CUMBERLAND HEIGHTS
WRITTEN PLAN FOR PROFESSIONAL SERVICES

I. Accessing Services and Screening/Initial Chemical Dependency Assessment Procedures

Anyone inquiring about Cumberland Heights' services may telephone the Admissions Center around the clock, 365 days a year. Admissions personnel are available to give information and begin initial screening. Persons may also come to the River Road Admissions Center at any time. Outpatient satellite offices in Jackson, Murfreesboro, Chattanooga, and Gallatin schedule assessment appointments during office hours. Admission may be scheduled at any time once appropriateness has been established. Initial screening, typically done over the telephone, includes at least demographic data, what brought the person to seek treatment (precipitating event), chemical use patterns, current crisis, treatment history, psychiatric screening for homicide/suicide risk, and/or psychotic symptoms, referral source, and financial resources. Clinical verification of appropriateness for admission and level of care occurs during the face-to-face chemical dependency assessment. This begins with the process of triage by a licensed nurse to determine what the patient's immediate needs may be. The patient may be referred for emergency services, taken immediately to the detoxification unit, or deemed stable to continue with the regular admissions process based upon their physical and emotional status at the time. The initial chemical dependency assessment, which follows, includes a more in-depth probe of the issues explored during screening, including chemical use history and major life areas review for consequences. In addition, such factors as general physical health, psychiatric history, and withdrawal potential, based on usage patterns, are considered. Collateral contacts with family, employers, and referral sources are also completed as needed. Releases of information are obtained. Financial resources verification is completed at this time. Based on all of this information, recommendations are made for treatment.

Potential patients and families are given an explanation of the initial chemical dependency assessment results and recommendations. Should the requested level of care be inappropriate, the reasons are explained and alternatives are presented. It is, however, the policy of Cumberland Heights to allow persons to start at a lower level of care than recommended in the belief that it is the addiction professionals' responsibility to meet the patient "where s/he is." This is, of course, barring threat of danger to self and/or others or court order to treat otherwise. Should a person require services not provided at Cumberland Heights, referral to the appropriate provider(s) is made. If a screening and recommendation for level of care has already been completed by a professional counselor or other qualified health care professional, screening by Cumberland Heights' staff is not repeated. In that case, the process starts at the initial chemical dependency assessment.

Potential patients who exhibit signs of or report symptoms of acute intoxication, acute withdrawal, and/or danger to self and/or others are considered to be in immediate need

of crisis intervention. If these are reported or detected via telephone screening, the person will be strongly advised to seek emergency evaluation. If at all possible, family members are engaged to assist with this process. The Chief Medical Officer or physician on duty, consulting psychiatrist as applicable, law enforcement, and local mental health crisis team are contacted for assistance as indicated. Persons appearing for screening in person and who exhibit these symptoms may be asked to undergo emergency evaluations prior to admission to determine appropriateness for the level of services offered. Again, the Chief Medical Officer, physician on duty, consulting psychiatrist as applicable, law enforcement, and local mental health crisis team are contacted as indicated. In all cases of crises, meeting the person's immediate needs for safety and care are paramount.

II. Admission and Continuing Assessment Procedures

Arrangements for admission may be scheduled or may begin immediately after the chemical dependency assessment. Admissions to subacute detoxification and residential rehabilitation (Men's Program, Young Adult Men's, the Women's Center, Adolescent, and Professionals' Program) programs include the following: signing of consent to treat and releases of information, health history, nursing assessment (including vital signs and mental status exam), collection of blood and urine samples for laboratory analysis, initial attending physician visit, physical examination within 24hours of admission, nutritional screening with assessment if indicated, leisure activities assessment, education/vocational assessment as needed, biopsychosocial clinical interview to review/expand initial chemical dependency assessment data, and specialty assessments (i.e., EEG, neuropsychiatric, etc.) as needed. Full psychiatric evaluation as indicated is available and is standard for professionals. In addition, professionals who require licensure advocacy will have a vocational assessment, as well as neuro-psychiatric testing as indicated.

Admission to intensive outpatient services includes similar components. The health history is by self-report; the need for a physical examination is determined by specific physician-determined flags on the outpatient health screen. Admission to the Extended Care Program, in most cases, will follow the completion of a Cumberland Heights' residential program. In rare cases, an individual who has had multiple previous treatments may be admitted to the detoxification unit for stabilization and then transferred directly to Extended Care. A face to face interview to assess for appropriateness and the level of patient motivation is conducted by the Professionals/Extended Care Director, Clinical Coordinator, or designee prior to admission to this level of care. Admissions decisions are made by the residential treatment team and the professionals/extended care team, with the Chief Medical Officer's or designee's approval, in conjunction with the patient, the family as appropriate, and referral sources as appropriate. Professionals/Extended Care counselors continue to build on the assessments that have been completed during the patient's residential stay.

Assessment of the patient's strengths, weaknesses, and motivation for treatment are included, as well as the clinician's recommendations for treatment focus. The priorities

for the plan of care are established and a general outline of the plan presented within this document. Treatment planning and continuing care planning flow from this document.

III. Treatment and Continuing Care Planning

Treatment planning is based on the cumulative results of all assessments to date, as well as knowledge of the disease of chemical dependency and current treatment modalities. Initial plans of care address the presenting problems in terms of crisis stabilization, focusing on withdrawal, milieu integration, and amelioration of the presenting crisis where possible. Those for the residential programs are completed by a Registered Nurse within 24 hours of admission. Counselors complete those for outpatient clients, including the Extended Care Program, by the third session.

The treatment plan is developed in conjunction with the patient, and the family as appropriate, and includes the patient's perceptions of his/her problems and goals for treatment. Needs are prioritized. Treatment planning includes the multidisciplinary team and is coordinated by the counselor. These are individualized according to the patient's specific circumstances. Treatment planning is due by day five in residential programs, by the seventh session in intensive outpatient services. Clinical needs may be of the following nature: acute intoxication/withdrawal, biomedical complications, emotional/behavioral complications, recovery environment related, readiness to change related, and/or relapse potential related. Though patients share some common needs, the manifestations of these are individual. Treatment planning, therefore, is individualized in terms of specific behaviorally measurable objectives for patients and varying types, frequencies, lengths, and intensities of staff interventions. Discharge/transition criteria and projected discharge/transition dates are drawn from treatment plan objectives, as well as completion of staff interventions to delineate minimal behavior changes recommended to successfully transition to the next level of care.

Treatment plan records and progress notes document the implementation of the treatment plan or core curriculum, the response of the patient and family, staff interventions and effectiveness, and the overall clinical course of the patient. The Men's Program, the Young Men's Program, the Women's Center, and Youth Programs conduct formal treatment plan reviews on a weekly basis as well as at critical clinical points for the individual patient as needed. Intensive outpatient programs conduct formal treatment plan reviews on a weekly basis as well as at critical clinical points for the individual patient as needed. A treatment plan review for the Extended Care Program patient is conducted every thirty (30) days. Reviews of patients with professional licensure advocacy needs include a specific review of those issues by the team and the attending physician. The initial discharge/transition criteria as well as the beginnings of the formal plan for continuing care are presented at the first Treatment Plan Review session. The continuing care plan is refined as treatment progresses. Traditional residential program reviews include the addictions counselor, family counselor, nursing, continuing care planner, program director, utilization review, and medical/psychiatric representation as needed. The recreation specialist, the art

therapist, dietician, or pastoral care counselor may also attend as needed, as may QM representatives. Outpatient service reviews include the addictions counselor, family counselor, and the program manager/supervisor. The Extended Care Program review includes the counselor, the program director, family counselor, and the Associate Medical Officer as needed. QM representatives also attend as needed.

IV. Treatment Modalities

Cumberland Heights operates with the belief that the Twelve Step programs and principles are the most effective tools with which to achieve long-term quality recovery from addiction. It is also our belief, and is supported by current data, that chemically dependent persons respond most effectively in group settings. Therefore, all treatment modalities support the use of such groups to assist patients and families in internalizing Twelve Step principles and philosophy. A variety of theoretical frameworks are used to assist. These frameworks include, but are not limited to, family systems, experiential, reality therapy, REBT, client centered, motivational interviewing, Adlerian, cognitive behavioral, acceptance commitment, EMDR, and Gestalt work. Specialty groups by age, gender, and professional background are also offered to provide an even more closely defined peer base for confrontation, support, and feedback. Individual counseling is used to supplement the basic group model. Traditional programs and intensive outpatient groups, in addition to the focus on chemical dependency and consequences, explore a variety of related issues, which may impact addiction recovery (i.e., family of origin dynamics, secondary addictive processes, dysfunctional relationship patterns, etc.). Extended Care focuses on processing dilemmas, obstacles, and opportunities in early recovery, as well as skill building and practical implementation of these skills in a real life environment. In addition, continued work on related issues such as family of origin impact, relationship patterns, secondary addictive processes, etc. is examined in more depth. Individual sessions for all programs are generally directed at problem solving or planning and topics may include treatment planning, continuing care planning, family program preparation, health education, and pastoral care issues.

Since many of our patients are unfamiliar with the addiction and recovery processes and/or may be cognitively impaired by chemical use, didactic learning groups are offered to assist. These groups focus on providing information about the physical, mental, emotional, social, and spiritual aspects of the disease of addiction and the recovery process. A highly interactive approach is used to maintain attention. A variety of audio-visual aids are available to support these groups. Topics include information about addiction, recovery, relationship skills, and relapse prevention in all programs.

Since development of a spiritual practice that works for the individual patient is a key part of recovery, pastoral care services are integrated into all programs. These services may include individual spiritual direction, interactive education groups, meditation practices (mindfulness, walking the labyrinth, etc.), and optional attendance at a non-denominational Christian chapel service. In addition, the Director of Pastoral Care coordinates with a variety of outside spiritual leaders of various traditions and faiths at the patient's request.

Specialty counseling and therapy groups are used to augment the patient's internalization of recovery concepts. Adventure based ropes course counseling and equine assisted learning groups are available, as well as expressive therapies, such as art therapy and music therapy, for residential patients. EMDR may be offered for select patients to address trauma related events that may block the recovery process.

Leisure and recreation activities, as well as educational activities for adolescents, are also in group settings to encourage the development of abstinence based social skills as well as constructive conflict resolution skills. Staff model behavior consistent with Twelve Step principles in order to allow patients to see a working role model in a daily life setting (i.e., bowling, the movies, etc.). A wide variety of on-site and off-site outings including arts and crafts activities, team sports, individual sports such as softball and volleyball, as well as social outings are provided.

Finally, patients and families engage in exercises designed to reduce denial of the addiction process, express and process feelings regarding the past and current impact of the addiction, and to teach open communication skills. A combination of group and individual sessions, learning groups, and a structured three day program may be used to facilitate this process. Individual and multiple family therapy sessions, as well as learning groups and a structured family program, are also provided for the families of adolescents to meet those specialty needs. Families unable to access Cumberland Heights Family Services due to scheduling or location may participate telephonically and are also given appropriate referrals for continuing care. Weekly aftercare is available for all families who participate in Family Services.

The Children's Family Program is a prevention program focusing on education and support for children ages 6-12 who are living in a home where chemical dependency is present. Weekly aftercare is available for children completing this program.

V. Continuing Care Planning

Planning for continuing care is not seen as separate from, but rather as a part of the treatment planning process. Decisions are made by the treatment team and the patient during the assessment and treatment planning process regarding issues to be addressed at the next level of care. In addition, a patient's progress toward objectives, from which actual discharge criteria are delineated, further determines continuing care requirements. Lengths of stay and level of care vary based on these factors.

A formal continuing care plan, developed in conjunction with the patient, family, and other professionals as appropriate, is used to further define behavioral changes needed to support the patient's recovery and to actively engage the patient in the next level of care. When possible, referral contacts and appointments are made prior to discharge. In the case of an already existing relationship, the referral source is kept updated on patient's progress throughout treatment as they request and releases of information permit. Referrals back to the referring source (i.e. therapist, physician, EAP) after discharge is standard practice. Continuing care planning meetings involving the

patient, family, counselor, continuing care planner, and collateral contacts among others are encouraged whenever possible. A Twelve Step contact is made prior to discharge and contracts regarding Twelve Step meetings attendance are made. Participation in weekly alumni-led aftercare sessions is also scheduled. In addition to the above, those professionals who are in the residential or extended care programs will have specific planning to ensure the successful completion of licensure advocacy requirements.

VI. The Multidisciplinary Team

Because Cumberland Heights subscribes to the belief that addiction is a biopsychosocial-spiritual, as well as developmental disease, treatment encompasses all of those areas and is provided by a multidisciplinary treatment team whose educational and experiential backgrounds provides such expertise. Specific composition of the treatment team varies with programmatic need as well as that of the individual patient.

A. Adult Residential Program Team

The Treatment Team for the Men's Program, the Young Men's Program, the Women's Center, and the First Step Adult programs at the level of subacute detox and residential rehabilitation includes the following:

1. CHIEF MEDICAL OFFICER – The Chief Medical Officer is ultimately responsible for assessment and establishment of a plan of care, supervision of care, and evaluation of care of detoxification and rehabilitation patient needs. This includes those needs related to the addiction as well as those which are not. The Chief Medical Officer may perform physical examinations, make diagnoses, prescribe medicinal and non-medicinal treatment, manage ongoing health problems and those occurring while in treatment, provide health education and recommend needed follow-up after discharge. All other physicians are ultimately responsible to the Chief Medical Officer. The CMO works closely with the disciplines of addiction medicine, psychiatry, psychology, social work, professional counseling, marriage and family therapy, pastoral care, addictions counseling and nursing to gather milieu based observational data to assist with care. In addition, the Chief Medical Officer directs and supervises the multidisciplinary plan of care. The Chief Medical Officer reports administratively to the Chief Executive Officer.

2. ASSOCIATE MEDICAL DIRECTOR – The Associate Medical Director is responsible for the assessment and establishment of a plan of care, supervision of care, and evaluation of care of detoxification and rehabilitation patient needs for the patients assigned to him/her. This includes those needs related to the addiction as well as those which are not. In the absence of the Chief Medical Officer, s/he is ultimately responsible for all patient care. S/he is also the Medical Director of the Professional/Extended Care Program and is responsible for the care of the patients within that program. The Associate Medical Director may perform physical examinations, make diagnoses, prescribe medicinal and non-medicinal treatment, manage ongoing health problems and those occurring while in treatment, provide health education and

recommend needed follow-up after discharge. In the absence of the Chief Medical Officer, other physicians report to him/her. The AMD works closely with the disciplines of addiction medicine, psychiatry, psychology, social work, professional counseling, marriage and family therapy, pastoral care, addictions counseling and nursing to gather milieu based observational data to assist with care. In addition, the AMO directs and supervises the multidisciplinary plan of care for those patients in the Professionals/Extended Care Program. The Associate Medical Director reports to the Chief Medical Officer.

3. CONTRACT PHYSICIAN--The contract physician provides medical services as assigned by the Chief Medical Officer. S/he is responsible for the assessment and establishment of a plan of care for newly admitting patients, including the supervision of that care and the evaluation of care provided for detoxification and medical needs. In addition, the contract physician is responsible for addressing the continuing health needs of those patients in treatment via direct care or referral. The contract physician may perform physician examinations, make diagnoses, prescribe medicinal and non-medicinal treatment, manage ongoing health problems and those occurring while in treatment, provide health education, and recommend needed follow-up after discharge. The contract physician reports to the Chief Medical Officer.

4. CONTRACT PSYCHIATRIST—the contract psychiatrist provides psychiatric services as assigned by the Chief Medical Officer. S/he is responsible for the assessment, plan development, supervision of implementation, and evaluation of patient care outcomes in the area of psychiatry. This includes psychiatric evaluation/assessment, individual therapy, and pharmacological approaches as well as the integration of this aspect of care with other services. The contract physician reports to the Chief Medical Officer.

5. DIRECTOR OF NURSING—The Director of Nursing is responsible for assessing, planning, implementing, supervising, and evaluating the patient care services provided within the assigned program. This includes policy and procedure development, programming development, and effective utilization of resources. This team member works closely with registered nurses, licensed practical nurses, medical assistants, and nursing technicians in an administrative and clinical supervision position, utilizing feedback from all other team members to evaluate patient care outcomes. Communication is done via daily/shift team reports and treatment planning reviews. The Director of Nursing reports to the Chief Administrative Officer.

6. NURSING SUPERVISOR—The Nursing Supervisor is responsible for the assessing, planning, implementing, supervising, and evaluating of patient care services provided during an assigned shift. This includes monitoring of policy and procedure implementation, effective utilization of resources, and quality of care. This team member works closely with registered nurses, licensed practical nurses, and medical assistants in an administrative and clinical supervision position, utilizing feedback from other team members to evaluate patient care outcomes within the assigned shift. Communication is done via shift report and staff meetings. The Nursing Supervisor reports to the Director of Nursing.

7. REGISTERED NURSE – The Registered Nurse is responsible for assessing, planning, supervising, implementing, and evaluating nursing care for the patient. Specific tasks include providing nursing assessments of physical/psychological and substance abuse status on

admission and throughout treatment, detoxification care (including administration of detoxification medications), health maintenance (including emergency and triage care, medication administration, and non-medicinal treatment), treatment planning of acute intoxication/withdrawal and biomedical complication needs, and health education. The Registered Nurse is also responsible for observation, supervision, and crisis intervention as needed in the milieu during the evening, night, and weekend hours. This team member serves as a focal point for interdisciplinary communication via shift reports, daily team reports, and treatment plan reviews. The Registered Nurse reports to the Director of Nursing via the assigned Nursing Supervisor.

8. LICENSED PRACTICAL NURSE—The Licensed Practical Nurse is responsible for assessing, implementing, and evaluating specific nursing care functions assigned to him/her by an RN. This may include such direct patient care services as collection of data for history purposes, monitoring of vital signs and signs/symptoms of withdrawal, mediation administration, etc. The LPN reports to the Director of Nursing via the assigned Nursing Supervisor.

9. MEDICAL ASSISTANT—The Medical Assistant provides support to the licensed nursing staff in both administrative and clinical areas that do not require a nursing license but do required specialized training and skills (e.g. phlebotomy and/or specified medication administration) The Medical Assistant is directed by RN and LPN staff members to perform specific duties for individuals or groups of patients. The Medical Assistant reports to the Director of Nursing via the assigned Nursing Supervisor.

10. NURSING TECHNICIAN—The Nursing Technician provides support to the licensed nursing staff in both administrative and clinical areas that do not require a nursing license. The Nursing Technician is directed by RN and LPN staff members to perform specific duties for individuals or groups of patients. The Nursing Technician reports to the Director of Nursing via the assigned Nursing Supervisor.

11 CHIEF CLINICAL OFFICER—The Chief Clinical Officer is responsible for the assessing, planning, implementation, supervision, and evaluation of all counseling and therapy services provided by the organization. This includes the development and maintenance of quality, cost effective models of service delivery that utilize state of the art addictions treatment modalities. The Chief Clinical Officer works closely with the Chief Medical Officer and other physician/nursing staff, supervising all program directors. The Chief Clinical Officer reports administratively to the Chief Executive Officer.

12. ASSOCIATE CLINICAL OFFICER—The Associate Clinical Officer is responsible for assisting the Chief Clinical Officer with the assessing, planning, implementation, supervision, and evaluation of all counseling and therapy services provided by the organization, including the direct supervision of adjunct therapy staff and float therapy staff members. This position works closely with all Program Directors and Clinical Coordinators, as well as with the Chief Administrative Officer and the Quality Management Director. The Associate Clinical Officer reports to the Chief Clinical Officer.

13. PROGRAM DIRECTOR –The Program Director, in conjunction with the Chief Clinical Officer and Associate Clinical Officer, is responsible for assessing, planning, implementing,

supervising, and evaluating the patient care services provided within the assigned program. This includes policy and procedure development, programming development, and effective utilization of resources. This team member works closely with other program directors, counselors, and clinical associates, in an administrative and clinical supervision position, utilizing feedback from all other team members to evaluate patient care outcomes. Communication is done via daily team reports and treatment planning reviews, as well as regular staff meetings. The Program Director reports to the Chief Clinical Officer.

14. CLINICAL COORDINATOR—The Clinical Coordinator is responsible for the daily operation of an assigned program and/or population of patients, including assessing, planning, implementing, supervising, and evaluating the daily patient care services provided. This team member works closely with the Program Director, counselors and clinical associates in a clinical supervision position, utilizing feedback from other team members to ensure smooth daily operations. Communication is done via daily team reports and treatment planning reviews. The Clinical Coordinator reports to the assigned Program/Services Director.

15. COUNSELOR/THERAPIST - Counselors/therapists of various disciplines and /or licensures are members of the team and may serve as the Primary Counselor or as an adjunct. These counselors/therapists may include those from the disciplines of substance abuse counseling, professional counseling, marriage and family therapy, clinical social work, and pastoral care counseling. This team member may assume the primary responsibility for coordinating the patient's course of treatment from completion of the assessment phase through the development of a master treatment plan and its implementation, establishment of discharge criteria, and development of a plan for continuing care. Issues regarding emotional/behavioral complications, relapse potential, recovery environment treatment plan and readiness for change are generally master treatment planned by the counselor in conjunction with the treatment team, patient, and family as indicated. Direct care services include psycho-education, individual, group, and family addictions counseling, as well as crisis management and specialty counseling as skills and licensure or certification allow. Communication with the family, referral sources, and other collateral contacts is also the responsibility of the counselor. The counselor/therapist presents the patient's plan and progress at treatment plan reviews. As adjuncts, these team members may provide specialty learning groups, specialty counseling services (i.e. equine assisted psychotherapy, adventure based counseling, EMDR, etc.).

16. CASE MANAGER—Counselors/therapists of various disciplines and/or licensures may serve in the role of Case Manager. The Case Manager is responsible for the coordination of specific functions that are essential to a successful treatment outcome. These include utilization review and discharge planning, as well as assisting with referral relations. In addition, the Case Manager may assist the counselor as needed with provision of direct services. Case Managers work closely with all members of the treatment team, as well as with patients, families, and outside referral sources. Case Managers report to the assigned Program Director via the Clinical Coordinator.

17.CLINICAL ASSOCIATE —The Clinical Associate performs one or more of the core functions of addiction counseling and practices under the clinical supervision of a LADAC and/or other appropriately licensed clinician. The Clinical Associate may coordinate a particular aspect of treatment (for example, orientation). The Clinical Associate may also provide structure and

support to the therapeutic milieu, assisting in facilitating Twelve Step meetings, directed topic groups, and related activities. The Clinical Associate reports to the Program Director and works closely with counseling staff, as well as nursing staff to ensure a smooth continuum of care.

18. FAMILY COUNSELOR – The Family Counselor is responsible for engaging the family and/or significant others in the family services component of treatment. Upon signing of the correct releases of information, the Family Counselor attempts to engage the family via mail and telephone contact to set up participation in Family Services. These may consist of family orientation, education, and participation in a structured family program with the patient. In addition, family counseling sessions are conducted both individually and via multi-family group therapy. The Family Counselor facilitates the dissemination of information regarding addiction, dysfunctional family systems, and available recovery resources. Family Program Counselors work closely with the Counselor, Clinical Associate, and the treatment team to maximize benefits of participation for both patient and family. The Family Counselor holds LADAC or other appropriate licensure or is supervised by a LADAC or other appropriately licensed staff. Depending on specific assignment, the Family Counselor reports to the Director of Family Services or to the Services Director.

19. PASTORAL CARE DIRECTOR– The Pastoral Care Director is responsible for assisting the patient in meeting spiritual needs. This may be achieved via individual sessions, psycho-education groups, arrangements for visits with other clergy, or nondenominational chapel attendance. Specifically, the Pastoral Care Director may assist patients in processing feelings of shame, guilt, and anger regarding past experiences via the Twelve Step principles, as well as the hearing of Fifth Steps. The Pastoral Care Director coordinates efforts with the counselor via treatment plan reviews. This position is a licensed minister with experience in working with chemically dependent patients and families in a Twelve Step context. The Pastoral Care Director reports to the Chief Clinical Officer.

20. ACTIVITIES COUNSELOR – The Activities Counselor is responsible for developing, implementing, supervising, and evaluating the therapeutic recreation component of the residential programs; including adventure based counseling activities such as the ropes course and climbing wall. This position is a Bachelor's prepared specialist in the area of recreation. Communication is via team report and treatment plan review. This position reports to the Associate Clinical Officer.

21. EXPRESSIVE THERAPIST—The Expressive Therapist is a licensed counselor with a specialty in an area such as music, art, etc. This counselor provides specialty services to the assigned individuals and/or group of patients and/or programs at the residential level of care. The Expressive Therapist communicates with the internal treatment team as well as documenting in the EMR. The Expressive Therapist reports to the Associate Clinical Officer.

22. CONSULTING DIETICIAN – The Consulting Dietician is responsible for completing nutritional assessments and educational counseling on a referral basis. The Dietician is responsible for developing a nutritional screening tool which triggers a nutritional assessment for those who need further follow up in this area. Working closely with the nursing staff, the Consulting Dietician assists with treatment planning of nutritional issues as needed. Communication with the treatment team is by written report as needed. The Consulting

Dietician also presents education groups regarding healthy nutrition in recovery to residential patient populations. The Consulting Dietician is a registered dietician and reports Director of Nursing. S/he also works closely with the Food Services Director.

23. UTILIZATION REVIEW SPECIALIST - This position is responsible for ensuring that effective utilization of treatment resources occurs. In addition, this position serves as the primary liaison between the treatment team and third party payors, including managed care organizations and health maintenance organizations for purposes of authorization of care. The Utilization Reviewers are supervised by the Utilization Review Director.

24. UTILIZATION REVIEW DIRECTOR- This team member serves as a training specialist and consultant to Case Management and Utilization Review staff members in all clinical programs with regard to utilization review matters. Working closely with Directors, Clinical Coordinators, and managed care organizations, this position works to ensure that the organization's resources are used efficiently and that its relationships with managed care organizations and third party payors function smoothly and for the patient's benefit. The UR Director reports to the Chief Administrative Officer.

25. QUALITY MANAGEMENT DIRECTOR–This team member works to evaluate the major processes serving patient care throughout the organization and serves as a consultant to the treatment team regarding difficult cases, risk management issues, patient complaints, etc., working closely with Program Directors. The QM Director serves as a patient advocate and staff resource in the case of a grievance or ethical dilemma. This position reports to the Chief Administrative Officer.

26. CHIEF ADMINISTRATIVE OFFICER—This team member is responsible for the creation, implementation, delivery, and evaluation of nursing services and other contract physical health services, such as pharmacy and laboratory services via the Director of Nursing. In addition, the CAO is responsible for utilization review and quality management for the organization via those directors. The Chief Administrative Officer works closely with the Chief Medical Officer, the Chief Clinical Officer, and the Associate Clinical Officer, as well as with a variety of management and staff at all levels of the organization.

Other professionals may be consulted on an as needed basis according to individual patient need. These include, but are not limited to, contracted pharmacists, pathologists, dentists, radiologists, etc. In addition, Master's level professional counseling, marriage and family therapy, advanced practice nursing, and/or social work interns may participate in the care of individuals or groups of patients under the supervision of the appropriate team member named above. All interns are accountable to the Program Director and ultimately to the Chief Clinical Officer.

B. Residential Youth Traditional Program Team

The treatment team for adolescent patients at the levels of subacute detoxification and residential rehabilitation include all of the previously mentioned team members. Other team members include:

1. PRINCIPAL – The Principal is a certified teacher who is Bachelor's prepared. This position works to structure the educational experience for the adolescent patient during treatment. The goal of primary care is to maintain and/or enhance the patient's academic educational process during treatment. The goal of extended care is to continue a quality high school education during their stay. This position works closely with Teachers and the Clinical Treatment Team and reports to the Director of Adolescent Services.
2. TEACHER—The Teacher is a certified teacher who is Bachelor's prepared. This position works to structure the daily educational experience for the adolescent patient during primary and extended care residential treatment. This position works closely with families and the home school, as well as with the Clinical Treatment Team and reports to the Headmistress.

As with the Residential Adult Programs Team, other team members may be consulted as needed. Staff without clinical privileges are supervised as previously described.

C. Outpatient Services Team

1. DIRECTOR OF OUTPATIENT SERVICES—The Director of Outpatient Services is responsible for assessing, planning, implementing, supervising, and evaluating all outpatient services. This includes program development, policy and procedure development, effective utilization of resources, and quality of care. The Director works closely with Outpatient staff in both an administrative and clinical supervision capacity. The Director of Outpatient Services reports to the Chief Clinical Officer.

Other members of the Outpatient Services team include counselor/therapist, clinical associate, and family counselor with the roles as described in the residential teams. Again, consultants may be called in as individual patient needs warrant and may include all team members previously mentioned.

D. PROFESSIONALS/EXTENDED CARE PROGRAM TEAM

1. DIRECTOR OF PROFESSIONAL/EXTENDED CARE PROGRAM—The Director of Professional/Extended Care Services is responsible for assessing, planning, implementing, supervising, and evaluating all outpatient services. This includes program development, policy and procedure development, effective utilization of resources, and quality of care. The Director works closely with the other residential program directors and counselors to ensure a smooth transition between programs. The Director reports to the Chief Clinical Officer.
2. PROFESSIONALS/EXTENDED CARE COORDINATOR—The Professionals/Extended Care Coordinator is responsible for serving as a liaison between the clinical team and the various referral sources, licensing boards, professional associations, and alternate discipline bodies of the professional groups serves. This position works closely with the treatment team, the patient, and the family as appropriate to ensure that all licensure advocacy requirements are met. This position reports to the Program Director.
3. PSYCHOLOGIST – The Psychologist is responsible for conducting clinical interviews and testing, including interpretation of same, that may be required for the comprehensive

evaluation of a professional who is being assessed, as well as for patients who are participating in the Professionals/Extended Care Program.

Other members of the Extended Care Program team include counselor/therapist, and family counselor. As mentioned previously, the Associate Medical Director serves as the Medical Director of this program. Again, consultants may be called in as individual patient needs warrant and may include all team members previously mentioned.

VII. SUMMARY

Cumberland Heights has verified the competency of its staff via an initial and ongoing competency assessment as well as through annual performance appraisals. Formal competency assessments are completed every three years as well. For those contracted professional staff, a clinical privileges and credentialing process exists to ensure competency. Education and licensure is verified via primary source as part of the organization's required background check for professional staff (see related policy). Support and administrative staff are sufficient to meet the goals and objectives of the organization. Optimal patient staff ratios have been set as follows: 12:1 in outpatient treatment services, 8:1 in residential adult programs, 6:1 in residential adolescent programs, and 3:1 in subacute detoxification for adults and adolescents. As previously mentioned a Registered Nurse supervises nursing care 24 hours/day and is responsible for assessing, planning, implementing, supervising, and evaluating client care at the residential level.

The Written Plan for Professional Services is reviewed on an annual basis and is revised as necessary. The Plan is made available to staff via the Clinical Management Team and the Leadership Team.

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