Capital BlueCross
OUTPATIENT SUBSTANCE ABUSE 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

Hours of Operation: _____
Program Capacity: _____
Ages served: _____
Average number of treatment sessions: _____
Average number of clients in group: _____
Most Frequent Diagnosis: _____
Handicap accessible ☐ Yes ☐ No
Written policy for treatment of minors ☐ Yes ☐ No
Emergency supplies available ☐ Yes ☐ No
Written patient medical emergency plan ☐ 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
On-call policy ☐ Yes ☐ No
Written confidentiality policy ☐ Yes ☐ No
Written policy on maintenance of medical records ☐ Yes ☐ No

QUALITY MANAGEMENT

Quality Activities

Performance Improvement Program ☐ Yes ☐ No
Performance Improvement Committee ☐ Yes ☐ No
If no, are quality issues discussed at staff meetings? ☐ Yes ☐ No
Frequency of meetings: _____
Position accountable for Performance Improvement activity: _____
Quality Reports forwarded to the Board of Directors/Administrators ☐ Yes ☐ No
List two current Quality Studies:
1. _____
2. _____
Written Infection Control policy ☐ Yes ☐ No
Written policy on communicable diseases ☐ Yes ☐ No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐ No
Most frequent issues identified:
1. _____
2. _____
Annual return rate for surveys: _____ **%**
Patient/family complaint process ☐ Yes ☐ No

Clinical Management

Time frame for scheduling initial appointment: _____
Written admission criteria ☐ Yes ☐ No
Written discharge criteria ☐ Yes ☐ No
Voluntary ☐ Yes ☐ No

Provider Name:

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

Written policy on physical exams ☐ Yes ☐ No

Written attendance policy ☐ Yes ☐ No

Written policy for other agency referrals ☐ Yes ☐ No

Timeframe for development of initial treatment plan: _____

Timeframe for development of master treatment plan: _____

Frequency of treatment plan updates: _____

Written aftercare plan provided to patients / 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 inpatient S/A treatment ☐ Yes ☐ No

Readmissions ☐ Yes ☐ No

Administrative Discharges ☐ Yes ☐ No

Average Length of Stay ☐ Yes ☐ No

Other, please list: _____

STAFF

Clinical Competency Evaluation ☐ Yes ☐ No

Frequency: _____

Annual performance evaluation of staff ☐ Yes ☐ No

Minimum number of educational programs annually attended by staff: _____

Written policy for credentialing of:

Physicians ☐ Yes ☐ No

Nursing ☐ Yes ☐ No

Written policy for verification of education / training and licensure / certifications of clinical staff ☐ Yes ☐ No

Written policy for training for Counselor Assistants ☐ Yes ☐ No

Written policy addressing recovery, abstinence and relapse issues in recovering clinical staff ☐ Yes ☐ No

Medical Staff

Medical Director ☐ Yes ☐ No

Name: _____

Board Certified ☐ Yes ☐ No

Specialty: _____

Other Staff:

Project Director

Name: _____

Provider Name:

Degree: _____

Clinical Supervisor
Name: _____
Degree: _____

_____ # of RNs
_____ # of CACs
_____ # of Licensed Psychologists
_____ # of Bachelor prepared Counselors
_____ # of Master prepared Counselors
_____ # of Counselor Assistants

List other clinical employees:

_____

_____

_____

Written policy on CPR certification ☐ Yes ☐ No

Minimum of 1 CPR certified staff present at all times ☐ Yes ☐ No

_____ **%** Direct patient care givers CPR certified

Written protocol for supervision of clinical staff ☐ Yes ☐ No

Staff to patient ratio for:
Outpatient Services _____
Partial Services _____

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
Dual Diagnosis	☐ Yes ☐ No

If **yes**, availability of:

Psychiatrist	☐ Yes ☐ No
Licensed psychologist	☐ Yes ☐ No
Psychiatric social worker	☐ Yes ☐ No
Mental health counselor	☐ Yes ☐ No

Other: _____

_____

_____

Therapies offered:

Individual	☐ Yes ☐ No
Group	☐ Yes ☐ No
Family/Couples	☐ Yes ☐ No

Other: _____

Other Substance Abuse Services:

	On-Site	**Off-Site**
Intensive Outpatient	☐ Yes ☐ No	☐ Yes ☐ No
Partial Hospitalization	☐ Yes ☐ No	☐ Yes ☐ No
Inpatient detoxification	☐ Yes ☐ No	☐ Yes ☐ No
Inpatient rehabilitation	☐ Yes ☐ No	☐ Yes ☐ No

If **yes**, total number of hours/week of treatment: _____

If **yes**, total number of hours/week of treatment: _____

Transportation

Public transportation route	☐ Yes ☐ No
Facility owned van	☐ Yes ☐ No

Other: _____

_____

_____

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 extinguishers: _____

Number of fire drills per year: _____

Fire extinguishers checked annually ☐ Yes ☐ No

Fire evacuation plan posted within facility ☐ Yes ☐ No

COMMENTS

_____

_____

Provider Name:

As a reminder, please be sure to include:

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

Provider Name:

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:

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:

Provider Name:

Phone: _____ Counties Served: _____

Contact Person: _____

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: _____

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 ❑ _____