**Capital BlueCross**
**INPATIENT DETOXIFICATION FACILITY SURVEY**

**Provider Name:** ______________________________
**CBC #:** ______________ **Medicare #:** ______________ **Medicaid #:** ______________
**Accrediting Organization:** ______________ **Date of most recent accrediting survey:** ______________
**Person completing survey:** ______________ **Phone:** ______________ **Date:** ______________
**Contact person (if different than above):** ______________ **Phone:** ______________

**Directions: Please complete each line with appropriate information.**
**Where applicable please indicate with a check mark (✓).**

# ADMINISTRATION

Medical Detox ☐ Yes ☐ No
Non-Medical Detox ☐ Yes ☐ No
Number of Beds: ______________
Average daily census: ______________
Average Length of Stay: ______________
Most Frequent Diagnosis: ______________
Written policy for treatment of minors ☐ Yes ☐ No
Handicap accessible ☐ Yes ☐ No
Emergency medications/supplies available ☐ Yes ☐ No
Written policy for checking emergency meds/supplies: ☐ Yes ☐ No
Written plan for patient medical emergency ☐ Yes ☐ No
Written plan for patient pyschiatric emergency ☐ Yes ☐ No
Written transfer agreement to acute care ☐ Yes ☐ No
If **yes**, list facilities: ______________

______________

______________

Written agreement for emergency transport ☐ Yes ☐ No
If **no**, access to 911 ☐ Yes ☐ No
Written on-call policy ☐ Yes ☐ No
Written confidentiality policy ☐ Yes ☐ No
Smoke-Free Facility ☐ Yes ☐ No

# QUALITY MANAGEMENT

***Quality Activities***

Written Performance Improvement Program ☐ Yes ☐ No
Performance Improvement Committee ☐ Yes ☐ No
Frequency of meetings: ______________
Position accountable for Performance Improvement activity: ______________

Quality Reports forwarded to the Board of Directors ☐ Yes ☐ No
List two current Quality Studies:
1. ______________
2. ______________

Written Infection Control policies ☐ Yes ☐ No
If **yes**, includes communicable diseases ☐ Yes ☐ No

***Patient Satisfaction***

Patient Satisfaction Surveys utilized ☐ Yes ☐ No
Most frequent issues identified:
1. ______________
2. ______________

Annual return rate for surveys: ______________ %
Written patient/family complaint process ☐ Yes ☐ No

***Clinical Management***

Provider Name:

Written policy on maintenance and retention of patient records: ☐ Yes ☐ No

Written admission criteria ☐ Yes ☐ No

Written discharge criteria ☐ Yes ☐ No

Voluntary ☐ Yes ☐ No

Involuntary ☐ Yes ☐ No

Formal level of care criteria utilized for:

Admission ☐ Yes ☐ No

Continued stay ☐ Yes ☐ No

Criteria used:

PCPC ☐ Yes ☐ No

ASAM ☐ Yes ☐ No

Timeframe for completion of physical exam: ______________

Timeframe for completion of nursing assessment: ______________

Timeframe for development of treatment plan: ______________

Written policy for treatment plan updates ☐ Yes ☐ No

Written policy for obtaining vital signs ☐ Yes ☐ No

Clients on pharmacotherapy to enhance stabilization: ______________ %

Type: ______________

Written restraint policy ☐ Yes ☐ No

Written policy for other agency referrals ☐ Yes ☐ No

Written aftercare plan provided to patient/family ☐ Yes ☐ No

Written policy for patient follow-up ☐ Yes ☐ No

***Patient Education/Public Health***

Patient/Family education ☐ Yes ☐ No

Education materials distributed to patients/family ☐ Yes ☐ No

Clinical pathways/standardized care plans utilized ☐ Yes ☐ No

Indicate number of pathways/care plans developed: ______________

Services for hearing impaired ☐ Yes ☐ No

Services for speech impaired ☐ Yes ☐ No

Services for visually impaired ☐ Yes ☐ No

Bilingual services ☐ Yes ☐ No

Bilingual patient education materials ☐ Yes ☐ No

Languages offered: ______________

***Data Collection***

Transfers to IP Substance Abuse rehab ☐ Yes ☐ No

Transfers to Acute Care ☐ Yes ☐ No

Administrative Discharges ☐ Yes ☐ No

AMA Discharges ☐ Yes ☐ No

Readmissions ☐ Yes ☐ No

Average Length of Stay ☐ Yes ☐ No

Other, please list: ______________

# STAFF

Written policy for credentialing of:

Physicians ☐ Yes ☐ No

Nurses ☐ Yes ☐ No

Allied Health ☐ Yes ☐ No

Written policy for re-credentialing of:

Provider Name:

Physicians ☐ Yes ☐ No

Nurses ☐ Yes ☐ No

Allied Health ☐ Yes ☐ No

Written policy for verification of licensure/certification of staff ☐ Yes ☐ No

Written policy for verification of education/training of staff ☐ Yes ☐ No

Clinical Competency Evaluation ☐ Yes ☐ No

Frequency: ____________________

Annual performance evaluation of staff ☐ Yes ☐ No

Minimum number of educational programs annually attended by staff: ____________________

Written policy addressing the following for clinical staff:

Recovery ☐ Yes ☐ No

Abstinence ☐ Yes ☐ No

Relapse ☐ Yes ☐ No

Medical Director ☐ Yes ☐ No

Name: ____________________

☐ Full Time ☐ Part Time

☐ Employed ☐ Contracted

Board Certified ☐ Yes ☐ No

Specialty: ____________________

Physician on-call 24 hrs/day ☐ Yes ☐ No

***Nursing Staff***

Nurses onsite 24 hrs/day ☐ Yes ☐ No

__________ # of Registered Nurses

__________ # of Licensed Practical Nurses

Minimum number of nurses on each shift:

__________ 7 a.m. – 3 p.m.

__________ 3 p.m. – 11 p.m.

__________ 11p.m. – 7 a.m.

Minimum number of staff on each shift:

__________ 7 a.m. – 3 p.m.

__________ 3 p.m. – 11 p.m.

__________ 11p.m. – 7 a.m.

***Other Staff***

__________ # of Certified Addiction Counselors

__________ # of Bachelor prepared counselors

__________ # of Masters prepared counselors

Bioengineering specialist ☐ Yes ☐ No

Degreed ☐ Yes ☐ No

Trained ☐ Yes ☐ No

List other: ____________________

__________ Staff to patient ratio

Written policy on CPR certfication ☐ Yes ☐ No

Minimum of 2 CPR certified staff present at all times ☐ Yes ☐ No

______% Direct patient care givers CPR certified

Written policy for supervision of clinical staff ☐ Yes ☐ No

24 hr awake coverage available ☐ Yes ☐ No

# SERVICES

Programs for:

Children ☐ Yes ☐ No

Adolescents ☐ Yes ☐ No

Adults ☐ Yes ☐ No

Men ☐ Yes ☐ No

Women ☐ Yes ☐ No

Pregnant women ☐ Yes ☐ No

Geriatrics ☐ Yes ☐ No

Other: ____________________

Therapies offered:

Individual ☐ Yes ☐ No

Group ☐ Yes ☐ No

Family/Couples ☐ Yes ☐ No

Other: ____________________

***Support Services***

Laboratory access ☐ Yes ☐ No

7 days/week ☐ Yes ☐ No

Pharmacy access ☐ Yes ☐ No

7 days/week ☐ Yes ☐ No

Provider Name:

***Other Substance Abuse Services***

| | On-Site | Off-Site |
|---|---|---|
| Outpatient Detox | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Inpatient Rehabilitation | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Outpatient | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Intensive Outpatient | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Partial Hospitalization | ☐ Yes ☐ No | ☐ Yes ☐ No |

## FACILITY / SAFETY

Written emergency preparedness plan ☐ Yes ☐ No

Plan includes procedures for the following:

Fire ☐ Yes ☐ No

Loss of utilities ☐ Yes ☐ No

Inclement weather ☐ Yes ☐ No

Number of fire drills per year: ____________________

Fire extinguishers available on each unit ☐ Yes ☐ No

Fire extinguishers checked annually ☐ Yes ☐ No

Fire evacuation plan posted within facility ☐ Yes ☐ No

## COMMENTS

___________________________________________

***As a reminder, please be sure to include:***

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***
- ***Program Description***

***Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.***

## Branch Offices

Name: ____________________

Services Provided: ____________________

Billing Site Only ☐ Yes ☐ No

Date of Acquisition or Establishment: __________

Address: ____________________

City: ____________________

Phone: ____________________

Contact Person: ____________________

Counties Served: ____________________

Provider Name:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Provider Name:

# HEALTHCARE FACILITY INFORMATION FORM

Provider Name:_______________________________________________________________

Parent:___________________________________________________________________

Affiliation:_______________________________________________________________

Affiliation:_______________________________________________________________

Number of Years in business:__________________________

## Type of Control

- ☐ **Voluntary Nonprofit**
- ☐ **Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)
  - ☐ Individual _________________________________
  - ☐ Partnership_________________________________
  - ☐ Corporation_________________________________
  - ☐ Other_____________________________________
- ☐ **Government**
  - ☐ Federal
  - ☐ State
  - ☐ County
  - ☐ Other, explain:______________________________

## Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

- ☐ Yes, explain:________________________________
- ☐ No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

- ☐ Yes
- ☐ No

If yes, provide a copy to Capital Blue Cross

## Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

**COMMENTS:** ____________________________________________________________

_______________________________________________________________________

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_______________________________________________________________________

Provider Name:

Please indicate the counties within your service area.  If services are limited to only a portion of the county, please identify.

- Adams ❑ ______
- Berks ❑ ______
- Centre ❑ ______
- Columbia ❑ ______
- Cumberland ❑ ______
- Dauphin ❑ ______
- Franklin ❑ ______
- Fulton ❑ ______
- Juniata ❑ ______
- Lancaster ❑ ______
- Lebanon ❑ ______
- Lehigh ❑ ______
- Mifflin ❑ ______
- Montour ❑ ______
- Northampton ❑ ______
- Northumberland ❑ ______
- Perry ❑ ______
- Schuylkill ❑ ______
- Snyder ❑ ______
- Union ❑ ______
- York ❑ ______

Other ❑ ______