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February 14, 2019

VIA EMAIL & REGULAR MAIL

Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Baltimore Detox Center
Matter No. 18-03-2419

Dear Mr. McDonald:

Provided below please find the responses of Baltimore Detox Center ("BDC") to the "Interested Party Comments of Maryland House Detox on the Modified CON Application for Baltimore Detox Center" (the "Comments") filed by Maryland House Detox ("MHD") on January 18, 2019. Before responding to the Comments, BDC would like to point out that MHD's comments which are not related to the "changes" in the modified application are impermissible pursuant to COMAR 10.24.01.08 E.(3)(a)(ii). Therefore, BDC respectfully requests that MHD's latest comments which are not related to such modification should be excluded from the record of this review and consideration of the Commission. Nevertheless, in the absence of the requested ruling that the MHD's comments addressing perceived deficiencies of the docketed BDC application unrelated to the substance of the modification will not be included in the record, BDC is compelled to rebut MHD's comments that the BDC application is "fatally flawed" and should not be approved.

COMAR 10.24.01.08(G)(3)(a): State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

In order to be approved for a Certificate of Need, an applicant must demonstrate that its project is consistent with COMAR 10.24.01.08(G)(3)(a), the State Health Plan ("SHP"). The applicable chapter of the State Health Plan for the project to establish and operate the proposed Baltimore Detox Center ("BDC") is found at COMAR 10.24.14, State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services.

MHD states in its comments that the modified application for the BDC is "fatally flawed" and should not be approved by the Commission because BDC, (1) "has provided information that conflicts with its own previous and current submissions," (2) does not meet the definition of an Intermediate Care Facility, (3) has asserted an average length of stay that is "in direct conflict with the SHP and MHCC," and (4) is inconsistent with COMAR 10.24.14.05(M) – Sub-acute

Detoxification. (Interested Party Comments of Maryland House Detox on the Modified CON Application for Baltimore Detox Center Docket No. 18-03-2419).

RESPONSE: MHD's Comments are beyond the scope of what is permissible.

The modification to the docketed CON Application submitted on January 9, 2019 proposed only two changes: (i) an increase in the number of proposed FTEs and (ii) an increase in expenses to account for such increase, as explained herein. First, the application was modified to increase the number of proposed FTEs budgeted for the position of "Case Manager" from one to two, and to add one "Nurse Practitioner" as a Contractual Employee. Second, BDC acknowledged that these additions to the BDC workforce proposed for CY 2023 is a change which will add to the projected expenses of the facility above those previously included in the docketed application. For this reason, revised tables also were submitted which continue to show that the income projected for the BDC in its second full year of operation continues to demonstrate its financial feasibility and consistency with applicable State Health Plan standards.

Despite the fact that no other changes to the docketed BDC application were made addressing the number of beds, levels of care, length of stay, CARF accreditation or other assumptions related to the operation of the BDC, MDC has taken the impermissible opportunity to offer additional comments on the BDC application's perceived deficiencies unrelated to the submitted modification to add employees. These impermissible comments cite information which was already in the record because such information (i) was included in the docketed BDC application and available for comment by MHD, or (ii) provided to the Commission by BDC (letter Jacobs to McDonald, January 10, 2019) responding to MHD's previously submitted December 21, 2018 comments. Other than the modification to add to the proposed workforce of BDC, neither the docketed CON application, nor BDC's responses to the MDC comments contain information that is "fair game" to MHD in making the additional comments found in the January 18, 2019 submission.

Pursuant to MHCC regulations at COMAR 10.24.01.08 E.(3)(a)(ii), the 10 day comment period is provided after the modification is posted so that parties may provide "comments on the changes." MHD's latest comments are clearly beyond the scope of the "changes", *i.e.*, information related solely to the modification and should therefore be excluded from the record of this review and consideration of the Commission

RESPONSE: BDC's modification by definition in part conflicts with its own previous and current submissions.

BDC acknowledges that its proposed modification provides new information on the record related to the increases in staffing of its proposed facility. By definition, this change in the proposed numbers and make-up of the workforce to BDC's docketed application will "conflict" with the information previously submitted and included in the docketed application. Hence, although the documentation that was submitted includes revised tables for the Commission's review, the revisions relate solely to the staffing changes referenced above. MHD's comments describing the perceived conflicts in the BDC application do not relate to the modified application, but rather to information that was previously submitted to the MHCC in its docketed

application and available to MHD well before January 18, 2019, or in BDC's January 10, 2019 response to MHD's interested party comments of December 21, 2018, neither of which is "fair game" for MHD's additional comments submitted on January 18, 2019. In this case, MHD cannot take a "second bite of the apple" and submit additional comments on BDC's modified application related to previously submitted information in the docketed CON application not related to the additional staffing, or to rebut information submitted by BDC in its response to MHD's interested party comments submitted on December 21, 2019.

Nevertheless, and as stated above, in the absence of the requested ruling that the MHD's comments addressing perceived deficiencies of the docketed BDC application unrelated to the substance of the modification will not be included in the record, BDC is compelled to rebut MHD's comments that the BDC application is "fatally flawed" and should not be CON approved.

RESPONSE: BDC proposes to be an Intermediate Care Facility.

First, the CON application submitted by BDC to establish and provide alcoholism and drug abuse intermediate care treatment services clearly spells out its intentions and qualifications to be a Track One, CARF accredited, 24-bed intermediate care facility licensed by the Maryland Department of Health to provide a full-range of inpatient care, including sub-acute detox services.

The definition of an Intermediate Care Facility is spelled out unambiguously in the State Health Plan at COMAR 10.24.14.08B.(13):

> "Intermediate care facility" means a facility designed to facilitate the subacute detoxification and rehabilitation of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide.

All of the information in the record of this review confirms that BDC will provide the facility, staffing and necessary resources to adequately treat the projected number of its future patients in its ICF. The specific operational capabilities of the BDC correspond directly to the CARF-accreditation standards that it intends to meet, including but not limited to, Residential Treatment, Inpatient Treatment and Detoxification/Withdrawal Management programs. In order to provide such programs, BDC will be licensed by the Maryland Department of Health ("MDH") as an ICF and must maintain its CARF accreditation in good standing.

RESPONSE: State licensing regulations require that BDC obtain a Certificate of Need because it will be providing Level III 7 Residential and Withdrawal Management services.

A copy of the MDH application form set of the Behavioral Health Administration ("BHA") is attached which indicates that a Residential-Intensive Inpatient Level 3.7 Program

requires a Certificate of Need. (See Attachment 1) BDC will operate both a residential-Intensive Level 3.7 Program and provide Withdrawal Management Services within that program. Its 24 beds will be available to treat 24 adults at 100% bed capacity, but realistically projects an average daily census of 21 patients by the second full year of its operation.

RESPONSE: The average length of stay assumption of 14 days is applicable to the State Health Plan bed need methodology for adults in Track One ICF facilities and does not conflict with the average length of stay assumption of 28 days for the services and levels of care to be provided at the BDC.

Because the BDC will be providing both a Residential Level 3.7 program and Withdrawal Management Services to its future patients, the proposed 28-day average length of stay assumption is reasonable and not in conflict with the State Health Plan. The State Health Plan at COMAR 10.24.14.07 B. sets forth a Bed Need Methodology for Intermediate Care Private Bed Need (Track One). This methodology, as updated by BDC, projects a significant unmet need for additional ICF beds in Central Maryland in 2020, which includes Baltimore County where the proposed BDC will be located. The method of calculation for private beds is found at COMAR10.24.14.07 B.(7) (g) which calculates the gross number of adolescent and adult intermediate care beds required by multiplying the total number of persons requiring intermediate care by a 22-day average length of stay for adolescents and a 14-day average length of stay for adults. BDC's update of the Bed Need methodology incorporated the 14-day length of stay assumption for adults consistent with the State Health Plan (See CON Application, p. 17).

Because BDC is proposing to provide Withdrawal Management Services for 10 days on average to its projected patients upon admission, an overall average length of stay of 14 days will be programmatically insufficient for its patients. BDC has assumed that 14 additional days of Level III.7 services will be needed to assure that patients are afforded the best opportunity to achieve their rehabilitation and treatment goals in the inpatient residential setting of the BDC prior to discharge. To clarify BDC's assumptions regarding average length of stay for the two ICF levels of care to be provided, BDC has re-labeled the average length of stay for the days of care to be provided by BDC at TABLE C. Statistical Projections – Entire Facility (See Attachment 2).

BDC believes in and promotes the availability and utilization of a 28-day continuum of care between levels 3.7-WM and 3.7 inpatient treatment. This continuum provides a longer structured care plan allowing an individual to stabilize in a highly structured environment promoting long term recovery. Aside from the structured environment, providing an individual more time to plan an appropriate discharge with clinical staff can ensure an individual completing a 28-day treatment stay to reintegrate back into life and society with secure aftercare.

BDC staff also has found that some outpatient providers have waiting lists. Under these circumstances, a short-term inpatient stay can possibly leave the individual patient who is otherwise ready for discharge without coordinated care for days, even weeks. BDC's 28-day inpatient program is multifaceted and flexible and provides the necessary resources for an individual's continuing journey from inpatient care to long term recovery.

RESPONSE: The program plan and levels and mix of staff resources proposed by the BDC in the modification are entirely consistent with COMAR 10.24.14.05(M) – Sub-acute Detoxification.

Despite the fact that the modification to the BDC CON Application increases (emphasis added) its proposed staffing, MHD continues to argue that BDC's proposed program of subacute detoxification/withdrawal management services is deficient with respect to this State Health Plan standard. BDC hesitates to repeat the same response to MHD's comments that were provided to the Commission on January 10, 2019 which explained specifically how the subacute care detoxification services would be provided at BDC, what clinical personnel would be available to BDC's patients, and how BDC's capabilities are not significantly different than those proposed and CON-approved by the Commission for MHD in 2016. Nevertheless, cited below are the same responses provided to rebut MDC incorrect assertions regarding BDC consistency with the State Health Plan standard addressing subacute detoxification services:

1. BDC does not propose to have a caseload of 24 patients requiring sub-acute detox services.

> First, please take note that BDC is not proposing to treat 24 patients per day requiring subacute detoxification as assumed by the Comments of MHD.
>
> BDC proposes to commence operations and begin to admit and treat patients in CY 2019 and projects that by CY 2022, the second full year of utilization, BDC will discharge 275 patients following an average length of stay of 28 days which represents an average of between five and six new patients per week. See chart below. This projected volume of patients is well within the capabilities of the proposed workforce of BDC. While BDC has a physical capacity of 24 beds, the BDC staffing plan is designed to address the actual projected patient day utilization in CY 2022 which is an average daily census of 21 total patients: between 7 and 8 patients are projected to require sub-acute detoxification services and between 13 and 14 patients will be receiving residential services.

2. The State Health Plan standard applies to Sub-acute Detoxification services only. (emphasis added).

3. The standard does not apply to any other ICF service, bed or levels of care to be provided at BDC.

4. Even if BDC were to find itself with an inpatient patient census of 24 patients admitted for Sub-acute Detoxification services (a highly unlikely possibility), its staffing levels and mix of qualified medical, nursing and other clinical professionals would be sufficient to meet any and all applicable standards, including standards found at

COMAR 10.47.02 and COMAR 10.63.03.14 for the Residential and Detoxification/Withdrawal Management Services BDC proposes to provide (see Attachment 3)

Shown below is a chart which illustrates the proposed staffing pattern necessary to provide Subacute Detoxification Services in the BDC consistent with State regulations and CARF accreditation standards.[1] The chart assumes a patient census at 100% bed capacity over three shifts every day for an entire month.

2019 JANUARY MONDAY

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
31	01 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	02 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	03 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	04 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	05 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	06 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT
07	08 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	09 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	10 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	11 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	12 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	13 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT
14	15 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	16 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	17 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	18 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	19 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	20 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT
21	22 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	23 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	24 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	25 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	26 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	27 Shift 1-RN, NP, CSC, 2 BHT Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT
28	29 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	30 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	31 Shift 1-RN, DON, CSC, THER, 2 BHT, MD, CD Shift 2-2 RN, 2 BHT Shift 3-2 RN, 2 BHT	01	02	03

[1] See e.g., Midwest Detox Center in Maumee, OH is an owned and operated Amatus Facility fully accredited by CARF to provide inpatient sub-acute detox and inpatient treatment for adults. https://www.midwestdetoxcenter.com/; https://www.naatp.org/resources/addiction-industry-directory/20064/midwest-detox-center-llc

Shift 1 – Shift One is comprised of multiple clinical and medical staff consistent with the applicable Maryland regulations found at COMAR 10.47.02 and COMAR 10.63.03.14., which require 1 RN must be on shift 40 hours/week. BDC's staffing plan for Shift 1 has 2 RNs Monday-Friday with 1 RN Sat-Sun, 1 RN and the contracted NP the MD on shift 40 hours Mon-Fri and the NP on shift Sat-Sun to provide for the needed medical services for patients in detox level of care and inpatient residential level of care, with the understanding that there may be after hours phone calls to address concerns. Three counseling staff members (CSC, THER) provide sufficient coverage for a 1:8 patient/counselor ratio. The CSC schedules are designed to assure sufficient counseling staff on site seven days per week and provide an added amount of available time to care for patients, and to assure that assessment, treatment and discharge planning is effective.

Shift 2 – Shift Two is comprised of 2 RNs and 2 BHT. In addition, a CSC may be scheduled for a "swing shift" from 12 – 8 pm some evenings to assist in evening programming. The 2 RNs on shift between the hours of 7 pm – 7 am is consistent with regulations which require for a staff trained in CPR to be on shift between the hours of 11 pm and 7 am. This staffing plan exceeds the regulatory requirement for one RN on shift at all times.
Shift 3 – Shift Three continues the staffing pattern of Shift Two.

SUMMARY

In summary, the Commission should recognize that the comments submitted by MHD on January 18, 2019 are by and large an effort to supplement its previously submitted comments from December 21, 2018. MDC's comments on the modified BDC CON application which addresses the level and mix of staffing necessary for BDC to provide the full range of services to its future patients is "fair game" for MHD. For this reason, both the modifications and MDC's comments on the staffing <u>increases</u> proposed by BDC should become part of the record in this review and should be given the weight they deserve by the Commission. All other comments presented by MHD on aspects of the BDC application that do not involve the modification should be stricken from the record, ignored, and given no weight whatsoever.

Sincerely,

Carolyn Jacobs

Carolyn Jacobs

cc: William D. Chan
Health Policy Analyst

Ruby Potter
Administrator
Health Facilities Coordinator

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ATTACHMENT 1

3) APPLICATION TYPE: Please check all program and/or service types that apply. Program/service types marked with an (*) do not require accreditation in order to receive a license for that particular program/service type *(COMAR 10.63.05.03)*. All other program/service types require accreditation in order to receive a license *(COMAR 10.63.02.02)*. "Capacity" means the total number of individuals that a program can accommodate. This section must be completed for **each physical site**, except for residential rehabilitation program sites with three or fewer beds.

Program Address: Insert Street Address Insert City, State, Zip	**County/Baltimore City:** **Capacity**			
	# Beds	**# Adults**	**# Adolescents**	**# Children**
☐ DUI Education Program *(COMAR 10.63.05.05)**				
☐ Early Intervention Level 0.5 Program *(COMAR 10.63.05.06)**				
☐ Group Homes for Adults with Mental Illness *(COMAR 10.63.04.03)*				
☐ Integrated Behavioral Health Program *(COMAR 10.63.03.02)*				
☐ Intensive Outpatient Treatment Level 2.1 Program *(COMAR 10.63.03.03)*				
☐ Mobile Treatment Services Program (MTS) *(COMAR 10.63.03.04)*				
☐ Opioid Treatment Services *(COMAR 10.63.03.19)*				
☐ Outpatient Mental Health Center (OMHC) *(COMAR 10.63.03.05)*				
☐ Outpatient Treatment Level 1 Program *(COMAR 10.63.03.06)*				
☐ Partial Hospitalization Treatment Level 2.5 Program *(COMAR 10.63.03.07)*				
☐ Psychiatric Day Treatment Program (PDTP) *(COMAR 10.63.03.08)*				
☐ Psychiatric Rehabilitation Program for Adults (PRP-A) *(COMAR 10.63.03.09)*				
☐ Psychiatric Rehabilitation Program for Minors (PRP-M) *(COMAR 10.63.03.10)*				
☐ Residential Crisis Services Program (RCS) *(COMAR 10.63.04.04)*				

3) Application Type: ***Continued***

	Capacity			
	# Beds	# Adults	# Adolescents	# Children
☐ Residential- Low Intensity Level 3.1 Program *(COMAR 10.63.03.11)*				
☐ Residential- Medium Intensity Level 3.3 Program *(COMAR 10.63.03.12)*				
☐ Residential-High Intensity Level 3.5 Program *(COMAR 10.63.03.13)*				
☑ Residential-Intensive Inpatient Level 3.7 Program *(COMAR 10.63.03.14)(Requires Certificate of Need)*	24	24		
☐ Residential Rehabilitation Program (RRP) *(COMAR 10.63.04.05)*				
☐ Respite Care Services Program (RPCS) *(COMAR 10.63.03.15)*				
☐ Substance-Related Disorder Assessment and Referral Program *(COMAR 10.63.05.14)**				
☐ Supported Employment Program (SEP) *(COMAR 10.63.03.16)*				
☑ Withdrawal Management Service *(COMAR 10.63.03.18)*		24		

ATTACHMENT 2

TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY Revised

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.

TABLE C. STATISTICAL PROJECT	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			2019	2020	2021	2022				
1. DISCHARGES										
a. III,7 Residental										
b. III.7D										
c. Other (Specify/add rows of needed)										
*TOTAL DISCHARGES**	*0*	*0*	*167*	*236*	*260*	*275*	*0*	*0*	*0*	*0*
2. PATIENT DAYS										
a. III,7 Residental			2,830	4,240	4,670	4,950				
b. III.7D			1,570	2,360	2,600	2,750				
c. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	*0*	*0*	*4,400*	*6,600*	*7,270*	*7,700*	*0*	*0*	*0*	*0*
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. III,7 Residental			18.0	18.0	18.0	18.0				
b. III.7D			10.0	10.0	10.0	10.0				
c. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY			28.0	28.0	28.0	28.0				
4. NUMBER OF LICENSED BEDS										
a. III,7 Residental			14	14	14	14				
b. III.7D			10	10	10	10				
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	*0*	*0*	*24*	*24*	*24*	*24*	*0*	*0*	*0*	*0*
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. III,7 Residental			55.4%	83.0%	91.4%	96.9%				
b. III.7D			43.0%	64.7%	71.2%	75.3%				
c. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %			*50.2%*	*75.3%*	*83.0%*	*87.9%*				
6. OUTPATIENT VISITS										
a. III,7 Residental										
b. III.7D										
c. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

* Includes discharges for patients who receive some combination of detox and residential services during an average stay.

ASSUMPTIONS:

1. BDC will commence operations during April, 2019.
2. ALOS comprises of both detox and intensive inpatient services.

ATTACHMENT 3

.09 Residential Services — Medically Monitored Intensive Inpatient Treatment Level III.7.

A. Program Description. A medically monitored intensive inpatient treatment program shall:

(1) Offer a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting;

(2) Act as an Intermediate Care Facility Type C/D; and

(3) Meet the certification requirements for detoxification services as described in COMAR 10.47.02.10E.

B. Patients who are appropriate for this level of treatment:

(1) Meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.7, or its equivalent as approved by the Administration; and

(2) Require 24-hour monitoring and care for subacute biomedical and emotional or behavioral conditions severe enough to warrant inpatient treatment.

C. Staffing. A program shall have:

(1) Appropriately credentialed staff as described in COMAR 10.47.01.06;

(2) Staffing which allows for detoxification and can provide services necessary for treatment of coexisting medical, emotional, or behavioral problems that could interfere with recovery;

(3) A patient to alcohol and drug counselor ratio not exceeding eight patients for one full-time alcohol and drug counselor;

(4) On-site physician, physician assistant, or nurse practitioner coverage available to provide initial assessment and documented referral for care, and to monitor progress in treatment;

(5) A physician on call 24 hours a day;

(6) Nursing services, between 7 a.m. and 11 p.m., 7 days a week, including:

(a) 8 hours a day, 5 days a week coverage by a registered nurse; and

(b) The remainder of coverage by a licensed practical nurse; and

(7) At least two employees on duty between the hours of 11 p.m. and 7 a.m., 7 days a week, trained in crisis management and cardiopulmonary resuscitation.

D. Program Services. A program shall provide:

(1) An assessment as described in COMAR 10.47.01.04 within 2 days of admission;

(2) An individualized treatment plan as described in COMAR 10.47.01.04C completed and signed by the alcohol and drug counselor and patient within 7 working days of the comprehensive assessment with a treatment plan update completed every 7 days;

(3) A minimum of 36 hours of therapeutic activities a week including, but not limited to:

(a) A minimum of one weekly individual counseling session;

(b) Group counseling;

(c) Alcohol and drug education;

(d) Nutrition education;

(e) Weekly family sessions; and

(f) Case management.

E. Medically Monitored Services.

(1) Nursing Services. Services shall include:

(a) An assessment at the time of the patient's admission, including a mental health focused assessment:

(i) Approved by the registered nurse and program physician;

(ii) Completed by qualified staff; and

(iii) Overseen by a registered nurse for patients admitted with any prescribed medication; and

(b) Medication monitoring conducted by:

(i) The registered nurse or overseen by the registered nurse in conjunction with the program's physician; and

(ii) Qualified nursing staff for patients who are admitted on or are prescribed any medications.

(2) Physician, Physician Assistant, or Nurse Practitioner Services.

(a) A physician, physician assistant, or nurse practitioner shall:

(i) Assess a patient within 24 hours of admission; and

(ii) Continue to assess the patient as is medically necessary after the first 24 hours of admission.

(b) A physician, physician assistant, or nurse practitioner shall conduct a physical examination of a patient within 96 hours of admission to the program.

(c) A physician or physician assistant shall assess a patient undergoing detoxification within 24 hours of admission or earlier if it is medically necessary to conduct the assessment in less than 24 hours.

(d) A physician or physician assistant shall provide on-site monitoring and further evaluation of patients undergoing detoxification on a daily basis, if medically necessary.

(e) A physician or physician assistant shall be available by telephone at all times to consult about patients undergoing detoxification.

F. Documentation. A designated clinical staff shall write a patient progress note at the end of each day services are provided and place the progress note in the patient's record.

G. Referral Services. The program shall offer the following services or maintain a listing of agency referral agreements for the following services:

(1) Services through the Division of Rehabilitation Services;

(2) Vocational assistance;

(3) Mental health services;

(4) Substance abuse treatment programs;

(5) Legal assistance; and

(6) Social services.

10.47.02.10

.10 Detoxification Services.

A. Description of Services. A detoxification program shall provide services to an intoxicated patient by:

(1) Monitoring the decreasing amount of psychoactive substances in the body;

(2) Managing the withdrawal symptoms; and

(3) Motivating the individual to participate in an appropriate treatment program for alcohol or other drug dependence.

B. A detoxification program shall:

(1) Avoid potentially harmful consequences of withdrawal from alcohol and drug dependence as medically possible;

(2) Provide a space to house and observe patients suffering from withdrawal symptoms;

(3) Ease physical discomfort during the withdrawal process; and

(4) Facilitate transition to a treatment continuum of care which may include:

(a) Ongoing alcohol or drug treatment in a residential or outpatient treatment program;

(b) Referral to mental health treatment; and

(c) Referral to self-help recovery programming.

F. Level III.7-D Medically Monitored Inpatient Detoxification.

(1) Description of Services.

(a) Medically monitored inpatient detoxification services offer 24-hour medically supervised evaluation and withdrawal management by medical professionals at an inpatient facility and may be offered with therapeutic community or medically monitored intensive inpatient treatment.

(b) This is an Intermediate Care Facility/C.

(2) Patients who are appropriate for this level of treatment:

(a) Meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Administration, for this level of treatment; and

(b) Are intoxicated, show physical signs of withdrawal, or both.

(3) Staffing. A program:

(a) Shall employ appropriately credentialed staff as described in COMAR 10.47.01.06;

(b) May not have a patient to alcohol and drug counselor ratio that exceeds eight patients to one full-time alcohol and drug counselor if counseling services are available;

(c) Shall have on-site physician, physician assistant, or nurse practitioner coverage available to provide initial assessment and documented referral for care, and to monitor progress in treatment;

(d) Shall have a physician, physician assistant, or nurse practitioner on call 24 hours a day; and

(e) Shall have nursing services during all hours of service, including at least 8 hours of service provided by a licensed registered nurse.

(4) Program Services. A program shall provide the following services:

(a) Nursing assessment upon admission;

(b) Physical examination by a medical doctor, physician assistant, or nurse practitioner within 24 hours of admission;

(c) An assessment as described in COMAR 10.47.01.04;

(d) Individualized treatment plan appropriate to a short term detoxification treatment regimen;

(e) Discharge or transfer planning as described in COMAR 10.47.01.04;

(f) Monitoring of vital signs;

(g) Administering of medication, as necessary; and

(h) Adjunct services, which may include:

(i) Basic alcohol and drug education;

(ii) Family services; and

(iii) Motivational counseling.

(5) Documentation. Designated clinical staff shall write a patient progress note at the end of each day services are provided and place the progress note in the patient's record.

(6) Referral Services. The program shall offer or have available through referral the following:

(a) Medical, psychological, and psychiatric consultation;

(b) Laboratory services;

(c) Transportation services; and

(d) Substance abuse or dependence and mental health treatment programs.

(7) A program shall have a written agreement with a nearby hospital to provide necessary emergency medical support services. This agreement shall include:

(a) An emergency protocol describing the manner in which patients are referred to the hospital and provided appropriate care;

(b) Cooperative arrangements that specifically assign responsibility to provide transportation;

(c) The manner in which hospital on-call coverage is provided;

(d) A mechanism to provide psychiatric evaluation, if necessary;

(e) A prescreening protocol for patients referred to the inpatient detoxification program from the hospital; and

(f) A written protocol for the transfer of a patient to continued treatment.

(8) Patients Treated with Opioid Maintenance Medication.

(a) A detoxification facility is not limited in the number of admissions for detoxification of patients who are treated with opioid maintenance medication.

(b) A detoxification facility is not limited in the total number of doses of opioid maintenance medication that it will accept from patients who:

(i) Attend the detoxification program; and

(ii) Require opioid maintenance medication for opioid detoxification or detoxification for substances other than opioids