patient, depending upon individual need, and is always followed by a transition or referral for ongoing, continuing care in a different level of treatment such as group counseling, vocational training, ongoing individual or family therapy, and/or self-help group participation.

PHILOSPHY OF THE PROGRAM:

The Addiction Recovery Inc. philosophy at all treatment levels is based on the belief that chemical dependency is a chronic, progressive, primary, incurable disease. The disease results in progressive physical, mental, emotional and social impairment and premature death unless intervention takes place and abstinence is maintained. The Addiction Recovery Inc. philosophy supports the belief that the patient is not responsible for having the disease of addiction, but is clearly supportive of the position that the patient is responsible for his or her recovery.

While addiction cannot be cured, it is treatable. The great majority of addicts can begin to recover with the help of professional treatment services. Most benefit from an intensive, short-term detoxification and treatment experience while others need further residential placement support based upon their history, support systems, vocational experience, and living environment. In addition, the high prevalence of co-occurring psychiatric disorders in the addicted population suggests that residential treatment settings that provide concurrent psychiatric treatment provide a strong foundation for the recovery process.

GOALS OF THE PROGRAM:

- Ongoing management of psychiatric issues.
- Continuing education regarding development of coping skills.
- Relapse prevention work based on a client's own personal triggers.
- Completion of the individual's treatment goals.
- Reduction of use so the client may remain a productive member of the community.
- Continuation/Introduction to abstinence or medication assisted recovery

SERVICE MODALITIES TO BE PROVIDED TO ACHIEVE THE PROGRAM OBJECTIVES AND GOALS:

Group therapy will be the standard component. And will be provided by a qualified clinician utilizing group processes and dynamics to facilitate the treatment process. Appropriateness for group therapy will be considered before patients will be admitted to group therapy situations. Before participating in group therapy, clients will be oriented regarding appropriate behavior in the group, and other group rules will be explained, such as those associated with attendance, participation, honesty, feedback to others, and confidentiality.

Group sessions will focus on here-and-now issues such as the desire to use AOD, recent relapses, struggles with potent emotions, or conflicts with other group members or family members. Other topics to be addressed include incest and abuse, gender or cultural issues, family relationships, and sexual orientation. Therapy groups will not include more than 12 patients. Coverage during the therapist's absence will be arranged pursuant to program standards of operation.

SPECIAL POPULATIONS AND MECHANISMS TO ADDRESS THEIR NEEDS:

Addiction Recovery Inc. is able to provide services to individuals which may be categorized as "Special Populations". These individuals include but are not limited to HIV individuals, IV drug users, pregnant women, older or aging adults, and DUI offenders. However, these individuals must meet criteria listed above, be medically/psychiatrically stable, and be able to participate fully in treatment.

SCOPE OF SERVICES:

Addiction Recovery Inc. will provide Out Patient services (1.1 ASAM) as part of the continuum of care for those clients meeting criteria. Those services include at a minimum:

- Counseling Services: Individual psychotherapy will be available as needed to help clients identify self-defeating patterns of behavior and unconscious motivations for specific behaviors not able to be addressed in the group process. The goals of individual counseling include:
    - Maintaining clients' participation in the treatment process by continual review and clarification of treatment goals and objectives
    - Reassuring clients about fears and anxieties that will be an expected part of the

behavioral change process
    - Enhancing retention of clients in the program by strengthening the client-counselor relationship
    - Identifying new and healthy responses and solutions to stressful and difficult situations.
- Crisis Management: Clients who present with behavioral concerns during the group setting will be redirected by clinical staff. If redirection is unsuccessful then client will be asked to leave group and one on one counseling will be provided. If the intervention is unsuccessful mobile crisis may be called in further escalations may result in a 911 call. Clients will be provided with information regarding hotlines, crisis intervention services, and hospital emergency rooms. County Mobile Crisis Units are also available 24 hours a day 7 days a week for additional management if needed.
- Psychiatric Services: Any person, who presents with perceived psychiatric concerns, will be assessed by the Psychiatric Nurse Practitioner at Addiction Recovery Inc. who is onsite weekly. If emergent care is needed, the Psych Nurse Practitioner is available by phone 24 hours a day 7 days a week. There are also additional Mental Health Services provided by adjunct LCPC/LCSW-C staff. If the psychiatric emergency cannot be managed at this level of care, the patient will be referred to the Emergency Department for emergency evaluation and treatment.
- Patient Education**:** Education regarding the disease model of addictions and the process of recovery will be an integral component of the OP program. The didactic presentation of information will include:
    - The dynamics of addiction and the addiction process
    - The role and process of treatment and recovery
    - Medical aspects of addiction
    - The importance of abstinence from alcohol and all other drugs
    - Appropriate use of prescribed and over-the-counter drugs
    - Powerlessness and unmanageability of AOD use
    - Maximizing the use of self-help and support groups
    - Spirituality and the development of an externalized source of support
    - The roles of nutrition, exercise, leisure, and recreation in recovery
    - Experiencing emotions and feelings without AOD
    - Relationship skills
    - Sex and sexuality and recovery
    - Conflict resolution and confrontation skills
    - Family dynamics of addiction
    - Healthy relationships and family functioning
    - Relapse management skills
    - AOD refusal skills
    - Avoiding and defusing triggers for craving and relapse
    - Minimizing risks for HIV, AIDS, and sexually transmitted diseases.
- Case management: Arrangements with other organizations for delivery of support services not provided by the treatment program (such as vocational rehabilitation, social services, and employment services) will be made on a case-by-case basis to address issues identified in the biopsychosocial assessment. Services include referral for financial assistance if available, housing, transportation as needed and assistance with activities of daily living as

needed. Some clients qualify for external case management as offered by outside entities and weekly meetings will be held as deemed necessary by providers of services.

- Information and Referral Services: Patients will be assessed by the nurse and or counselor to determine when discharge criteria from this level of care have been met. A determination and recommendation is
  made to the client to safely discharge to the community. If the determination is made for discharge, the appropriate referrals will be made. Emphasis is placed on developing community based recovery support in the patient's own community.
- Auricular acupuncture (Acudetox) is available and offered to clients to help reduce cravings to use mood altering substances and to decrease their level stress, thus enhancing the treatment experience.
- Addiction Recovery Inc. does not restrict client's right for an infraction of programing rules however repeated infractions could result in staff discharge from the program at which time the client will receive an appropriate referral for continuing services.

ADMISSION CRITERIA TO THE OUT PATIENT LEVEL OF CARE:

All patients requiring Out-Patient services must meet admission/entry criteria for service, as described below determined by medical/behavioral health assessment:

- 18 years old or older
- Meet diagnostic criteria for substance-related disorder of the DSM V
- Must be at minimal risk of withdrawal symptoms or have minimal remaining withdrawal symptoms.
- Be physically and psychologically stable.
- Client meets the following:
  a) The member has been discharged from an inpatient hospital stay for the treatment of a Substance-Related Disorder, or outpatient is the initial level of care for the member whose severity of illness and level of functioning require treatment to change substance abuse and addictive behaviors (e.g., pharmacotherapy, psychotherapy, and/or psychoeducation provided by physicians, psychologists, and nurses and). (CMS NCD Manual, Section 130.2; ASAM Criteria, 2013).
  b) Services must be for the purpose of diagnostic study or reasonably expected to improve the member's condition, and designed to reduce or control the member's symptoms, to prevent relapse or hospitalization, and improve or maintain the member's level of functioning (CMS Benefit Policy Manual, Chapter 6-20).

DISCHARGE AND TRANSITION CRITERIA TO A LOWER LEVEL OF CARE:

- The patient no longer requires services 1-8 hrs. Per week of treatment.
- The patient is mentally competent and cognitively stable to be discharged to the community.

To ensure that the recovery process continues beyond the point of outpatient treatment, a continuing care plan will be developed by the patient and the therapist. The objectives and goals identified during the initial phases of treatment are carried forth in this written plan, which specifies the activities and objectives that

will enable the client to sustain abstinence and a recovery-oriented lifestyle. Issues left unresolved will be addressed in the continuing care treatment plan.

Transition planning will be established early in the treatment process and may include outpatient services, group counseling, vocational training, ongoing individual or family therapy, and/or self-help group participation.

POLICY ON PRE-ADMISSION FOR CLIENTS COMING FROM THE COMMUNITY OR DOOR TO DOOR FROM THE HOSPITAL

INITIAL TELEPHONE CONTACT:

The administrative office staff accepts referrals from outside agencies or individuals seeking treatment, Monday through Friday, 8:00 AM – 5:00 PM. The administrative office staff enters initial information into a new Credible electronic record and puts the record ON HOLD or SCHEDULED. This includes information regarding the demographic information, patient's condition, drugs of choice, living environment, past treatments, current health problems, mental health history and insurance information. In the case of referrals from AACo HD OTF program, refer to OTF manual.

3. If the client's screening information does not have to undergo a review for admission by the DOT or DON, the administrative office staff will have that individual come in that day if possible for admission once the client's insurance has been checked on-line or telephonically. If the client is unable to come in that day for admission, they are scheduled for the next available admission date/time.

4. If the caller does not have insurance and are Anne Arundel county residents, they are referred to the OTF Department for assessment through that funding source. If the client is an IV drug abuser, every effort is made to admit provide admission to Addiction Recovery Inc.'s within 14 days. The patient will be placed on a waiting list.

VERIFICATION AND EXPANSION OF INITIAL INFORMATION:

Categories of applicants who may require a pre-admission review or Treatment team review include:

- Un-stabilized Co-occurring Disorder
- Re-admission of previous patients
  HIV Positive applicants – recent CD4 counts are usually requested.

Priority status for admission is given in accordance with directives from the Maryland Alcohol and Drug Abuse administration to include:

- Individuals who are pregnant, or have given birth within the past 12 months
- HIV Positive applicants
- IV drug abusers

CLIENTS INELIGIBLE FOR ADMISSION:

1. Clients who are requesting a different level of treatment not available at Addiction Recovery Inc.
2. On admission clients will be assessed by clinical staff/Medical Director/NP and all clients that require inpatient care will be referred to a higher level of care.
3. Mental health issues requiring immediate intervention such as active SI or hallucinations.
4. Married couples, significant others or related family who are currently in treatment.

The Directory of Community Services in Maryland is used as a resource as well as service providers known to Addiction Recovery Inc. locally and through the Alcohol and Drug Abuse Administration. Specific programs, telephone numbers, addresses and contact persons are provided to the client. Persons requiring mental health/medical/dental intervention are referred to available public agencies, private treatment providers, or if none is available, to a local emergency room or University of Maryland Dental Clinic. Documentation of the referral is made on the Screening Assessment.

NOTIFICATION OF THE ANNE ARUNDEL ADDICTION COORDINATOR REGARDING TOTAL CAPACITY:

Within 1 week of reaching 90% capacity, the Intake office will notify Anne Arundel Addiction Coordinator that 90% capacity has been met. Addiction Recovery Inc. will admit individuals in need of treatment who are currently IV drug abusers not later than 14 days after the request for treatment has been made.

CAPACITY NOTIFICATION TO THE STATE OF MARYLAND – IV Drug Users:

Within 7 days of reaching 90% capacity, Addiction Recovery Inc. will notify the State of Maryland that 90% capacity has been reached.

WAITING LIST:

Individuals accepted into the program that cannot be admitted within 24 hours will be placed on waiting list. Each client on this list will be assigned a unique patient identifier which is the last 4 digits of a patient's SSN. The front office will call individuals who are on the waiting list daily. If the potential client cannot be admitted into Addiction Recovery Inc. within 10 days, the DOT or DON will contact other appropriate treatment programs in order to arrange admission or transfer within a reasonable geographic area.

The priority of the waiting list for admission slots will be as follows: HIV positive individuals, pregnant women who have been detoxed and IV drug users. After those individuals have been given slots, the final criteria for an admission slot is the date the individual was placed on the list.

When an admission slot becomes available, the clients will be contacted in order of priority. If that individual is not reachable, then the next individual who has been on the list the longest will be contacted. Addiction Recovery Inc. will remove individuals on the waiting list only if they cannot be located or when they refused treatment when they were contacted.

POLICY AND PROCEDURES FOR ADMISSION/INTAKE FOR CLIENTS COMING FROM THE COMMUNITY OR ANOTHER PROGRAM:

Intake is a process whereby an individual, who has previously been screened for eligibility and diagnostic impression, presents on day of admission for final determination of appropriateness for admission. This involves a preliminary assessment by the clinician to admit the patient based upon the diagnosis and needs of the patient. At any time during this process, if the individual is determined to be ineligible, inappropriate, or more suited to a different level or type of care not available at Addiction Recovery Inc., referral to another treatment provider who more closely meets the needs of the patient is facilitated by the case manager and or the Director of Treatment.

FRONT OFFICE STAFF:

2. For admissions Monday through Friday, the OP coordinator will scan in the patient's electronic record a copy of the patient's identification (driver's license, social security card, insurance card).. (***If the admission comes on Saturday or Sunday, this admission data entry into the electronic record is done on the first day when the business office is open). If patients call at other times, and they need immediate admission, they are either directed to Anne Arundel Medical Center or Laurel Regional Medical Center.

FINANCIAL REGISTRATION AND FEE ASSESSMENT – Monday through Friday

3. The patient then meets with the OP coordinator who describes all treatment costs to be borne by the patient. The administrative staff member will complete the following forms in the Credible electronic record:

m. Promissory notes for clients approved for waiver of admission/copay amounts are by the Executive Director.
n. Promissory note for any pharmacy co-pays/laboratory costs
o. Patient Rights review and explanation
p. Family Assessment completed by the client on Credible
q. Consent for Department of Social Services for OTF clients
r. Consent for Bridging the Gap
s. Consent to any third party payer (i.e. OTF, Medical Assistance VO, private insurance carriers, and various other contracted agencies/counties.)
t. Emergency contact consent
u. Consent for any financial concerns if patient is having another individual pay for their stay.
v. A General Consent/Consents if patient wishes communication with other person/persons.
w. Verification of income form which assesses a patient's ability to pay fees for program services.
x. Consent for Intervention psychiatric services.

4. Fees are assessed on the day of admission depending on the funding source of the individual's treatment stay. A synopsis of the current fees assessed is reviewed one on one with the client and the client initials the appropriate block on the form. Some of the various funding sources and associated fees are listed below.

Privately insured clients (other than Medical Assistance):

Addiction Recovery Inc. maintains contracts with a variety of insurance companies and Health Maintenance Organizations to assist in paying for treatment for covered individuals. These clients/patients work with Utilization Review for precertification and authorization for by the insurance company throughout their stay. When an individual has OP benefits, Addiction Recovery Inc. will require authorization to assign payment to Addiction Recovery Inc. and will accept the contracted amount as payment in full, less any patient deductible and/or co-pay or uncovered medication and laboratory costs, for which the patient will be responsible. Reimbursement rates differ, as do billing practices for each company.

Screening:

An initial, brief screening of a potential patient may be done during the first phone contact or through a scheduled or unscheduled walk-in. During this initial screening, basic data will be gathered and the individual is encouraged to participate in an assessment if appropriate.

To the extent possible, medical emergencies will be screened and the client will be given a brief overview of the services provided by the program. The purpose of this initial screening is to determine whether the individual is likely to be an appropriate candidate for the program according to clear, previously determined admission criteria that include guidelines on clinical and financial eligibility.

The purposes and reasons for screening include:

- Determining the need for an AOD assessment
- Ensuring immediate placement in the appropriate level of will be
- Responding to communications from referral sources, self-referrals, families, and others about the potential for AOD treatment
- Engaging and involving the referral source with the treatment program and the treatment process
- Documenting information gained during crisis interventions and assisting clients to reach other levels of will be such as emergency room treatment
- Scheduling appointments for assessment and preparing patients for the assessment process.

Clinical staff will conduct front-line AOD screening.

Assessment and Intake:

An assessment will be arranged as soon as possible if the person seems to be an appropriate candidate for OP level of care. The assessment process will provide a complete biopsychosocial-spiritual profile of each person, including all problems will be such as AOD use; psychological, physical, legal, and vocational problems and issues; and family and other social relationships.

Clients will be informed about confidentiality regulations and other informed consent issues. Both of these will help to promote a trusting relationship between the client and the program staff.

Clients can be placed in treatment at the earliest opportunity. Encouragement and positive reinforcement for clients' participation will be required throughout this process. Those for whom medical stability is in question will be examined by a physician prior to admission. If the assessment reveals that a client is inappropriate for participation in the OP program, the program is responsible for linking the client with an appropriate level of care.

Intake and registration procedures will be include patient education regarding program policies and procedures, rules and regulations, expectations and rights, program schedules, the consequences of noncompliance, the use of AOD during treatment, the role of toxicology screening results, the extent and limits of confidentiality, and the clients are given an out-patient handbook.

Toxicology Screening:

Routine screening will be performed once a week, in the beginning of treatment then randomly as treatment progresses and goals will be attained. If deemed appropriate routine screenings can be observed.

Patients will be required to provide written informed consent regarding who, outside of the program staff, may have access to or be informed of toxicology screen results. The therapist will address positive drug screens.

Appropriate procedures are followed regarding the safe collection, handling, storage, and testing of urine samples per program policy.

Treatment Planning:

The treatment plan will be based on the patient's expressed objectives and on findings from the initial assessment, toxicology screenings, and the biopsychosocial-spiritual assessment. Treatment planning will follow the standard for AOD treatment. Based on the findings of the assessment, goals will be established for an individualized master treatment plan that describes specific goals and actions to be taken. The treatment plan will be updated periodically reflecting the client's cognitive, emotional, social, physical, and behavioral changes.

Specific, measurable patient centered goals that the patient agrees to accomplish during the course of treatment will be identified in the master treatment plan. A treatment contract will be used as needed.

FAMILY INVOLVEMENT:

Family member participation is a critical area of AOD treatment. Didactic and experiential sessions will be provided for family members and significant others of patients. These sessions will help engage clients' families in treatment and enhance family members' understanding of the treatment and recovery process. Topics to be covered include:

- The dynamics of addiction, treatment, and recovery in the family
- Relapse and relapse prevention
- Family issues common in addicted families
- Enabling and denial
- Healthy family functioning
- Healthy detachment and "tough love"
- Communication and problem solving in the family
- Management of family social functions
- Introduction to Al-Anon, Alateen, and other relevant support systems for family members.

Self-Help and Support Group Orientation:

Patients will be advised of the times and locations of 12-step group meetings and other support groups.

OP staff members will be sensitive to the need for matching individual patients to a "home group" of people with similar backgrounds, culture, and experience. ARI treatment staff will be willing to help such clients explore reasonable alternatives that will genuinely help them establish and

maintain sobriety and promote emotional and spiritual growth. The effectiveness of the self-help experience will be based on the client's comfort level and assumed benefit rather than on the experience or traditional outlook of the treatment provider.

ARI treatment staff will be familiar with alternatives to 12-step programs that may be available in their area, such as Rational Recovery Systems, Addicts Victorious and Women for Sobriety.

Group Therapy:

Group therapy will be the standard component. And will be provided by a qualified clinician utilizing group processes and dynamics to facilitate the treatment process. Appropriateness for group therapy will be considered before patients will be admitted to group therapy situations. Before participating in group therapy, clients will be oriented regarding appropriate behavior in the group, and other group rules will be explained, such as those associated with attendance, participation, honesty, feedback to others, and confidentiality.

Group sessions will focus on here-and-now issues such as the desire to use AOD, recent relapses, struggles with potent emotions, or conflicts with other group members or family members. Other topics to be addressed include incest and abuse, gender or cultural issues, family relationships, and sexual orientation. Therapy groups will not include more than 12 patients. Coverage during the therapist's absence will be arranged pursuant to program standards of operation.

INTAKE INTERVIEW:

1. All applicants eligible and appropriate for admission will be scheduled for a face to face interview with the Counselor. The Intake interview is an assessment to insure that the patient's needs correlate with the services available at Addiction Recovery Inc. based on admission criteria. Exceptions to this are on a case by case basis.

2. Criteria for determining the eligibility of patients for admission to the various levels of care are clearly described in the following in the Credible Treatment Plan:

    a. DSM - V Diagnostic Criteria

    b. ASAM PPCII –R

3. The counselor uses the collected data to complete the DSM-V Criteria to determine a presumptive diagnosis of Substance Dependence. If two or more criteria are met, the counselor proceeds with the ASAM PPC-2–R. The purpose of the criteria and check lists is to ensure that treatment required by the patient is appropriate to the intensity and restrictions of care provided by Addiction Recovery Inc.

4. A Gambling Assessment is also conducted by the counselor.

*** It is the intention of this process to insure the appropriateness of the patient and the ability of Addiction Recovery Inc. to meet the patient needs and/or suggest alternative services. The patient is matched to the type and level of services that best meets his/her needs. In the event that the screening process reveals there are medical, psychiatric, legal or other complicating factors which require further assessment in order to determine the appropriate disposition of the applicant, the review conducted by one or more of the following individuals will be performed: Director of Treatment, Director of Nursing, Physician, and/or Charge Nurse.

POLICY AND PROCEDURES FOR ADMISSION/INTAKE FOR CLIENTS TRANSITIONING FROM INTENSIVE OUT PATIENT SERVICES HERE AT ARI:

The counselor at Addiction Recovery Inc. makes the referral to transition the client from INTENSIVE OUT PATIENT level of care to an OP level of care on the date of completion of their treatment plan/goals.

If the counseling staff determines the client meets one or more of the transition criteria, a transition plan is then developed with the input of the client.

Finally, the OP Coordinator will discharge the client in the Credible electronic record and change to the level of care The patient is transitioning to.

ADDICTION RECOVERY INC. PROCEDURES FOR DISCHARGE FOR THE OP LEVEL OF CARE:

A patient's readiness for discharge from all levels of care is determined by the treatment team through the process of treatment plan review (see policies on therapeutic reviews) and based upon ASAM PPC II R. However, the process of discharge planning from OP is initiated at the time of admission as the treatment team assists the patient in making responsible, discharge decisions. It is the philosophy of Addiction Recovery Inc. to provide the least restrictive environment, which is conducive to the recovery process based upon each individual's need and their ability to achieve therapeutic goals and objectives.

All discharged patients are given referrals for continuing chemical dependency treatment at a level of care best suited to their needs. Medical, dental, psychiatric, or other types of referrals are offered as individually needed.

THE DISCHARGE PLAN:

Discharge planning procedures begin on the day of admission when the patient assessment process begins. The patient is questioned, at the initial screening, concerning his/her discharge plans (living environment). The assessment process, completed at the first appointment, also incorporates the patient's discharge plans.

Completion of the full bio-psychosocial assessment provides the initial information from which the treatment team begins to consider the appropriate level of care for the patient following discharge from Out Patient. Each individual's full set of circumstances is taken into consideration from the initial assessment and throughout treatment. Recommendations for appropriate discharge plans are based upon: a. Patient's living environment, b. Active drug use in the home or neighborhood, c. Patient's financial resources, d. Patient's family support, e. Patient's ability to reach therapeutic goals and objectives and demonstrate commitment to the recovery process f. access continuing treatment facilities, g. Patient's perception(s) of his/her continuing care needs, h. Patient's responsibilities toward children, i. Patient's legal status and court influences regarding continuing care, j. Patient's physical or mental health status, k. Patient's relapse history and/or potential.

During the assessment phase, the primary counselor begins discussing, with the patient, his/her needs at discharge. The primary counselor will prepare a treatment plan during the assessment phase regarding continuing care to assist the patient in making a healthy decision for ongoing treatment after discharge from Addiction Recovery Inc. Treatment Center.

The primary counselor continues to assess the safety of the home environment through contact with the patient and his/her family members. This information is shared with the treatment team to assist in the discharge decision-making process.

Readiness for discharge is based upon integrating all of the above information through the treatment team review process.

PROCEDURES FOR DISCHARGE REFERRALS:

1. Discharge referrals for continuing chemical dependency treatment are made based upon the individual circumstances of the client, recommendation of the treatment team and willingness of the patient to follow those recommendations. Referral Agreements will be made with those outside agencies that agree to do so.

2. As soon as an appropriate level of care is determined (outpatient, 12-step fellowships mental health counseling and family counseling) and agreed upon by the patient, the primary counselor begins the process of making a referral.

3. Consents to the referral agency are obtained both to release and obtain information prior to giving the agency any information about the patient.

4. The primary counselor telephones the agency to determine if there is a treatment slot and whether the patient may be eligible, based upon available information.

5. The primary counselor notifies the Medical Records Technician to insure required documents (agency specific) are forwarded as soon as possible. This is accompanied by a Referral Form.

These may include but are not limited to:

a. Consent to release information

b. Screening Form

c. All Assessment Forms

d. History and Physical

e. All laboratory reports including Urine Drug Screens

f. Treatment Plans

g. Progress Notes

h. Psychiatric Evaluation

l. Medication Records
m. TB Test Results
n. Discharge Instruction Sheet which is completed for all clients whether they chose to sign and take them with them no matter what the type of discharge.

6. All attempts are made to have an F/U appointment for continuing care occur prior to the patient's actual discharge from Addiction Recovery Inc. The purpose is to help insure appropriate linkage. However, when that is not possible due to distance and schedules, the primary counselor attempts to schedule the patient's initial appointment as soon as possible after discharge.

7. All attempts are made to help the client/patient obtain personal transportation to initial continuing care appointments. However, in some instances (when distance is not a concern), Addiction Recovery Inc. will provide transportation for OP in the Annapolis, Glen Burnie area. In the event a patient requires transportation, a request is made indicating that transportation is needed. If scheduling permits, the patient may be transported to and from OP by the ARI staff.

8. In the event the patient requires a mental health referral at discharge, in addition to the chemical dependency referral, all attempts are made by the counselor to facilitate an initial appointment prior to discharge or as soon after discharge as possible.

9. Individuals requiring medical or dental referrals will receive information from their primary counselor.

10. All discharge referrals are documented in the chart, the patient discharge instruction sheet, and indicated in the discharge summary, and reported at the Daily Clinical Team Meeting

11. If family members request assistance with understanding discharge referrals, the primary counselor will meet with family members prior to discharge to explain the nature of the referral, with the consent of the patient.

CLIENTS WITH A PRIMARY DIAGNOSIS OF OPIOID DEPENDANCE

Clients who have a primary diagnosis of opiate dependence are scheduled intake appointments for opioid maintenance therapy unless they refuse this referral.

WOMEN WITH DEPENDANT CHILDREN

Women with dependent children are given linkages on the discharge instructions which include but are not limited to :

m. Case management
n. Transportation needs
o. Legal needs
p. Assistance with accessing insurance
q. Education needs
r. Housing needs
s. Physical health
t. Behavioral health
u. Prenatal Care and other health services
v. Therapeutic daycare for children
w. Head Start
x. Trauma Informed Care service

PROCEDURES FOR DISCHARGE CLOSURE OF THE ELECTRONIC RECORD

1. All paper documents (medical records from hospital, urine results, medication Kardexes etc.) are scanned into the record by the Nursing Assistant.
2. The Front office changes the client electronic record from ACTIVE to DISCHARGED.

Appendix R

Patient- Served Days

Addiction Recovery Inc.
Patients Served-Patient Days

Fiscal Year	# of Patients	Total Patient Days	Average Patient Stay
2015	917	13677	14.91
2016	950	14023	14.76
2017	1013	19645	19.39

* This data represents all patients served, including those who have left our program unsuccessfully (5 days <). Our average patient-stay for successfully completed patients is around 21 days.

Tables

Table Number	Table Title	Instructions
Table A	Physical Bed Capacity Before and After Project	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	Project Budget	All applicants, regardless of project type or scope, must complete Table B.
Table C	Statistical Projections - Entire Facility	Existing facility applicants must complete Table C. All applicants who complete this table must also complete Table D.
Table D	Revenues & Expenses, Uninflated - Entire Facility	Existing facility applicants must complete Table D. The projected revenues and expenses in Table D should be consistent with the volume projections in Table C.
Table E	Statistical Projections - New Facility or Service	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table E. All applicants who complete this table must also complete Table F.
Table F	Revenues & Expenses, Uninflated - New Facility or Service	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who complete a Table F must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table E.
Table G	Work Force Information	All applicants, regardless of project type or scope, must complete Table G.

Table A

Physical Bed Capacity Before and After Project

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Service Location (Floor/Wing)	Before the Project					After Project Completion					
	Current Licensed Beds	Based on Physical Capacity				Service Location (Floor/Wing)	Location (Floor/ Wing)*	Based on Physical Capacity			
		Room Count			Bed Count			Room Count			Bed Count
		Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
III.7 AND III.7D						III.7 AND III.7D					
				0	0	Second Floor			5	5	14
				0	0	Third Floor			2	2	8
				0	0					0	0
				0	0					0	0
				0	0					0	0
Subtotal III.7 AND III.7D	0	0	0	0	0	Subtotal III.7 and III.7 D		0	7	7	22
RESIDENTIAL						RESIDENTIAL					
III.3 -Second Floor	10		5	5	10					0	0
III.3 -Third Floor	6		2	2	6					0	0
Subtotal Residential	16	0	7	7	16	Subtotal Residential		0	0	0	0
TOTAL	16	0	7	7	16	TOTAL		0	7	7	22
Other *(Specify/add rows as needed)*				0	0	Other *(Specify/add rows as needed)*				0	0
TOTAL OTHER	0	0	0	0	0	TOTAL NON-ACUTE		0	0	0	0
FACILITY TOTAL	16	0	7	7	16	FACILITY TOTAL		0	7	7	22

Table B

Project Budget

TABLE B. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE: Inflation should only be included in the inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds.

	III.7 and III.7D	RESIDENTIAL	TOTAL
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	$0	$0	$0
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	$0	$0	$0
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance			$0
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	$0	$0	$0
TOTAL CURRENT CAPITAL COSTS	$0	$0	$0
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	$0	$0	$0
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees (CON)			$0
d. Legal Fees (Other)			$0
e. Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON)			$0
f. Non-Legal Consultant Fees (Other)			$0
g. Liquidation of Existing Debt			$0
H. Debt Service Reserve Fund			$0
I. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	$0	$0	$0
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	$0	$0	$0
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS			$0
	III.7 and III.7D	RESIDENTIAL	TOTAL
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

* No additional capital expenditures are necessary to implement this project. *

TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY'16**	**FY'17**	**FY'18**	**FY'19**	**FY'20**					
\										
a. Residential	0	0								
b. III.7 and III.7D	0	0	1,740	1,827	1,827					
c. PHP (	911	989								
d. Ambulatory Detox	648	669								
TOTAL DISCHARGES	***1,559***	***1,658***	***1,740***	***1,827***	***1,827***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental		0								
b. III.7 and III.7D	0	0	15,712	16,497	16,497					
c. PHP (Partial Hospitalization) III.3	10,157	11,619								
d. Ambulatory Detox	3,473	3,345								
TOTAL PATIENT DAYS	***13,630***	***14,964***	***15,712***	***16,497***	***16,497***	***0***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	0.0	0.0	0.0	0.0	0.0					
b. III.7 and III.7D	0.0	0.0	9.0	9.0	9.0					
c. PHP III.3 (Partial Hospitalization)	11.1	11.7	0.0	0.0	0.0					
d. Ambulatory Detox	5.4	5.0								
TOTAL AVERAGE LENGTH OF STAY	8.7	9.0	9.0	9.0	9.0					
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation-III.7	52	52	52	52	52					
g. Comprehensive Care										
h. Detox III.7D	13	13	35	35	35					
i. PHP (Partial Hospitalization) III.3	16	16	0	0	0					
TOTAL LICENSED BEDS	***81***	***81***	***87***	***87***	***87***	***0***	***0***	***0***	***0***	***0***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Residential	0.0%	0.0%	0.0%	0.0%	0.0%					
b. III.7 and III.7D	#DIV/0!	#DIV/0!	49.5%	52.0%	52.0%					
c. PHP (Partial Hospitalization) III.3	73.2%	70.5%	0.0%	0.0%	0.0%					
TOTAL OCCUPANCY %	**46.1%**	**50.6%**	**49.5%**	**52.0%**	**52.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Residential										
b. III.7 and III.7D										

Table C
Statistical Projections – Entire Facility

TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY'16	FY'17	FY'18	FY'19	FY'20					
c. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

* In FY'16 + FY'17 Medcaid did not pay 111.7 or 111.7.D levels of care. Therefore, we could not contract with them for these levels, Only 111.3 (Partial Hospitalization) and Ambulatory Detox.

Table D

Revenues & Expenses, Uninflated – Entire Facility

TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table D should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table C and with the costs of Manpower listed in Table G. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instructions in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY'16	FY'17	FY'18	Fy'19	FY'20					
1. REVENUE										
a. Inpatient Services	$ 4,558,924	$ 4,959,339	$ 6,727,889	$ 7,106,238	$ 7,106,238					
b. Outpatient Services	$ 122,061	$ 96,994	$ 106,195	$ 158,909	$ 158,909					
Gross Patient Service Revenues	***$ 4,680,985***	***$ 5,056,333***	***$ 6,834,084***	***$ 7,265,147***	***$ 7,265,147***	$ -	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt	$ 330,346	$ 283,920	$ 202,276	$ 47,115	$ 47,115					
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 4,350,639***	***$ 4,772,413***	***$ 6,631,808***	***$ 7,218,032***	***$ 7,218,032***	$ -	$ -	$ -	$ -	$ -
f. Other Operating Revenues										
Grants	$ 209,800	$ 86,541	***$ 82,102***	***$ 78,600***	***$ 78,600***					
Contributions	$ 7,790	$ 30,779	$ 32,583	$ 4,856	$ 4,856					
Other	$ 7,364	$ 2,667	$ 12,988	$ 12,417	$ 12,417					
NET OPERATING REVENUE	***$ 4,575,593***	***$ 4,892,400***	***$ 6,759,481***	***$ 7,313,905***	***$ 7,313,905***	$ -	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 3,286,182	$ 3,738,634	$ 4,662,284	$ 5,152,603	$ 5,410,233					
b. Contractual Services	$ 135,752	$ 167,106	$ 176,480	$ 180,655	$ 189,688					
c. Interest on Current Debt	$ 3,917	$ 2,351	$ 2,200	$ 2,000	$ 2,000					
d. Interest on Project Debt										
e. Current Depreciation	$ 128,658	$ 148,247	$ 135,091	$ 155,659	$ 163,442					
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 21,404	$ 25,350	$ 26,528	$ 38,201	$ 40,111					
j. Other Expenses (See attached detail)	$ 735,593	$ 765,699	$ 1,756,898	$ 1,784,787	$ 1,508,431					
TOTAL OPERATING EXPENSES	***$ 4,311,506***	***$ 4,847,387***	***$ 6,759,481***	***$ 7,313,905***	***$ 7,313,905***	$ -	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	$ 264,087	$ 45,013	$ -	$ -	$ 0	$ -	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	***$ 264,087***	***$ 45,013***	$ -	$ -	***$ 0***	$ -	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	***$ 264,087***	***$ 45,013***	$ -	$ -	***$ 0***	$ -	$ -	$ -	$ -	$ -

TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table D should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table C and with the costs of Manpower listed in Table G, Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY'16	FY'17	FY'18	Fy'19	FY'20					
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%					
2) Medicaid	41.0%	48.0%	87.0%	87.0%	87.0%					
3) Blue Cross	19.0%	17.0%	7.0%	7.0%	7.0%					
4) Commercial Insurance	14.0%	12.0%	3.0%	3.0%	3.0%					
5) Self-pay	16.0%	15.0%	2.0%	2.0%	2.0%					
6) Other	10.0%	8.0%	1.0%	1.0%	1.0%					
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%					
2) Medicaid	57.0%	65.0%	93.0%	93.0%	93.0%					
3) Blue Cross	19.0%	13.0%	5.0%	5.0%	5.0%					
4) Commercial Insurance	15.0%	14.0%	2.0%	2.0%	2.0%					
5) Self-pay	1.0%	1.0%	0.0%	0.0%	0.0%					
6) Other	8.0%	7.0%	0.0%	0.0%	0.0%					
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Detail of Other Expenses
(From Table D)

	FY'16	FY'17	FY'18	FY'19	FY'20
Food Service	193,149	214,476	317,847	311,143	326,700
Utilites	126,285	132,457	131,277	175,451	184,224
Building maintenance, and security	110,587	121,631	146,747	183,574	192,753
Professional fees	105,421	84,096	85,809	93,333	98,000
Purchase of service	59,952	66,989	68,895	75,908	79,703
Medical supplies	60,444	54,146	68,827	148,562	155,990
Insurance	37,714	43,073	44,711	49,585	52,064
Bank fees	6,392	11,817	9,686	3,909	4,104
Miscellaneous	12,220	12,675	35,170	36,786	38,625
Auto and travel	12,182	11,251	11,397	20,131	21,138
Professional dues	4,186	5,718	5,826	10,231	10,743
Loss on claim	2,369	2,723	-	-	-
Advertising	15	2,707	24,000	51,961	54,559
Staff training	4,677	1,940	5,000	2,093	2,198
Investment Reserve	-	-	801,706	622,120	287,631
Total	735,593	765,699	1,756,898	1,784,787	1,508,431

Table E

Statistical Projects – New Facility or Service

TABLE E. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY'16	FY'17	FY'18	FY'19	FY'20					
1. DISCHARGES										
a. Residential										
b. III.7 and III.7D				264	264					
c. Other (Specify)	192	192	192							
TOTAL DISCHARGES	***192***	***192***	***192***	***264***	***264***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental										
b. III.7 and III.7D				7,920	7,920					
c. Other (Specify)	5,760	5,760	5,760							
TOTAL PATIENT DAYS	***5,760***	***5,760***	***5,760***	***7,920***	***7,920***	***0***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	0.0	0.0	0.0	0.0	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	0.0	0.0	0.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Other (Specify)	30.0	30.0	30.0	0.0	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	30.0	30.0	30.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation										
g. Comprehensive Care				22	22					
h. Other (Specify)	16	16	16							
TOTAL LICENSED BEDS	***16***	***16***	***16***	***22***	***22***	***0***	***0***	***0***	***0***	***0***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Residential	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	98.6%	98.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Other (Specify)	98.6%	98.6%	98.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	***98.6%***	***98.6%***	***98.6%***	***98.6%***	***98.6%***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***
6. OUTPATIENT VISITS										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

Table F

Revenue & Expenses, Uninflated – New Facility or Service

TABLE F. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table F should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table E and with the costs of Manpower listed in Table G. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.

Indicate CY or FY	FY'19	FY'20						
1. REVENUE								
a. Inpatient Services	$ 2,032,281	$ 2,032,281						
b. Outpatient Services								
Gross Patient Service Revenues	**$ 2,032,281**	**$ 2,032,281**	$ -	$ -	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt								
d. Contractual Allowance								
e. Charity Care								
Net Patient Services Revenue	**$ 2,032,281**	**$ 2,032,281**	$ -	$ -	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify)								
NET OPERATING REVENUE	**$ 2,032,281**	**$ 2,032,281**	$ -	$ -	$ -	$ -	$ -	$ -
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 1,476,631	$ 1,550,462						
b. Contractual Services	$ 70,371	$ 73,890						
c. Interest on Current Debt	$ -	$ -						
d. Interest on Project Debt								
e. Current Depreciation	$ 16,500	$ 17,325						
f. Project Depreciation								
g. Current Amortization								
h. Project Amortization								
i. Supplies	$ 9,081	$ 9,535						
j. Other Expenses (See attached)	$ 222,296	$ 233,411						
TOTAL OPERATING EXPENSES	**$ 1,794,879**	**$ 1,884,623**	$ -	$ -	$ -	$ -	$ -	$ -
3. INCOME								
a. Income From Operation	**$ 237,402.00**	**$ 147,658.00**	$ -	$ -	$ -	$ -	$ -	$ -
b. Non-Operating Income								
SUBTOTAL	**$ 237,402.00**	**$ 147,658.00**	$ -	$ -	$ -	$ -	$ -	$ -
c. Income Taxes								
NET INCOME (LOSS)	**$ 237,402.00**	**$ 147,658.00**	$ -	$ -	$ -	$ -	$ -	$ -
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare								
2) Medicaid	100.0%	100.0%						
3) Blue Cross								
4) Commercial Insurance								
5) Self-pay								

TABLE F. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table F should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table E and with the costs of Manpower listed in Table G. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	**FY'19**	**FY'20**					
6) Other							
TOTAL	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Other Expenses
(From Table F)

	FY'19	FY'20
Food Service	70,009	73,509
Utilities	47,648	50,030
Building maintenance, and security	24,511	25,735
Professional fees	15,710	16,496
Purchase of service	16,993	17,842
Medical supplies	16,924	17,769
Insurance	11,028	11,579
Bank fees	1,174	1,232
Miscellaneous	5,653	5,941
Auto and travel	957	1,005
Professional dues	893	938
Advertising	10,072	10,575
Staff training	724	760
Total	222,296	233,411

TABLE G. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost (should be consistent with projections in Table D, if submitted).	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost (should be consistent with projections in Table D)
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Executives	5.6	$100,451	$562,526			$0			$0	5.6	$562,526
Billing	3.0	$48,505	$145,515			$0			$0	3.0	$145,515
Accounting	2.0	$38,366	$76,732			$0			$0	2.0	$76,732
Compliance	1.0	$34,549	$34,549			$0			$0	1.0	$34,549
Admissions	6.0	$35,149	$210,894							6.0	
Total Administration	17.6		$1,030,216	0.0		$0			$0	17.6	$1,030,216
Direct Care Staff *(List general categories, add rows if needed)*											
Addiction Counselors	10.0	$46,511	$465,110			$0			$0	10.0	$465,110
Mental Health Counselor	1.0	$62,550	$62,550			$0			$0	1.0	$62,550
Out Patient	2.3	$47,124	$108,385			$0			$0	2.3	$108,385
Nurses	35.2	$44,322	$1,560,134	3.0	$46,538	$139,614			$0	38.2	$1,699,749
Total Direct Care	48.5		$2,196,180	3.0		$139,614			$0	51.5	$2,335,794
Support Staff *(List general categories, add rows if needed)*											
Out Patient Driver	0.6	$14,976	$8,986			$0			$0	0.6	$8,986
Cooks	8.4	$27,516	$231,134			$0			$0	8.4	$231,134
Housekeeping	3.0	$36,213	$108,639			$0			$0	3.0	$108,639
Maintenance	2.0	$46,582	$93,164			$0			$0	2.0	$93,164
Treatment Aides	19.0	$28,015	$532,285	3.0	$29,416	$88,247				22.0	
Total Support	33.0		$974,208	3.0		$88,247			$0	36.0	$1,062,455
REGULAR EMPLOYEES TOTAL	99.1		$4,200,603	6.0		$227,862			$0	105.1	$4,428,465
2. Contractual Employees											
Medical Doctor	1.0	$50,000	$50,000	0.2	$50,000	$10,000			$0	1.2	$60,000
Nurse Practicioner	2.0	$41,600	$41,600	0.5	$41,600	$20,800			$0	2.5	$62,400
Psychiatric Nurse Practicioner	1.0	$70,720	$70,720	0.4	$70,720	$28,288			$0	1.4	$99,008
			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL	4.0		$162,320	1.1		$59,088			$0	5.1	$221,408
Benefits *(State method of calculating benefits below)*:											
Based on percentage of salaries											
TOTAL COST	103.1		$4,362,923	7.1		$286,950	0.0		$0		$4,649,873

* Differences between total costs shown on Table G and Table D are due to benefits costs.