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**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
OFFICE OF THE INSPECTOR GENERAL**

**EXCERPT OF  
REPORT OF SPECIAL EVALUATION:  
THE ADDICTION PREVENTION AND RECOVERY  
ADMINISTRATION  
DETOXIFICATION AND STABILIZATION CENTER**



**CHARLES J. WILLOUGHBY  
INSPECTOR GENERAL**

**The following excerpt consists of information extracted from a full Report of Special Evaluation that the Office of the Inspector General sent to the Department of Health on August 10, 2011. The Office of the Inspector General is providing this excerpt in lieu of the full report in accordance with D.C. Code § 7-3006, as much of the information in the full Report of Special Evaluation is confidential under that statute. Also, we have redacted the identity of private individuals and health information in accordance with D.C. Code § 2-543(a)(2) (Supp. 2011).**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Office of the Inspector General

Inspector General



September 14, 2011

The Honorable Vincent C. Gray  
Mayor  
District of Columbia  
Mayor's Correspondence Unit, Suite 316  
1350 Pennsylvania Avenue, N.W.  
Washington, D.C. 20004

Dear Mayor Gray:

Please find enclosed a copy of *Excerpt of Report of Special Evaluation: Addiction Prevention and Recovery Administration – Detoxification and Stabilization Center*. The full report of special evaluation was sent to the Department of Health on August 10, 2011. However, in accordance with D.C. Code § 7-3006, any information provided by substance abuse treatment clients to the Addiction Prevention and Recovery Administration (APRA) must remain confidential. Therefore, to comply with this confidentiality requirement, the Office of the Inspector General (OIG) extracted from the report of special evaluation those findings that can be disseminated to the public. The enclosed report will be available to the public on the OIG's website, [www.oig.dc.gov](http://www.oig.dc.gov).

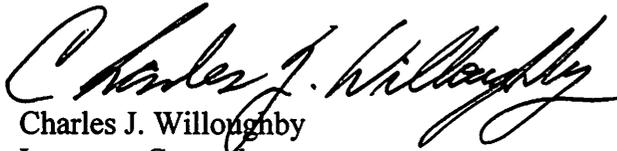
The purpose of the special evaluation was to examine APRA's oversight and management practices and events surrounding the December 2008 death of a client who was being treated at APRA's Detoxification and Stabilization Center, which closed in August 2009. The enclosed report highlights instances of poor oversight, questionable decisions, and inaction by APRA management, and presents recommendations to enhance APRA's effectiveness in monitoring the District's substance abuse treatment and detoxification facilities.

The issues and concerns resulting from the special evaluation will necessitate OIG follow-up to our recommendations. To aid in this process, I asked Dr. Mohammad Akhter, Director of the Department of Health, and Dr. Kimberly Jeffries Leonard, Senior Deputy Director of the Addiction Prevention and Recovery Administration, to provide information to my Office regarding any corrective actions that they direct and enhancements to APRA protocols and operations that they implement.

Letter to Vincent Gray  
September 14, 2011  
Page 2 of 4

If you have questions about this report or if we can be of further assistance, please feel free to contact me on (202) 727-2540.

Sincerely,

A handwritten signature in black ink, reading "Charles J. Willoughby". The signature is written in a cursive style with a large, looping initial "C".

Charles J. Willoughby  
Inspector General

CJW/ef

cc: See **Distribution List**

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The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness and economy in operations and programs. I&E's goals are to help ensure compliance with applicable laws, regulations, and policies, identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

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**TABLE OF CONTENTS**

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**ACRONYMS AND ABBREVIATIONS..... ACR-i**

**CHRONOLOGY OF EVENTS: APRA MANAGEMENT, OVERSIGHT OF DSC ..... CHR-i**

**ORGANIZATION CHARTS..... ORG-i**

**INTRODUCTION, BACKGROUND .....1**

**SYSTEMIC DEFICIENCIES, QUESTIONABLE MANAGEMENT PRACTICES AT DSC AND  
APRA: 2008-2010 .....4**

**Issues and Findings.....6**

        DSC Not Penalized for Lack of Responsiveness .....6

        DSC Policies and Procedures Outdated or Undated, Voluminous, and  
            Unorganized.....8

        DSC Unable to Maintain Required Staffing Levels .....10

        DSC Employees Poorly Supervised.....12

        DSC Did Not Formally Train Employees.....13

        DSC Granted Full, Retroactive Certification Despite Unaddressed Problems.....14

**APPENDICES.....18**

    Appendix 1: List of Findings and Recommendations .....20

    Appendix 2: Memorandum from APRA’s SDD to DSC Managers (April 2008).....23

    Appendix 3: Letter from Outside Consultant Summarizing His Evaluation of DSC  
        (December 17, 2008) .....27

    Appendix 4: *APRA Detoxification Center Evaluation*.....33

    Appendix 5: Documents Pertaining to APRA SDD’s Decision to Fully, Retroactively  
        Certify DSC .....59

## ACRONYMS AND ABBREVIATIONS

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AIDS	Acquired Immune Deficiency Syndrome
APRA	Addiction Prevention and Recovery Administration
ARC	Assessment and Referral Center
ATOD	Alcohol, Tobacco, and Other Drugs
CAP	Corrective Action Plan
CARF	Commission on Accreditation of Rehabilitation Facilities
D.C.	District of Columbia
DCMR	District of Columbia Municipal Regulations
DCRA	D.C. Department of Consumer and Regulatory Affairs
DCYITC	D.C. Children and Youth Investment Trust Corporation
D/DOH	Director of the D.C. Department of Health
DEA	U.S. Drug Enforcement Administration
DOH	D.C. Department of Health
DSC	Detoxification and Stabilization Center
DTCP	Drug Treatment Choice Program
FY	Fiscal Year
HIV	Human Immunodeficiency Virus
HRLA	Health Regulation and Licensing Administration
I&E	Inspections and Evaluations
LICSW	Licensed Independent Clinical Social Worker
MOU	Memorandum of Understanding
OCR	Office of Certification and Regulation
OIG	D.C. Office of the Inspector General

## ACRONYMS AND ABBREVIATIONS

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OSHA	Occupational Safety and Health Administration
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SDD	Senior Deputy Director
SOD	Statement of Deficiencies
SSA	Single State Agency
WSC	Women's Services Center

**CHRONOLOGY OF SIGNIFICANT EVENTS:  
APRA MANAGEMENT, OVERSIGHT OF DSC**

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## CHRONOLOGY OF EVENTS: APRA MANAGEMENT, OVERSIGHT OF DSC

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- April 30, 2007** KPMG, a consulting firm hired by the District, published an organizational assessment of the Addiction Prevention and Recovery Administration (APRA).<sup>1</sup> The report concluded, among other things, as follows:
- APRA does not routinely utilize data or metrics to guide their business decisions, or have policies in place to require this. . . . APRA does not appear to use data or standardized methodologies to monitor programs . . . . APRA does not have a meaningful performance management system that is used for guiding and monitoring the careers of its non-management staff . . . . APRA’s current strategic plan has not been updated to reflect the current and future strategic direction of the administration . . . . APRA’s local budget has remained stagnant or decreased despite annual increases in personnel costs, effectively decreasing the portion of the budget for providing direct services . . . . The APRA organization exhibits an internal conflict, such as competition for resources and hiring, between its dual-roles as both a Single State Agency and a provider of direct services.... A considerable amount of unprofessional behavior was reported to the study team....
- 
- February 4, 2008** APRA’s Office of Certification and Regulation (OCR) sent two inspectors to the Detoxification and Stabilization Center (DSC) to conduct an unannounced visit as part of the OCR inspection process. The inspectors were refused entry into the facility.
- March 11-13, 2008** OCR conducted a planned site visit of DSC.
- April 1-2, 2008** APRA’s Senior Deputy Director (SDD) made two unannounced visits to DSC then wrote a memorandum to DSC management citing significant operational and clinical issues at the facility that warranted immediate attention. She wrote that “[t]he clinical environment of the [DSC] is unstructured.... Clients also reported negative staff engagement at all levels (administration, clinical, medical, etc).... There is little evidence of clinical service delivery.... All charts simply recorded the assignment of clients to counselors, yet no follow-up sessions.... [I]t is unclear how determinations are made for continued treatment and level of care needs.” (See Appendix 2)
- April 15, 2008** OCR’s chief wrote a letter to DSC’s program manager and enclosed a statement of deficiencies (SOD) pertaining to the March 11-13, 2008,

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<sup>1</sup> The D.C. Council requested this assessment after a city-wide crime emergency was declared.

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## CHRONOLOGY OF EVENTS: APRA MANAGEMENT, OVERSIGHT OF DSC

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site visit. The completed SOD forms<sup>2</sup> were due within 30 days of receipt of the letter.

- May 9, 2008** OCR's chief emailed APRA Manager 1 to report that a recertification application was hand-delivered to DSC the week of February 4, 2008, but that it had not yet received a completed recertification application.
- May 13, 2008** DSC's provisional certification expired.<sup>3</sup> [The Office of the Inspector General (OIG) team could not determine why DSC was only provisionally certified prior to this date; OCR site inspectors could not recall details or provide documentation of DSC's certification history.]
- June 17, 2008** DSC's program manager sent a memorandum to OCR's chief requesting a 30-day extension to correct deficiencies noted in DSC's SOD.
- June 20, 2008** OCR's chief emailed DSC's program manager granting an extension for the due date for DSC's Corrective Action Plan (CAP) until July 17, 2008.
- July 9, 2008** OCR's chief emailed APRA Manager 1 stating that DSC's program manager must, "at least, make an attempt to complete [a certification] application like every other provider. The information submitted should be current; the previously submitted information is not what we are requesting. Please explain."
- July 17, 2008** DSC's deadline for submitting its CAP.
- September 3, 2008** APRA Manager 1 emailed DSC's Medical Director to inquire about the status of the CAP and asked, "Can you please look in to [sic] this urgent matter?"

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<sup>2</sup> SOD forms note deficiencies at substance abuse treatment facilities. Completed SOD forms with plans for rectifying deficiencies are referred to as a corrective action plan (CAP).

<sup>3</sup> APRA may grant provisional certification to a facility:

that has received a statement of deficiencies. Provisional certification is contingent on: (a) The Department's inspection report that continued operation of the facility or program would not pose a danger to the health, safety and welfare of individuals receiving services; (b) The Department's approval of the facility or program plan of correction; and (c) The facility's or program's initiation of corrective actions prior to the Department issuing a provisional certification . . . . Provisional certification may restrict a facility or program from accepting new patients/residents or delivering specified services that it would otherwise be authorized to deliver once appropriate corrective action is taken . . . . Provisional certification shall not exceed a period of one (1) year and is not renewable.

29 DCMR §§ 2301.8-2301.10.

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## CHRONOLOGY OF EVENTS: APRA MANAGEMENT, OVERSIGHT OF DSC

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- September 19, 2008** APRA contracted with Peter F. Luongo, Ph.D., an outside consultant,<sup>4</sup> to conduct a 3-month assessment of DSC, from October 2008 until December 2008.
- September 24, 2008** OCR's chief wrote a letter to DSC's program manager noting that DSC was required to correct the noted deficiencies from the March 2008 site inspection. The OCR chief asked DSC's program manager to revise DSC's CAP and return it to OCR within 5 calendar days.
- September 26, 2008** DSC's program manager signed and dated DSC's recertification application.
- October 20, 2008** OCR's chief sent a second letter to DSC's program manager noting that DSC was required to correct the deficiencies cited in March 2008. The OCR chief again asked DSC's program manager to revise DSC's CAP and return it to OCR within 5 calendar days.
- December 10, 2008** OCR's chief emailed APRA Manager 1, informing him that DSC had not yet submitted a revised CAP: "Previous CAP submitted...was not acceptable for some deficiencies cited, included responses, such as NA; No completion dates—planned or actual; Incomplete responses; and No documents submitted to support actions taken."
- December 12, 2008** The administrator of pharmaceutical services at the D.C. Department of Health (DOH) emailed DSC's Medical Director and a chemist/addiction specialist, among others at APRA, to say that the Health Regulation and Licensing Administration (HRLA) recently informed her that the dispensing area at DSC was "out of regulatory compliance, and is subject to corrective action because "the *nursing staff*, who are currently providing medications to the Center patients, are *'dispensing medications outside of the scope of their practice.'*" The Center does not have a pharmacist on duty to dispense the medications and there is no direct oversight or involvement from the physicians on duty at the Center." (Emphasis in the original.)

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<sup>4</sup> The assessment was obtained through a Memorandum of Understanding executed by the D.C. Children and Youth Investment Trust Corporation (DCYITC) and Dr. Luongo. According to APRA's SDD, this arrangement was used because APRA had a memorandum of understanding (MOU) in place with DCYITC that allowed APRA to obtain a consultant's opinion quickly. DCYITC's website describes itself as:

the primary resource for developing partnerships that expand and improve services and opportunities for children and youth in the District of Columbia, especially during their time out of school. The partnerships include public schools, city agencies, and employers, including non-profit providers. Since its inception in 1999, the Trust has provided grants, technical assistance, youth worker training, capacity building, learning opportunities, convenings, and policy support in the District.

[Http://www.cyitc.org](http://www.cyitc.org) (last visited Nov. 22, 2010).

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**CHRONOLOGY OF EVENTS: APRA MANAGEMENT, OVERSIGHT OF DSC**

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- December 15, 2008**      A client was found unresponsive at DSC and later pronounced dead.
- December 17, 2008**      Luongo emailed to APRA’s SDD a preliminary evaluation of DSC. (See Appendix 3) He wrote that:
- [t]he Center is an inefficient, costly[,] and clinically outdated program . . . . The Center currently cannot meet minimal certification standards under Title 29 [of the District of Columbia Municipal Regulations (DCMR)] and does not have the infrastructure and management processes in place to become certified . . . . Administrative and medical management practices are uninformed by modern practice, are archaic, resistant to change and significantly contribute to poor patient outcomes.... [T]he staff must be characterized, as a group, as not meeting minimal professional competencies for work at a detoxification center.
- December 18, 2008**      APRA Manager I emailed OCR’s chief to inquire about the certification status of APRA’s Women’s Services Center (WSC), an outpatient treatment center located on the campus. OCR’s chief confirmed that WSC had been operating in an uncertified status since April 17, 2006.
- December 19, 2008**      Luongo submitted his final evaluation report to APRA’s SDD. (See Appendix 4)
- A Decision/Information Form from OCR’s chief, but signed by a lower level staffer, was sent through APRA’s Deputy Director for Administration to APRA’s SDD stating that DSC was granted “full certification to provide Level III Residential Detoxification for Adults.” DSC’s certification award was retroactive, from May 13, 2008 (the date DSC’s provisional certification expired), until May 12, 2009. (See Appendix 5)
- December 22, 2008**      APRA’s SDD emailed a memorandum and DSC’s CAP to DSC’s Medical Director, noting that DSC “has now been operating in an uncertified capacity for nearly seven months and this is unacceptable.” The memorandum instructed DSC’s Medical Director to oversee the CAP’s implementation.
- December 30, 2008**      APRA’s SDD sent an improvement plan to the Director of the D.C. Department of Health (D/DOH) addressing ways to improve service delivery at DSC.
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**CHRONOLOGY OF EVENTS: APRA MANAGEMENT, OVERSIGHT OF DSC**

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**January 11, 2009**

A DSC nurse emailed APRA and DSC managers about staffing shortages, noting that over that weekend there was 1 nurse to care for 70 patients at DSC. In this email, the nurse recounted that:

January 10<sup>th</sup> [through] 11<sup>th</sup> of 2009 was a weekend of horror. My license was in jeopardy and the patient's [sic] lives as well. I worked with a census of 70 plus patients this weekend with no other nurses . . . . My license and the patient's [sic] lives were definitely put in jeopardy this past weekend. It is not safe for one nurse to manage 70 patients.... The facility should have been closed do [sic] to lack of staff.

**June 8, 2009**

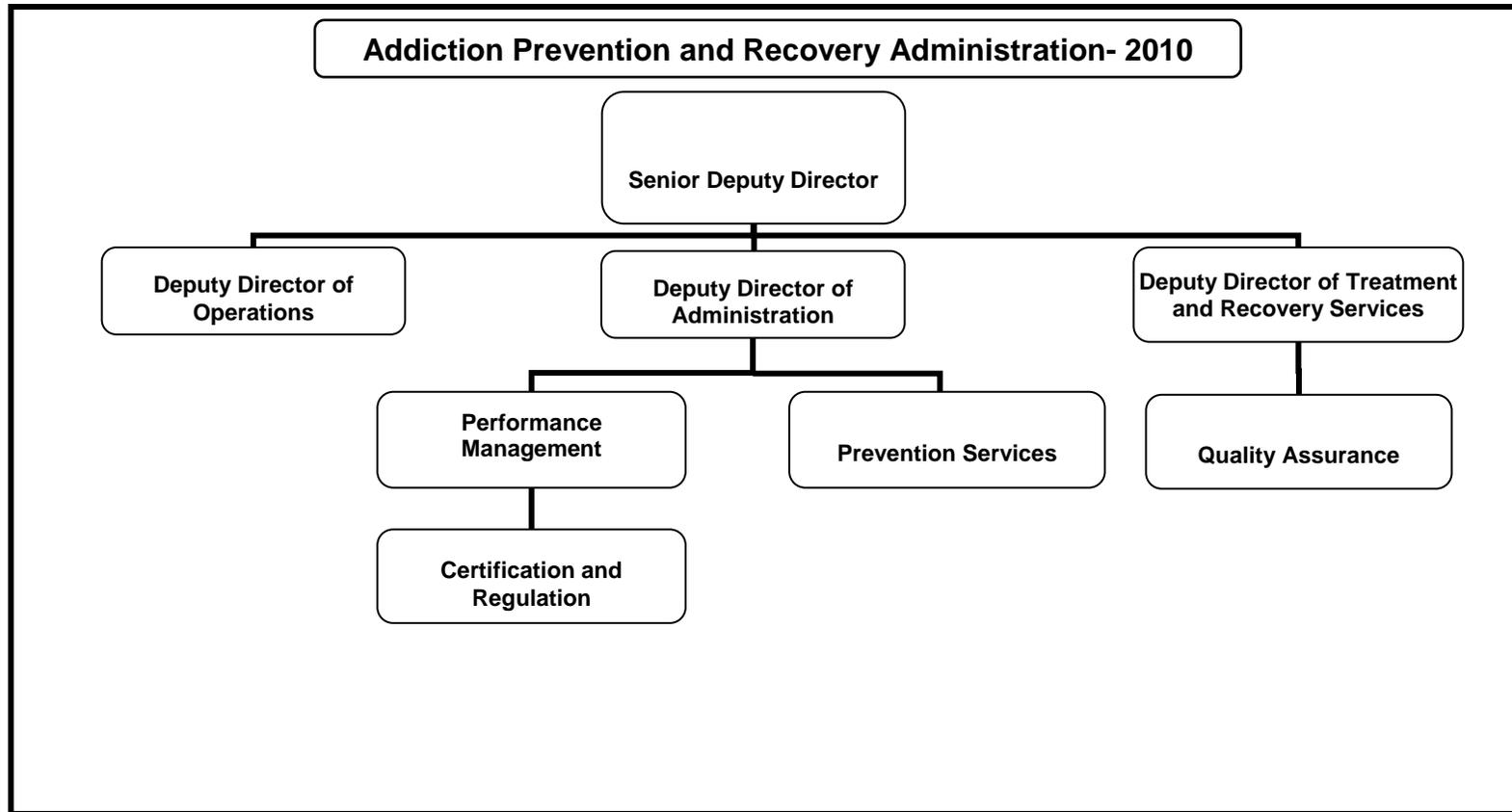
Another consultant hired by APRA submitted a report entitled "Risk Reduction Strategies for APRA's Detoxification/Stabilization Center" recommending numerous risk reduction measures.

**August 14, 2009**

APRA closed DSC.

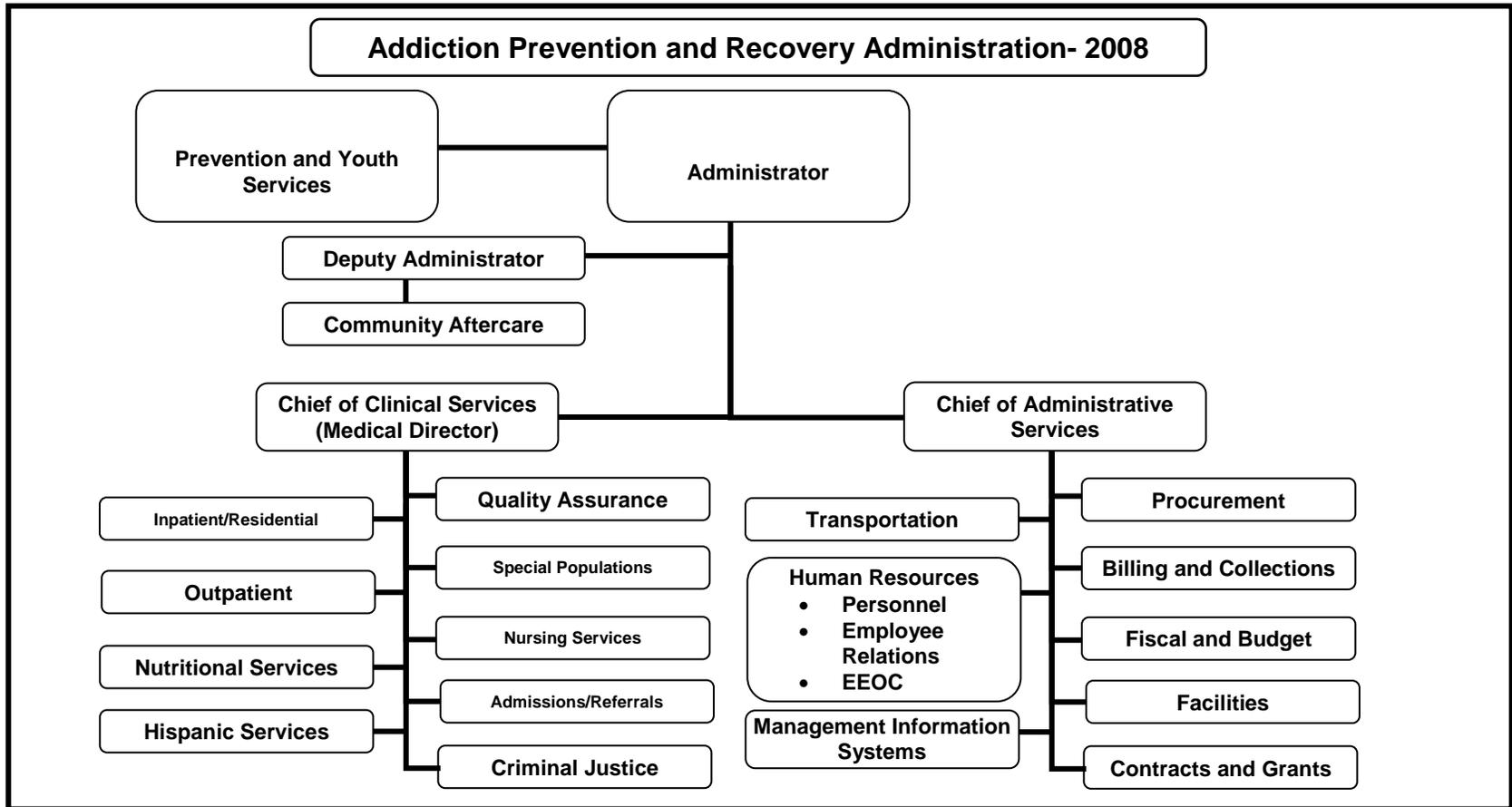
**ORGANIZATION CHARTS**

ORGANIZATION CHARTS



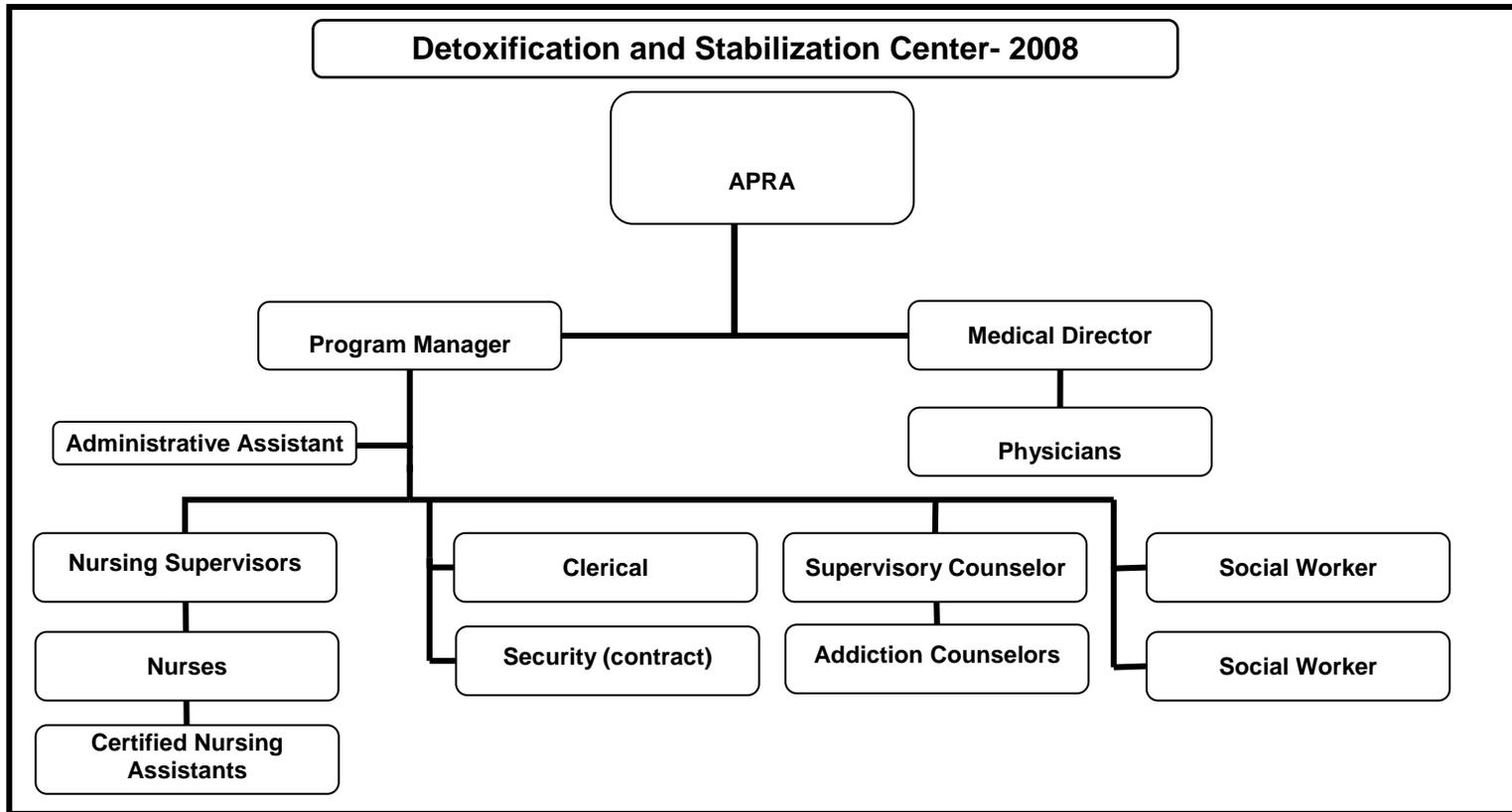
Source: APRA website, current as of June 2010.

ORGANIZATION CHARTS



Source: APRA application for recertification, current as of September 2008.

ORGANIZATION CHARTS



Source: APRA application for recertification, current as of September 2008.

**INTRODUCTION AND BACKGROUND**

### **Introduction**

This report is an excerpt of a Special Evaluation addressing deficiencies at the Addiction Prevention Recovery Administration (APRA), and APRA's Detoxification and Stabilization Center (DSC) from 2008 through 2010. Due to confidentiality concerns, the full report could not be published for public dissemination.

### **Organization and History of APRA and DSC**

The D.C. Department of Health (DOH) formed APRA in 1997 through Organization Order Number 7 as the District of Columbia's Single State Agency (SSA) for alcohol, tobacco, and other drug (ATOD) abuse prevention, treatment, and recovery services. As such, APRA oversees and regulates public substance abuse initiatives for DOH and is the primary funding administration for substance abuse treatment services for uninsured and underinsured District residents at risk or suffering from substance use disorders. APRA's mission is to "establish a substance abuse prevention, treatment and recovery support system of care for District residents and families coping with the disease of addiction or at risk of becoming addicted to alcohol and illicit drugs."

APRA receives the majority of its budget from local funds (approximately 62%) and the remainder from federal dollars and other grants. APRA's total budget for fiscal year (FY) 2011 is \$35.353 million, a 21.5% decrease from FY 2008, when DSC was providing direct services to residents.

A prominent consulting firm hired by the District published an organizational assessment of APRA in April 2007. The report noted a number of deficiencies, including:

- insufficient data supporting business decisions;
- insufficient program monitoring;
- potential conflicts as an overseer and direct provider of services; and
- ineffective policies and procedures.

**Drug Treatment Choice Program (DTCP):** The D.C. Council enacted the Choice in Drug Treatment Act of 2000, effective July 18, 2000, mandating the implementation of the DTCP.<sup>5</sup> DOH proposed regulations to implement this Act in Title 29 of the District of Columbia Municipal Regulations (DCMR) Chapter 23, Certification Standards for Substance Abuse Treatment Facilities and Programs. These regulations became final on November 24, 2000.

The purpose of the DTCP is to facilitate District residents' access to quality services at certified substance abuse treatment facilities of their choice, subject to the availability of funding and eligibility requirements. In order to participate in the DTCP, a potential substance abuse treatment provider must submit an application to APRA. APRA then determines the program's certification eligibility, pursuant to the DCMR, and is responsible for continually monitoring the provider.

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<sup>5</sup> See D.C. Code § 7-3003 (2008).

## INTRODUCTION AND BACKGROUND

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**Intake:** APRA currently manages two assessment and referral sites. The main Assessment and Referral Center (ARC) is located at 1300 First Street, N.E., Washington, D.C. APRA also provides assessment and referral services in Jury Room 114 of the D.C. Superior Court, located at 500 Indiana Avenue, N.W., Washington, D.C. Both sites assess individuals for services and refer them to appropriate substance abuse treatment facilities.

**DSC:** DSC was an 80-bed, 24-hour inpatient detoxification center located on the campus of D.C. General Hospital that operated until August 2009.<sup>6</sup> The center provided medical detoxification services for a variety of substances, including heroin, cocaine, alcohol, and PCP. DSC provided detoxification services to 3,056 individuals in FY 2008 and 2,147 individuals in FY 2009. The typical length of stay at the DSC was between 7 and 9 days.

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<sup>6</sup> APRA did not bill Medicaid for services rendered at the DSC prior to its closure in August 2009. It remains unclear why APRA did not bill Medicaid for these services, and the employees who worked at APRA during this time period have since exited government service.

**SYSTEMIC DEFICIENCIES, QUESTIONABLE MANAGEMENT  
PRACTICES AT DSC AND APRA:  
2008 TO 2010**

Issues and Findings:

- DSC was not penalized even though it repeatedly failed to respond timely to OCR's requests for documentation of corrective actions.
- DSC policies and procedures were outdated or undated, voluminous, and poorly organized.
- Maintaining proper staffing levels at DSC was a persistent challenge.
- DSC employees were poorly supervised.
- DSC did not formally train its employees.
- DSC was permitted to operate while uncertified and, despite numerous unaddressed operational failures, APRA's SDD problematically granted DSC full certification and made the effective date retroactive to May 2008.

**Substandard Conditions and Practices at the Detoxification and Stabilization Center (DSC)**

While investigating the events surrounding a death at DSC, the team learned of systematic, recurring service failures at DSC. The team reviewed an April 2008 memorandum written by the Addiction Prevention and Recovery Administration’s (APRA) Senior Deputy Director (SDD) to DSC managers after she made two unannounced visits to DSC. The memorandum noted significant operational and clinical issues at DSC needing immediate attention. It stated that “[t]he clinical environment of the facility [DSC] is unstructured . . . [t]here is little evidence of clinical service delivery . . . [and, therefore,] it is unclear how determinations are made for continued treatment and level of care needs.”

The team also reviewed reports written by outside parties that reiterated significant issues. The first report was written by Dr. Peter Luongo, a consultant APRA hired to conduct an assessment of DSC operations from October 2008 until December 2008. According to the memorandum of understanding (MOU) between Luongo and the D.C. Children and Youth Investment Trust Corporation, Luongo was paid \$63,000 to:

Evaluate the quality, utilization and effectiveness of detoxification and stabilization services operated by the Addiction Prevention and Recovery Administration...; [ ] identify deficiencies in the medical, clinical and business operations in the delivery of these services; and [ ] develop recommendations to improve the medical, clinical and business operations . . . that are consistent with evidence-based practices and widely-accepted medical and clinical standards of care.

APRA’s SDD told the team that at the time Luongo was retained, she wanted to close DSC and, in effect, to document conditions and services at DSC so that she would be justified in closing it. According to APRA’s SDD, DSC was a politically sensitive topic and people would have protested its closing. She said she needed a clear idea of the facility’s deficiencies and that it was “nearly impossible to get information from DSC staff members.” She needed a clear recommendation and ideas of next steps.

In December 2008, Luongo concluded:

[DSC] does not meet minimal certification standards under Title 29 [of the District of Columbia Municipal Regulations (DCMR)] and does not have the infrastructure and management processes in place to become certified . . . . Administrative and medical/clinical management practices are uninformed by modern practice and science . . . [and] the staff must be characterized, as a group, as not meeting minimal professional competencies for work at a detoxification center.<sup>7</sup>

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<sup>7</sup> APRA Detoxification Center Evaluation at 2 (Dec. 2008). (See Appendix 4)

A second report, dated June 2009 and entitled “Risk Reduction Strategies for APRA’s Detoxification/Stabilization Center,” was written by another consultant APRA hired. The report noted numerous steps to reduce risk at DSC, which included the following suggestions:

- improve the assessment process;
- improve shift-by-shift documentation;
- improve employee training;
- conduct regular searches of the facility;
- do not keep patients in treatment beyond their assessed need; and
- collect and analyze data about incidents and take appropriate action.

Although APRA management officials were well aware of DSC’s systemic service failures, the DSC continued to serve vulnerable clients until August 2009. Due to slow responses to long-standing operational failures at DSC, and an unwillingness or inability to take swift, decisive action to close DSC, APRA senior managers continued to not only expose DSC clients and employees to significant, well-documented health, safety, and security issues, but also unnecessarily prolonged the District’s exposure to legal liability.

#### **ISSUES AND FINDINGS**

#### **DSC was not penalized even though it repeatedly failed to respond timely to the Office of Certification and Regulation’s (OCR) requests.**

After certification, if APRA’s OCR discovers that a substance abuse treatment facility is not compliant with any certification standards set forth in Title 29 DCMR Chapter 23, OCR documents the noncompliance in a statement of deficiencies (SOD) and issues it to the facility within 30 days of the inspection.<sup>8</sup> After receiving an SOD, the facility must submit a Corrective Action Plan (CAP)<sup>9</sup> to APRA within 30 days.<sup>10</sup> The CAP must contain, at a minimum:

- (a) A statement of the deficiency;
- (b) A description of the corrective action(s) to be taken;
- (c) The date of completion for each action; and
- (d) The signature of the person responsible for the program.<sup>11</sup>

APRA then determines whether the CAP is acceptable and provides a written determination to the facility within 15 business days of receiving a CAP.<sup>12</sup> APRA has authority to enter and inspect a substance abuse treatment facility during normal operating hours to conduct announced or unannounced visits.

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<sup>8</sup> See 29 DCMR § 2307.1.

<sup>9</sup> A CAP is the standardized format for responding to an SOD. See *id.* §§ 2307.5, 2307.7.

<sup>10</sup> See *id.* §§ 2307.5, 2307.7.

<sup>11</sup> *Id.* § 2307.6.

<sup>12</sup> *Id.* § 2307.7.

If APRA discovers that a substance abuse treatment facility is noncompliant with any federal, state, or local laws, the DCMR, local ordinances, rules, regulations, or D.C. Code, APRA may penalize the facility in one of several ways:

- (a) Summary suspension – which takes effect immediately without benefit of a hearing, for infractions posing imminent risk;
- (b) Suspension – which may be delayed until the program or facility has an opportunity to be heard on the charges when the charges do not pose an imminent risk;
- (c) Revocation – which may be delayed until the program or facility has an opportunity to be heard on the charges when the charges do not pose an imminent risk;
- (d) Denial of an application for certification; or
- (e) Civil fines and penalties.<sup>13</sup>

On February 4, 2008, OCR sent two inspectors to DSC to conduct an unannounced visit “in order to review the progress made by the facility to correct cited deficiencies from the last visit. The deficiencies resulted in the facility receiving a Provisional Certification which is due to expire on 05-13-08.”<sup>14</sup> The inspectors were refused entry into the facility by DSC’s program manager, who apparently “instructed his staff to [advise them] that he didn’t have time to deal with [them] because he and his supervisory staff were preoccupied with an emergency project.”<sup>15</sup>

Following the incident, however, DSC was not penalized. DSC also was not penalized when it did not meet a deadline for providing OCR with a CAP to address cited deficiencies. From March 11 through 13, 2008, OCR conducted a planned site visit at DSC. On April 15, 2008, OCR’s chief wrote a letter to DSC’s program manager and enclosed the SOD from the March 2008 site visit. The completed SOD forms were due within 30 days of receipt of the letter. DSC did not respond to OCR’s requests by the deadline. DSC’s provisional certification then expired on May 13, 2008.

On June 17, 2008, more than 30 days after receipt of the SOD, DSC’s program manager sent a letter to OCR’s chief requesting a 30-day extension to correct the noted deficiencies. On June 20, 2008, OCR’s chief emailed DSC’s program manager to grant an extension for the due date for DSC’s CAP until July 17, 2008. Again, DSC did not send a completed CAP to OCR by the requested date.

The OCR chief emailed APRA Manager 1 on July 9, 2008, to note that DSC’s program manager must “at least, make an attempt to complete [a certification] application like every other provider.” On September 30, 2008, APRA Manager 1 emailed DSC’s Medical Director regarding DSC’s SOD, noting that the extended deadline for submitting the CAP had passed. On September 24, 2008, and again on October 20, 2008, OCR’s chief wrote a letter to DSC’s program manager noting that DSC had not yet corrected the deficiencies OCR initially cited during the March 2008 site inspection. These letters asked DSC’s program manager to return

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<sup>13</sup> *Id.* §§ 2367.2, 2367.3.

<sup>14</sup> Unannounced Visit Report, APRA Detox Unit Bldg: 12 (Feb. 4, 2008).

<sup>15</sup> *Id.*

DSC's CAP within 5 calendar days. Again, on December 10, 2008, OCR's chief emailed APRA Manager 1 to inform him that DSC had not yet submitted a CAP. On December 22, 2008, APRA's SDD emailed a memorandum to DSC's Medical Director attaching DSC's CAP. She wrote:

[DSC] has now been operating in an uncertified capacity for nearly seven months and this is unacceptable.

In order to achieve certification for Detox on an expedited basis, I called together staff from throughout APRA to address the problem areas identified in the latest statement of deficiencies provided by OCR.... Following several days of collaboration, the team prepared the attached corrective action plan and attachments that were submitted to OCR for review.

I am directing you to review the attached documents and work with [the DSC program manager] and Detox staff to implement each corrective measure outlined by the deadline indicated.

Pursuant to 29 DCMR § 2300.5, noncertified substance abuse treatment facilities should be subject to penalties.<sup>16</sup> Yet, despite DSC's prolonged uncertified status, OCR did not impose any penalties on the facility.

#### **RECOMMENDATION**

- That the Director of the D.C. Department of Health (D/DOH) ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:
  - That substance abuse treatment providers promptly respond to OCR's requests.

#### **DSC policies and procedures were outdated or undated, voluminous, and poorly organized.**

Federal regulations dictate that all opioid treatment programs must maintain "current quality assurance" mechanisms, which include, "among other things, annual reviews of program policies and procedures . . ."<sup>17</sup> Likewise, 29 DCMR § 2320 stipulates that substance abuse treatment facilities develop and implement policies and procedures that accurately describe the services provided.<sup>18</sup> A number of other DCMR sections provide that substance abuse treatment facilities must develop and implement written policies and procedures regarding a variety of topics,<sup>19</sup> including:

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<sup>16</sup> The D.C. Code states that the penalty for the operation of a substance abuse treatment facility without the proper certification shall be: 1) A civil fine of not less than \$100 for each day of operation without certification; and (2) Revocation of the certificate of occupancy issued by [DCRA] for the premises occupied by the substance abuse treatment facility. See D.C. Code § 44-1204(f) (2003).

<sup>17</sup> 42 C.F.R § 8.12(c)(1).

<sup>18</sup> See 29 DCMR § 2320.1.

<sup>19</sup> See *id.* §§ 2313.2, 2315.2, 2315.15, 2318.2, 2326.1, 2326.2, 2326.3, 2327.3, 2327.13, 2329.2, 2329.7, 2329.8, 2330.7, 2334.7, 2335.9, 2336.7, 2337.3, 2339.9, 2348.2, 2348.5, 2350.1, 2351.1, 2352.1, 2355.7, 2360.2, 2360.17, 2360.26, 2360.28, 2366.1.

- service delivery;
- emergency preparedness;
- personnel rights and responsibilities;
- patient confidentiality;
- rights and privileges of patients; and
- drug testing.

The December 2008 Luongo report concluded that “[a] major management problem [with DSC] [wa]s the lack of standard operating policies and procedures.”<sup>20</sup> This report noted that DSC’s policies and procedures were located in the Director’s office, not generally updated, and not specific to the Center. Former DSC employees confirmed these assertions to the team. Likewise, the team reviewed DSC’s improvement plan, created by APRA management in December 2008. This improvement plan noted that, among other deficiencies, DSC employees did not have adequate access to policies and procedures.

The team reviewed DSC policies and procedures provided by APRA and found them deficient. The team noted that DSC’s policies and procedures: 1) were not updated regularly and did not seem to reflect changes in services or accommodate newly developed clinical practices; 2) had conflicting instructions and sometimes contradicted requirements set forth in the DCMR; 3) mainly related to the APRA system as a whole and were not specific to DSC’s services; and 4) were voluminous and unorganized.

The team found that some of DSC’s policies and procedures were dated around the year 2000, and did not appear to have been updated. Others simply were undated. The team also found potential conflicts between DSC policies and procedures and the DCMR. For example, the policy and procedure entitled *Assessment* states that obtaining some assessment information, such as a history of substance abuse treatment, from DSC patients is discretionary while Title 29 DCMR § 2334 mandates obtaining this information from patients during the assessment process. The team also found inconsistencies within DSC’s policies and procedures. For example, depending on the document consulted, policies and procedures dictated that patient records should have been stored in a secure, on-site medical records room, in the Central Registry Division, or in the APRA administrative office.

According to the Luongo report, no one at DSC was assigned the responsibility to develop, implement, monitor, and update DSC’s policies. The report also noted that without a full working set of policies and procedures, the “day-to-day operations of the facility [DSC] are haphazardly and idiosyncratically applied.”<sup>21</sup> The report also concluded that the clinical program at DSC lacked an “internal quality assurance process . . . for self-correction, reflective practice, or to identify and integrate modern medical and clinical practices.”<sup>22</sup>

APRA managers and former DSC employees repeatedly said that they were unaware of and/or unfamiliar with DSC policies and procedures.

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<sup>20</sup> APRA Detoxification Center Evaluation at 10 (Dec. 2008). (See Appendix 4)

<sup>21</sup> *Id.* at 11.

<sup>22</sup> *Id.* at 17.

### RECOMMENDATIONS

- That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:
  - That substance abuse treatment providers have adequate policies and procedures that are readily available to all employees in accordance with DCMR.
  - That substance abuse treatment facilities establish a regular schedule and standardized process for updating policies and procedures.

#### **Maintaining proper staffing levels at DSC was a persistent challenge.**

The DCMR dictates that substance abuse treatment facilities must have adequate employee coverage during hours of operation to admit, treat, and discharge patients.<sup>23</sup> Medical detoxification centers are subject to more specific regulatory requirements regarding staffing. Medical detoxification centers, such as DSC, are required to maintain a patient-to-nurse ratio that cannot exceed 12:1 during the day shift (7:30 a.m. to 4:00 p.m.), 17:1 on the evening shift (3:30 p.m. to 12:00 a.m.), and 25:1 on the night shift (11:30 p.m. to 8:00 a.m.).<sup>24</sup> Additionally, medical detoxification centers must maintain on-site physician coverage 24 hours a day.<sup>25</sup>

The SOD that DSC received from APRA's OCR in April 2008, following the March 2008 site visit, noted that, generally, DSC did not maintain the required nurse-to-patient ratio. On the evening of Sunday, January 11, 2009, a nurse at DSC emailed APRA and DSC management to recount a "weekend of horror:"

My license was in jeopardy and the patient's [sic] lives as well. I worked with a census of 70 plus patients this past weekend with no other nurses. The same duties are performed as through the week days. The observation unit had to be monitored, the methadone had to be given, the patient's [sic] had to be admitted and the orders had to be taken off and the CID patients had to be processed. Clients had to be sent to the hospitals, and they had to be followed up on. Furthermore, sick call had to be done, patients had to be counseled, notes had to be written and the telephones had to be answered.

My license and the patient's [sic] lives were definitely put in jeopardy this past weekend. It is not safe for one nurse to manage 70 patients. Please show me where the nurse ratio to patients is 1:70 for a twenty[-]four hour facility.

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<sup>23</sup> See 29 DCMR §§ 2326.1(f), 2364.3.

<sup>24</sup> See *id.* § 2364.6.

<sup>25</sup> See *id.* § 2364.4.

The facility should have been closed due to lack of staff. I will not continue to work in an unsafe environment, and I believe that [a] meeting is needed to discuss nursing issues. ALL supervisors need to be listened to and heard [and] not just some.

The nurse further recounted to a colleague that the nurse-to-patient ratio “was pure hell. I refuse to work like a dog and do the same duties that you have 3-4 nurses doing on the day shift.”

Inability to maintain adequate physician coverage was also a persistent issue. KPMG’s April 2007 report noted that DSC did not have in place the required 24-hour physician coverage. The SOD that DSC received from APRA’s OCR in April 2008 also cited the lack of on-site physician coverage 24 hours a day. On December 16, 2008, DSC’s Medical Director emailed APRA management to discuss staffing deficiencies at DSC, stating:

As you know, the Detox Center [DSC] is severely understaffed in terms of physicians. I have requested [ ] two additional full-time physicians for the Detox Center, and one additional full-time female physician for the Women’s Services Center; with no response. It is critical that we get these physicians in place for the proper medical care of our clients, and to meet standards. Treat this as an URGENT matter.

The resulting email dialogue eventually reached the D/DOH, who wrote to DSC’s Medical Director on December 17, 2008: “As managers, we bear the responsibility of ensuring that the public we serve can be well taken care of. As the person responsible for the clinical team at APRA, I expect that you will handle this matter swiftly.”

#### **RECOMMENDATIONS**

- That the D/DOH ensure that APRA monitors substance abuse treatment facilities’ adherence to established protocols and addresses facilities’ noncompliance with these standards, specifically:
  - That substance abuse treatment facilities maintain adequate nursing staff in compliance with the mandatory nurse-to-patient ratio set forth in the DCMR.
  - That detoxification centers maintain 24-hour a day on-site physician coverage in accordance with the DCMR.
  - That substance abuse treatment facilities accurately track and document their daily patient populations to ensure staff-to-patient ratio requirements are consistently met.

**DSC employees were poorly supervised.**

According to the DCMR, all substance abuse treatment employees must be adequately supervised, consistent with their job functions and responsibilities.<sup>26</sup> Facilities providing medical detoxification services must also have a designated registered nurse (RN) who is responsible for general supervision of the nursing staff.<sup>27</sup>

The DCMR also dictates that certain documents be co-signed by a licensed professional counselor, licensed psychologist, a Licensed Independent Clinical Social Worker (LICSW), licensed psychiatric or chemical dependency nurse, or physician licensed in the District who has at least 1 year of experience in the treatment or rehabilitation of substance abuse.<sup>28</sup> Documentation that must be co-signed includes: assessments, rehabilitation plans, updates, continuing care plans, aftercare plans, and discharge summaries. Two signatures should indicate an upper-level review and approval of the underlying work recorded, thereby providing some level of monitoring.

The December 2008 Luongo report, which was based on several months of direct observation of and interaction with DSC staff members, provided an unequivocal assessment of supervisory roles at DSC:

There is a loose sense of the chain of command and the prevailing sense that an ad hoc response to problems is the norm. Except for their immediate supervisor, staff had only a vague understanding of their chain of command and how problems and concerns were to be surfaced, and importantly how and when they were resolved.... The culture of the organization as inferred from the management and staff is that the program is a victim of benign, if not active, neglect, and there is very little control that they can exercise over their work environment and product....

The Center Director consistently demonstrated marginal engagement with the work of the Center. Direct questions regarding operations or documentation were frequently met with, "I don't know," or "You need to ask the nurses or doctor".... The unmistakable impression was that the director took little responsibility for the operation of the program.<sup>29</sup>

**RECOMMENDATION**

- That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:

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<sup>26</sup> *Id.* § 2328.1.

<sup>27</sup> *Id.* § 2364.5.

<sup>28</sup> *Id.* §§ 2328.5, 2328.3(a).

<sup>29</sup> APRA Detoxification Center Evaluation at 10, 12 (December 2008). (*See* Appendix 4)

- That substance abuse treatment facilities provide and document effective employee supervision.

**DSC did not formally train its employees.**

Pursuant to the DCMR, every substance abuse treatment facility in the District must maintain and implement a plan for staff development.<sup>30</sup> This plan must include mechanisms for ensuring adequate employee orientation and training, and training must be sufficiently documented.<sup>31</sup>

Substance abuse treatment facilities are required to provide training to employees on a number of topics, such as concepts of quality improvement and treatment outcomes, providing care to dually diagnosed patients,<sup>32</sup> and meeting Occupational Safety & Health Administration (OSHA)<sup>33</sup> requirements.<sup>34</sup> Employees who have contact with patients must also receive training in the safe and effective use of behavior management methods permitted by their facility.<sup>35</sup> Employees in medical detoxification facilities must also receive training on medical management and supervision of detoxification from alcohol and drugs, and recognizing the signs and symptoms of chemical dependency.<sup>36</sup> In addition, all clinical and/or professional employees must participate in 20 hours of in-service training or continuing education each year, exclusive of required orientation, with at least 10 hours of continuing education provided by an outside source.<sup>37</sup> Further, according to APRA policies and procedures in place at the time, all DSC employees were required to receive annual, in-service training on managing a patient's violent and aggressive behavior.<sup>38</sup>

The lack of employee training at DSC was cited repeatedly. KPMG's April 2007 report noted that APRA did not track employee training adequately and that APRA employees were not informed of existing training opportunities. OCR's April 2008 SOD concluded that DSC did not train its employees on OSHA requirements, such as reducing exposure to hepatitis, tuberculosis, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), and the use of universal precautions. The SOD also noted that DSC failed to train its employees in concepts of quality improvement, treatment outcomes, and ensure adequate documentation of in-service and off-site training as required by the DCMR. According to the June 2009 report entitled *Risk Reduction Strategies for APRA's Detoxification/Stabilization Center*, DSC still had not developed its own program of in-service education classes focusing on DSC-specific procedures.

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<sup>30</sup> 29 DCMR §§ 2327.3, 2327.4, 2327.7.

<sup>31</sup> *Id.* § 2327.11.

<sup>32</sup> Dual diagnosis is defined as "the presence of concurrent diagnosis of substance abuse/dependency and a mental disease or disorder." *Id.* § 2399.

<sup>33</sup> OSHA's mission is to "to ensure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education and assistance."

[Http://www.osha.gov/about.html](http://www.osha.gov/about.html) (last visited Nov. 22, 2010).

<sup>34</sup> *See* 29 DCMR §§ 2362.6, 2327.1, 2327.5, 2327.10.

<sup>35</sup> *See id.* § 2366.2.

<sup>36</sup> *See id.* §§ 2364.2, 2364.7.

<sup>37</sup> *See id.* § 2327.9.

<sup>38</sup> APRA Notice Series (unnumbered), Management of Violent and Aggressive Behavior (Sept. 1, 2000) at 1.

According to an APRA manager, DSC employees did not receive training because no one at DSC was assigned the responsibility of developing and implementing a training program for the employees. As a result, DSC employees may not have been able to provide adequate, uniform care to patients.

**RECOMMENDATION**

- That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:
  - That substance abuse treatment facilities provide employees both the initial and ongoing training needed to competently fulfill their job responsibilities.

**DSC was permitted to operate while uncertified and, despite numerous unaddressed operational failures, APRA's SDD problematically granted DSC full certification and made the effective date retroactive to May 2008.**

According to 29 DMCR § 2300.4, no one can own or operate a substance abuse treatment facility in the District without being certified by APRA. However, continued operation of a facility is not unlawful if an application for certification or re-certification was timely filed and through no fault of its own, APRA has not recertified the facility.<sup>39</sup> The D.C. Code states that the penalty for operating a substance abuse treatment facility without proper certification shall be:

- a civil fine of not less than \$100 for each day of operation without certification; and
- revocation of the certificate of occupancy issued by the D.C. Department of Consumer and Regulatory Affairs (DCRA)<sup>40</sup> for the premises occupied by the substance abuse treatment facility.<sup>41</sup>

On December 19, 2008, a Decision/Information Form from OCR's chief (prepared and signed by a lower level staff member), was sent through APRA's Deputy Director for Administration to APRA's SDD stating that DSC was granted "full certification to provide Level III Residential Detoxification for Adults." APRA's SDD sent a letter to DSC granting it full certification for 1 year,<sup>42</sup> retroactive to May 13, 2008. In effect, it gave the appearance that DSC's certification had never lapsed, even though it had lapsed for 7 months.

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<sup>39</sup> 29 DCMR §§ 2300.6, 2305.6.

<sup>40</sup> The mission of DCRA is to "protect the health, safety, economic interests, and quality of life of residents, businesses, and visitors in the District of Columbia by issuing licenses and permits, conducting inspections, enforcing building, housing, and safety codes, regulating land use and development, and providing consumer education and advocacy services." [Http://dcra.dc.gov/DC/DCRA/About+DCRA/Who+We+Are](http://dcra.dc.gov/DC/DCRA/About+DCRA/Who+We+Are) (last visited Mar. 3, 2011).

<sup>41</sup> D.C. Code § 44-1204(f) (2003).

<sup>42</sup> Detoxification facilities are regulated under a "tripartite system." Under this system, detoxification facilities are regulated by their respective Single State Agency (SSA), the U.S. Drug Enforcement Administration (DEA), and Substance Abuse and Mental Health Services (SAMHSA). According to the Narcotic Addict Treatment Act of

Two days prior to the APRA SDD's issuance of the certification, Luongo submitted via email to APRA's SDD his preliminary evaluation of DSC. He wrote:

- The Center is an inefficient, costly and clinically outdated program.
- The Center currently cannot meet minimal certification standards under Title 29 and does not have the infrastructure and management processes in place to become certified.
- Administrative and medical management practices are uninformed by modern practice, are archaic, resistant to change and significantly contribute to poor patient outcomes and extended lengths of stay.
- While individual Center staff display outstanding professional qualities and skill, the staff must be characterized, as a group, as not meeting minimal professional competencies for work at a detoxification program ....

The management structure is unclear and chaotic. Management roles and responsibilities are not definitively articulated .... Basic and routine functions necessary to effective day-to-day operations of a 24/7 facility are haphazard .... Standard detoxification protocols were found only in the director's office, not at the nurse's station, nor in the physician's office where they should be normally found. The protocols that do exist, are outdated and do not reflect current standards of care .... The Center is directly operated by APRA, but at times over half of the staff are contract employees from professional staffing agencies.<sup>43</sup>

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1974, a practitioner using Schedule II narcotic drugs, such as methadone, for detoxification must be certified by the DEA as a narcotic treatment program. This registration allows a practitioner to administer or dispense scheduled narcotic drugs for the treatment of narcotic addiction. In addition to DEA certification, all detoxification facilities must be certified by SAMHSA. *See* 42 CFR § 8.1. As a prerequisite to SAMHSA certification, detoxification facilities must receive an accreditation from an accrediting body approved by SAMHSA, such as the Commission on Accreditation of Rehabilitation Facilities (CARF). *See id.* Accreditation is a peer-review process in which the accrediting body conducts site visits and evaluates a facility against federal opioid treatment standards and the accreditation body's standards. *See id.* § 8.4(a). Federal opioid treatment standards include, among other things, requirements regarding organizational structure, quality assurance mechanisms, staff credentials, patient admission criteria, required services, assessment services, counseling services, and recordkeeping. *See id.* § 8.12. Following accreditation, SAMHSA certifies facilities. According to federal regulations, as a condition to SAMHSA certification, all detoxification centers must comply with all pertinent state laws and regulations and the aforementioned federal opioid treatment standards. *See id.* §§ 8.11(f) & 8.12. Although the team was doubtful that DSC met federal opioid standards, and has shown throughout this report that DSC did not comply with pertinent state laws, as required for CARF accreditation and SAMHSA certification, the team confirmed that DSC was in fact accredited by CARF and certified by SAMHSA prior to its closure.

<sup>43</sup> APRA Detox Summary Letter at 1, 2, 3. (December 2008). (*See* Appendix 3)

On the same day that APRA's SDD granted DSC full, retroactive certification, Luongo submitted his final report of evaluation of DSC, which reiterated his preliminary findings.

Given the preponderance of evidence that DSC could not provide an acceptable level of services to its clients, the APRA SDD's decision to fully certify the facility and make the effective date of certification retroactive to May 2008, is highly questionable. The OIG can only speculate about what motivated APRA managers to hasten the process and grant full certification to the facility on December 19, 2008. It is unsettling that given the magnitude and duration of the DSC's operational deficiencies and the unequivocal opinion of a highly qualified consultant that DSC was an "inefficient, costly[,] and clinically outdated program,"<sup>44</sup> APRA management not only fully certified the facility following the death of a DSC patient, but allowed it to serve clients for another 8 months before finally closing it.

The team interviewed APRA managers and reviewed correspondence from 2008 and learned that APRA's certification of DSC did not follow the usual protocol. Typically, an applicant submits materials to OCR, which then reviews the information (and collaborates, if necessary, with the applicant on necessary improvements) and then determines whether to grant the facility certification. OCR attempted to collaborate with DSC on a CAP so that it could obtain certification, but was repeatedly thwarted by DSC management's unresponsiveness. APRA senior management took the lead in securing DSC's certification. Although Title 29 of the DCMR does not prohibit the practice, retroactive certifications do not appear to serve a purpose consistent with APRA's mission.

According to APRA management, DSC was allowed to operate while uncertified because it was in a "pending" status. According to the DCMR, a facility is allowed to continue to operate while its application is pending with OCR if, through no fault of the facility, OCR is untimely in recertifying the facility.<sup>45</sup> However, in this instance, DSC was solely to blame for its failure to maintain certification. DSC did not respond to OCR's requests and operational deficiencies persisted. Therefore, this facility should not have been allowed to operate in an uncertified status for such a prolonged period. According to APRA's SDD, APRA's management was unable to close DSC due to its "pending status." APRA's SDD stated that "[a] facility [can]not be closed while it was in a 'pending' state." However, the team was unable to find support for this rationale in the D.C. Code or the DCMR.

DSC was not the only substance abuse treatment facility that APRA allowed to operate without certification. Most notably, another APRA-operated facility on the D.C. General Hospital campus, the Women's Services Center (WSC) (an outpatient treatment center), operated in an uncertified status from April 2006 until 2009. APRA also allowed programs run by other service providers to operate without proper certification.

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<sup>44</sup> APRA Detoxification Center Evaluation at 2 (December 2008). (See Appendix 4)

<sup>45</sup> 29 DCMR § 2305.6.

**RECOMMENDATION**

- That the D/DOH establish and promulgate clear criteria for closing substance abuse treatment facilities that do not meet the District's standards, and define conditions and events that would automatically trigger the closure of a substandard facility.

**APPENDICES**

## APPENDICES

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- Appendix 1: List of Findings and Recommendations
- Appendix 2: Memorandum from APRA's SDD to DSC Managers (April 2008)
- Appendix 3: Letter from Outside Consultant Summarizing His Evaluation of DSC (December 17, 2008)
- Appendix 4: *APRA Detoxification Center Evaluation* (December 2008)
- Appendix 5: Documents Pertaining to APRA SDD's Decision to Fully, Retroactively Certify DSC

**APPENDIX 1**

## List of Findings and Recommendations

1. **DSC was not penalized even though it repeatedly failed to respond timely to OCR's requests.**

That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:

- a. That substance abuse treatment providers promptly respond to OCR's requests.

2. **DSC policies and procedures were outdated or undated, voluminous, and poorly organized.**

That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:

- a. That substance abuse treatment providers have adequate policies and procedures that are readily available to all employees in accordance with DCMR.
- b. That substance abuse treatment facilities establish a regular schedule and standardized process for updating policies and procedures.

3. **Maintaining proper staffing levels at DSC was a persistent challenge.**

That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:

- a. That substance abuse treatment facilities maintain adequate nursing staff in compliance with the mandatory nurse-to-patient ratio set forth in the DCMR.
- b. That detoxification centers maintain 24-hour a day on-site physician coverage in accordance with the DCMR.
- c. That substance abuse treatment facilities accurately track and document their daily patient populations to ensure staff-to-patient ratio requirements are consistently met.

4. **DSC employees were poorly supervised.**

That the D/DOH ensure that APRA monitors substance abuse treatment facilities'

adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:

- a. That substance abuse treatment facilities provide and document effective employee supervision.

**5. DSC did not formally train its employees.**

That the D/DOH ensure that APRA monitors substance abuse treatment facilities' adherence to established protocols and addresses facilities' noncompliance with these standards, specifically:

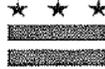
- a. That substance abuse treatment facilities provide employees both the initial and ongoing training needed to competently fulfill their job responsibilities.

**6. DSC was permitted to operate while uncertified and, despite numerous unaddressed operational failures, APRA's SDD problematically granted DSC full certification and made the effective date retroactive to May 2008.**

That the D/DOH establish and promulgate clear criteria for closing substance abuse treatment facilities that do not meet the District's standards, and define conditions and events that would automatically trigger the closure of a substandard facility.

**APPENDIX 2**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH



Office of the Senior Deputy Director  
for Substance Abuse Services

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To: [REDACTED] Interim Clinical Director  
[REDACTED] Program Manager, APRA Detoxification and Stabilization Center

From: [REDACTED] Senior Deputy Director

Date: April 2, 2008

Re: APRA Detoxification and Stabilization Center

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On April 1, 2008 and April 2, 2008 I made two unannounced visits to the APRA Detoxification and Stabilization Center. Each visit included client and staff engagement, chart reviews, identification of supply needs, and an inventory of outstanding facility repair needs. There are significant operational and clinical issues at the APRA Detoxification and Stabilization Center that require immediate attention and action, including the following:

Facility Condition

Overall, the facility was clean and orderly. The temperature was appropriately moderated. However, there are a number of operational issues that have not been addressed in a timely manner.

- There are a number of clinical staff offices with buckled ceiling tiles that appear to be the result of a water leakage. In one office putrid smelling water drips down the wall from the site of the buckled ceiling tile.
- Two showers on the male unit are out of order and in need of repair.
- One commode on the female unit is out of order and in need of repair.
- The ice machine is out of order and in need of repair.
- Hypothermia unit requires deep cleaning and sanitization, including cots/beds, floor and walls.
- Tripping hazards created as a result of janitorial staff placing pieces of cardboard boxes at door entrances/exits to minimize staff and clients from tracking rain water into the facility.
- Game tables in the recreation room out of order and in need of replacement.

### *Immediate Actions Required*

- Place call to OPM facilities personnel to identify the sources of leakage that resulted in buckled ceiling tiles. Is it condensation? Drip pans? Other? Ceiling tiles should not be replaced until the sources of leakage are identified.
- The bathrooms on the male and female units require immediate attention. Work with appropriate personnel to get emergency repair orders placed. This is a 24/7 facility near maximum capacity. All bathrooms must remain in working order.
- The ice machine has been serviced twice and remains out of order. Who signed to verify that the work was satisfactorily completed? Work with appropriate personnel to get repair orders placed.
- The Hypothermia unit needs to be cleaned and sanitized immediately. Please see specifics noted above.
- Janitorial staff should be instructed verbally and in writing that boxes will not be used as floor mats. All staff should be instructed verbally and in writing that boxes cannot be used as floor mats. Further, staff should be instructed to immediately remove any boxes that are inappropriately used as floor mats.
- Work with appropriate personnel to identify and procure new game tables for recreation room.

In addition, please identify an internal point of contact to place work orders and to follow-up with OPM and appropriate personnel on work orders placed. This person should be the conduit for all such requests from the Detoxification and Stabilization Center. All staff should be instructed verbally and in writing to report identified repair needs to this person for processing.

### Clinical Environment

The clinical environment of the facility is unstructured, and many clients expressed uncertainty and anxiety about post-Detox treatment placement and available choices. While the facility regularly conducts group sessions with clients, it is not clear whether or not the group sessions conducted appropriately meet the needs of participants.

Clients also reported negative staff engagement at all levels (administrative, clinical, medical, etc). This has been a reoccurring theme over my last three visits to the facility. Clients also reported outstanding and respectful engagement with [REDACTED]

### Clinical Service/Chart Review

There is little evidence of clinical service delivery at the Detoxification and Stabilization Center. Random chart reviews demonstrated the following:

- Significant delays in clients meeting with assigned counseling staff. In all charts reviewed, first contact documented with clients is at case conference.

- Poor clinical documentation, no progressive treatment plans or indication of interventions.
- All charts simply recorded the assignment of clients to counselors, yet no follow-up sessions.
- In the absence of appropriate clinical documentation, it is unclear how determinations are made for continued treatment and level of care needs.
- The impact of interventions and group sessions are not monitored and evaluated in the context of the client's future treatment needs.

### Client Orientation

Information posted for client reference is incomplete, and in some instances, misplaced. For example, facility dress code and shaving policies are posted in the main corridor instead of dormitory areas and restrooms. The following information is not posted for client reference:

- Patient's Rights
- Detoxification and Stabilization Center Rules and Regulations
- Grievance Policy
- Emergency Program Contact that includes alternate contact numbers

### *Immediate Actions Required*

- Post patient's rights, rules and regulations, grievance policy and emergency program contact information in main corridor.
- Post dress code and shaving policies in dormitory areas and restrooms.
- Enlarge daily program schedule.
- Develop an alpha-numeric code for public display of client staff assignments.
- Identification of evidence-based practices utilized at the Detoxification Center. Reorientation and training of staff on the identified evidence-based practice.
- Mandatory training for all clinical staff and supervisors on clinical documentation. These trainings will occur on an ongoing basis.

We will meet to discuss other observations and changes that require immediate implementation. [REDACTED] will follow-up with you shortly to schedule a time before the conclusion of this week.

**APPENDIX 3**

[REDACTED]

**From:** Peter Luongo [REDACTED]  
**Sent:** Wednesday, December 17, 2008 1:00 PM  
**To:** [REDACTED]  
**Subject:** Detox Evaluation Summary Letter  
**Attachments:** APRA Detox Summary Letter.doc

[REDACTED]

Attached is a letter summarizing the detox evaluation. I will have a draft final report on Friday for electronic submission. A sample RFP will be delivered within a week [REDACTED]

Regards,

Pete

12/3/2009

**Peter E. Luongo, Ph.D., LCSW-C**  
[REDACTED]

December 17, 2008

[REDACTED]  
Senior Deputy Administrator  
Addiction Prevention and Recovery Administration  
1300 First Street, NE  
Washington, DC

[REDACTED]  
This letter summarizes the findings of my evaluation of the Detoxification Center (Center). A draft of the final report will be delivered for your review on December 19, 2008.

- The Center is an inefficient, costly and clinically outdated program.
- The Center currently cannot meet minimal certification standards under Title 29 and does not have the infrastructure and management processes in place to become certified.
- Administrative and medical management practices are uninformed by modern practice, are archaic, resistant to change and significantly contribute to poor patient outcomes and extended lengths of stay.
- While individual Center staff display outstanding professional qualities and skill, the staff must be characterized, as a group, as not meeting minimal professional competencies for work at a detoxification center.
- The problems at the Center are unrelated to funding. There is sufficient funding to design and operate an efficient, cost effective and clinically effective non-hospital detoxification program.
- The program of services should be re-designed and re-sized with the introduction of performance-based compensation for the Center and programs accepting Center referrals.

Critical problems areas are detailed below.

#### Management/Administration

The management structure is unclear and chaotic. Management roles and responsibilities are not definitively articulated. There is a loose sense of the chain of command. Except

for their immediate supervisor, staff had only a vague understanding of the chain of command and how problems and concerns were to be surfaced, and importantly, how and when they were resolved. This circumstance unfortunately contributes to the overall malaise of the program.

Basic and routine functions necessary to effective day-to-day operations of a 24/7 facility are haphazard. Supplies are not inventoried, nor organized to facilitate timely and expedient ordering. Expired medical supplies in use were observed on more than one site visit.

Patient records are not securely maintained as required by law and are generally difficult to locate and retrieve. This is a troubling failure given the nature of a detoxification center where return patients are expected. If there are record handling protocols in place, they were not produced.

The director consistently demonstrated marginal engagement with the work of the Center. Direct questions regarding operations or documentation were frequently met with, "I don't know," or "You need to ask the nurses or doctor." Any of the questions should have been able to be answered by the program director. The unmistakable impression was that the director took little responsibility for the operation of the program and even less interest in cooperating with this study.

The facility is managed as a collection of separate autonomous departments with no evidence of the departments functioning together as an integrated addiction program.

### Clinical

The Medical Director of the Center, unfortunately, displayed a similar disengagement from the work of the program. While always polite and courteous he displays little initiative to change his practice or influence patient care at the facility in which he is nominally the medical director.

There is no Director of Nursing (DON) for the program. The program instead has a nurse supervisor per shift. Typically, a DON ensures quality patient care and establishes and maintains quality assurance processes. Operating a 24/7 detoxification facility without a DON is unwise.

There is no Physician Assistant (PA), nor Nurse Practitioner (NP) as part of the medical staffing, as is typical of non-hospital detoxification programs. PA's and NP's perform physicals, treat somatic conditions and provide comprehensive medical services under the supervision of a physician. This is cost efficient, as well as cost effective, medical staffing. Inadequate medical care will not be improved by additional physician time. In fact, there is an excess of physician time allocated to the Center. It is not used effectively.

Standard detoxification protocols were found only in the director's office, not at the nurse's station, nor in the physician's office where they should normally be found. The protocols that do exist, are outdated and do not reflect current standards of care.

The counseling program is rudimentary and does not follow the standards of best practices for a detoxification setting. Patients should be engaged in a counseling relationship to motivate them to continue their care in the community. This can be accomplished in both group and individual sessions. It is ineffective to have the entire facility population convene in the cafeteria for a group session.

A troubling clinical concern is the care given to women at this program. The patient population is overwhelming male and there is no evidence of a clinical track available to engage addicted women. The unique treatment needs of addicted women are underplayed.

### Personnel

The Center is directly operated by APRA, but at times over half of the staff are contract employees from professional staffing agencies. These employees receive no benefits. A de facto "two-tiered" personnel system is in place. This does not contribute to staff cohesion and unintentionally, may send the message that the work at the Center is not important enough to be considered career, professional work.

Based on the position descriptions used in the Department of Health, and observations of the functions of incumbents in those positions, and interviews with those individuals, it appears that few of those individuals are qualified to perform the professional functions assigned to their position. The exception would be nurses, who have a standardized curriculum and licensing requirement for their professional. Staff members, who have the title of counselor, have a variety of degrees and certifications, some from private certification agencies. Determining minimal competence and knowledge is not possible since their training and education is not standardized.

### Budget

The budget allocated to the Center is not the problem. The \$5.6 million expended in FY 2008 is more than sufficient to provide an excellent program of detoxification services.

APRA is overpaying for this service in the range of \$2 million to \$2.5 million.

### Individuals Served

The number of individuals admitted to this program is uncertain. ACIS is yet to be fully implemented and there is no systematic, reliable data collection mechanism in place. Executing this study was challenging and required going to hand written nursing admission logs to get basic information. Equally challenging was understanding how data is aggregated and reported. Data that does exist suggest there are as few as 1,880

individuals admitted to the facility in a year, or as many as 3,400. It is not possible to know.

What is certain is that the average length of stay for individuals, derived from a sample of admissions, was over 8 days. The average for a facility that functions as a non-hospital detoxification program is 4 days. It is fair to speculate that the Center functions more as a shelter than as a non-hospital detoxification program.

Recommendation

The program of services at the Center must be re-designed and the number of beds reduced to no more than 60. The length of stay should be commensurate with that of similar facilities.

It is recommended that APRA specify a scope of services required of a public non-hospital detoxification program and issue a competitive procurement to select an entity to operate and manage this level of care. Performance based compensation should be included as part of the solicitation for services. Clear performance standards must be articulated that are consistent with current business and clinical practices.

A sample solicitation will be developed for your review to illustrate a program re-design, and performance contracting.

If you may have any questions regarding this letter, please feel free to call me anytime.

Sincerely,

Peter F. Luongo, Ph.D., LCSW-C

**APPENDIX 4**

**Final Report**  
**APRA Detoxification Center Evaluation**

**Submitted by:**

**Peter F. Luongo, PhD., LCSW-C**

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Executive Summary

This is a summary of an evaluation of the Addiction Prevention and Recovery Administration's (APRA) Detoxification Center (Center), located at 1905 E St. SE, Washington, DC. The study was commissioned by APRA and conducted by Peter F. Luongo, Ph.D., LCSW-C, from October 1, 2008 through December 12, 2008.

- The Center is an integral part of the District of Columbia continuum of addiction treatment services, but as currently operated it is inefficient, costly and clinically outmoded.
  
- The Center does not meet minimal certification standards under Title 29 and does not have the infrastructure and management processes in place to become certified.
  
- Administrative and medical/clinical management practices are uninformed by modern practice and science. The effect is poor patient care and outcomes.
  
- While individual Center staff display outstanding professional qualities and skill, the staff must be characterized, as a group, as not meeting minimal professional competencies for work at a detoxification center.

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- The Center currently operates 80 beds with an average length of stay of over 8 days per admission. The expected number of yearly admissions at a 90% occupancy rate is 3,285. Published reports indicate annual admissions range from a low of 1,880 to a high of 3,200. Based on the current record keeping at the Center it was not possible to establish an actual, verifiable number of admissions for the last 2 fiscal years. This insufficiency hampers calculations of an actual cost per patient day.
  
  - The program of services should be re-designed and re-sized to a maximum of 60 beds with an average length of stay of 4 – 5 days, which is consistent with lengths of stay reported from similar programs. At an average length of stay of 5 days and a 90% occupancy, the program would admit over 3,900 individuals per year.
  
  - The service should not be directly operated by APRA. Directly operated services by the Single State Authority are incompatible with the mission of planning, funding, implementing and regulating services.
  
  - The service should be competitively procured and operated at the current facility. The function of a detoxification service in a continuum of care lends itself to the use of performance-based compensation. APRA should consider establishing a portion of the compensation contingent on satisfying clearly set performance criteria.

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- The problems at the Center are unrelated to funding. The available funding (\$5.6 million) is more than sufficient to operate an efficient, cost effective and clinically effective non-hospital detoxification program.
  
  - An efficient and effective non-hospital detoxification service should cost approximately \$3.1 million a year and save a minimum of \$2 – 2.5 million a year of the current funds budgeted. These savings are then available to be re-directed within the system.

A sample Scope of Services representative of a solicitation using performance-based compensation will be forwarded under a separate cover.

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Introduction

An evaluation of the Addiction Prevention and Recovery Administration's (APRA) Detoxification Center, located at 1905 E St. SE, Washington, DC., was commissioned by APRA and conducted by Peter F. Luongo, Ph.D., LCSW-C, from October 1, 2008 through December 12, 2008.

The purpose of the evaluation was to study the efficiency and effectiveness of the detoxification services operated by APRA, and to recommend changes in clinical and business operations consistent with the best standards of care.

The Detoxification Center (Center) is an 80 bed, non-hospital detoxification facility for adult men and women that is a component of the APRA continuum of care. The facility is directly operated by APRA. This is a somewhat unique arrangement, since APRA functions as the Single State Authority (SSA) for substance abuse in the District of Columbia. An SSA is usually the purchaser, not provider of services. The present configuration presents competing demands for management and leadership time and resources.

A particular challenge in conducting the study was related to data and record keeping. The APRA Client Information System (ACIS) is completing development and is being phased into use with programs. One of the last phases of programming and implementation is the report function. At the time of the evaluation that function was not

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yet available. Therefore, except for viewing individual admission screens for specific clients using ACIS, data for this evaluation were derived from manual legacy information systems. Aggregate information and patient specific information are kept via a series of log sheets, individual staff's tally sheets and patient medical records. Verifying data was difficult and required cross checking between several sources within the Center (nursing logs, administrative reports, patient records) and the APRA Assessment and Referral Center (ARC). Data was excluded from this report that could not be crosschecked against another source internal to the Center or APRA.

The implementation of the ACIS automated information system will facilitate data collection and analysis and be useful to support executive and operational decisions for the APRA system.

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Methodology

The evaluation process consisted of 3 phases.

Phase I was a review of documents that outlined the mission, goals, strategies, operations and performance data for APRA. This provided a system overview and specific detail about current operations of the system. APRA senior staff provided documents for review.

Documents reviewed included:

- FY 2008 and FY 2009 Substance Abuse Prevention and Treatment Grant Application
- City Council Oversight Report (March 5, 2008)
- KPMG APRA Organizational Assessment Final Report (April 30, 2007)
- ACIS Training Manual
- Human Services Contract
- APRA Organization Chart
- Detoxification Center Expenditure Report
- Title 29, Chapter 23 Certification Standards

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Phase II consisted of on site interviews and observations at the Center. Individual interviews were held, both formal and informal with administrative, supervisory and medical/clinical staff. A list of interviewees is in the appendix.

The following areas were examined during Phase II of the study:

- Management and Administrative Structure and Processes
- Personnel and Staffing
- Clinical Operations

Between October 15 and December 11 a total of 14 site visits were made to the Center, APRA or ARC for interviews and observations. Information gathered during these visits was used in Phase II and Phase III of the evaluation.

Phase III consisted of on site data collection activities and data analysis. These activities primarily consisted of data extraction from a selected sample of individual patient records (data strategy will be discussed in more depth in a following section) with verification of information from ACIS admission screens.

The purpose of the data extraction was to determine the following:

- What is the population served by the current APRA detoxification program?
- Are there patient admission, continued stay, and discharge criteria in place that are used?
- Are patients admitted to this service actually in need of this level of care?

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- What is the history of patients prior to the current admission? Are there substantial repeat admissions?
  - Where do referrals for the program originate?
  - What is the time before referral to the program and admission?

The majority of these questions received at least partial answers. Again, the limitations of the current data collection system inhibited a more thorough exploration.

Aggregate data was also collected from comparable non-hospital detoxification programs in the area to offer a point of comparison. FY 2008 data from Baltimore City and Montgomery County, Maryland were available from the Maryland state-wide automated information system, SMART (State of Maryland Automated Record Tracking).

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Management and Administrative Structure and Processes<sup>1</sup>

The management and administrative structure of the Center significantly contribute to the program's operational difficulties and effectiveness.

The organization chart for the Center satisfies bureaucratic requirements, as would be expected. However, as implemented, the management structure and processes are unclear and chaotic. It is readily apparent that management roles and responsibilities are not definitively articulated. There is a loose sense of the chain of command and the prevailing sense that an ad hoc response to problems is the norm. Except for their immediate supervisor, staff had only a vague understanding of the chain of command and how problems and concerns were to be surfaced, and importantly, how and when they were resolved. Typically, operational problems were attributed to external factors, and in particular, "headquarters." The culture of the organization as inferred from the management and staff is that the program is a victim of benign, if not active, neglect, and there is very little control that they can exercise over their work environment and product.

A major management problem is the lack of standard operating policies and procedures. While there are binders referenced as Policy and Procedures in the director's office, they are not updated, nor generally specific to the Center. The majority of policies relate to the APRA system. These are necessary, but insufficient, to operate a complex 24/7 health facility.

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<sup>1</sup> There is considerable overlap in management, clinical operations and personnel issues in healthcare. The choice to place certain discussions in one particular section was done for clarity of presentation, readability and emphasis.

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A Policy and Procedure Manual specific to the management and administration of a 24/7 detoxification center is a basic necessity, not an option. There is no responsibility assigned to develop, implement, monitor and revise policies and procedures. The result is that basic and routine functions necessary to effective and safe day-to-day operations of the facility are haphazardly and idiosyncratically applied.

Some examples help to illustrate the problem:

- Supplies are not inventoried, nor organized to facilitate timely and expedient ordering. Expired medical supplies were observed in use on more than one site visit. Recently, it was reported that no clean towels were available for patient use and it was unclear who was responsible for ensuring linens and towels were properly laundered.
- Patient records are not securely maintained as required by law and are generally difficult to locate and retrieve. This is a troubling problem given the nature of a detoxification center where return patients are expected. If there is a record handling protocol in place, it was not produced.
- Emergency procedures, as well as documenting and reporting critical incidents at the facility, should be clearly spelled out, continuously updated and trained. There was no evidence produced that this happens.

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The Center Director consistently demonstrated marginal engagement with the work of the Center. Direct questions regarding operations or documentation were frequently met with, "I don't know," or "You need to ask the nurses or doctor." Any of the questions should have been able to be answered by the program director. The unmistakable impression was that the director took little responsibility for the operation of the program.

A review of the position description associated with the director position indicates that essential tasks and functions of the position are not being executed. There was no evidence that the following major duties of the position were being performed<sup>2</sup>:

- Conduct program evaluation in accordance with established research methods and valid data collection techniques to assess the performance and effectiveness of in patient/outpatient services.
- Maintain a consistent schedule of data collection and site visits for ongoing program evaluation. Keep Administrator abreast of problems, deficiencies, and status of program through oral and written reports.
- Makes periodic inspections of the facility for the purpose of evaluating its adequacy in relation to program objectives. Supervise the development of

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<sup>2</sup> This is a representative, not exhaustive list. From: *Position Description, APRA Program Manager – Detox MS340-13*

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narrative and statistical data for use in submission of periodic reports to supervisors and others.

- Develops and issues rules, regulations, policies and procedures needed to promote smooth and efficient staff operations and to maintain client discipline, decorum and morale. Participate in the development of procedure manuals.

The Center's senior leadership position does not function in the manner proscribed. This has a direct and detrimental effect on the program's operations and effectiveness.

The Center operates as a collection of independent, autonomous departments rather than an integrated 24/7 non-hospital detoxification program. The conclusion is that the program was not properly implemented from its creation and has attempted to operate with a loosely defined and functioning management structure without the guidance of standard policies and procedures. As currently functioning, this program cannot meet certification standards.

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Personnel and Staffing

The Center is directly operated by APRA, but at times over half of the staff are contract employees from professional staffing agencies. These employees receive no benefits. A de facto “two-tiered” personnel system is in place. This does not contribute to staff cohesion, and unintentionally, may send the message that the work at the Center is not important enough to be considered career, professional work. An accurate, updated, staff roster, that distinguishes between merit and contract employees could not be produced by the Center’s management.

Based on the position descriptions used in the Department of Health, and observations of the functions of incumbents in those positions, and interviews with those individuals, it appears that few of those individuals are qualified to perform the professional functions assigned to their position. The exception would be nurses, who have a standardized curriculum and licensing requirement for their profession. Staff members, who have the title of counselor, have a variety of degrees and certifications, some from private certification agencies. Most do not have Master’s degrees. Determining minimal competence and knowledge is not possible since their training and education is not standardized.

The Medical Director, unfortunately, displayed the same disengagement from his work, as did the director. While always polite and courteous, he displayed little initiative to change his practice or influence patient care at the facility. The Medical Director reports that he has no specialty certification in addiction medicine and is, in fact, a urologist. It is

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normal practice for a Medical Director to be certified in addiction medicine. This helps to explain the situation that will be discussed in the following section, why detoxification and clinical protocols are outdated and not reflective of the current standard of care.

There is no Director of Nursing (DON) for the program. The program instead has a nurse supervisor per shift. Typically, a DON ensures quality patient care and establishes and maintains quality assurance processes. Operating a 24/7 detoxification facility without a DON contributes to the impression that this program provides inadequate clinical services to its patients.

There is no Physician Assistant (PA), nor Nurse Practitioner (NP) as part of the medical staffing, as is typical of non-hospital detoxification programs. PA's and NP's perform physicals, treat somatic conditions and provide comprehensive medical services under the supervision of a physician. This is cost efficient, as well as cost effective, medical staffing. The medical practice at the Center will not be improved by additional physician time. In fact, there may be an excess of physician time allocated to the Center. It is not used effectively.

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Clinical Operations

Standard detoxification protocols were found only in the director's office, not at the nurse's station, nor in the physician's office where they should normally be found. The protocols that do exist, are outdated and do not reflect current standards of care. These standards should be regularly updated in keeping with newly developed clinical practices. An example follows:

As will be reported in greater detail later, patient admissions for the week of October 1 – 7, 2008 were examined. During that period there were 68 admissions. Eighteen (18) heroin addicts were detoxified with a 5-day tapering methadone dose starting at 30 mg. This is the standard detoxification practice at the Center. A five-day methadone detox for heroin addiction is considered a poor practice and a set up for relapse and re-admission. In fact, the subsequent data show histories of readmission to the system and the Center, in particular. Inexplicably, 3 of the patients detoxified using methadone were then referred to a methadone maintenance program.

Further evidence of dated medical practice is the fact that the Center formulary does not include buprenorphine, a highly effective, safe medication used to stabilize and detoxify individuals addicted to opiates. Practice guidelines exist for buprenorphine, but there appears to be no motivation to include this medication in the formulary.

The counseling program is rudimentary and does not follow the standards of best practices for a detoxification setting. Patients should be engaged in a counseling

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relationship to motivate them to continue their care in the community.<sup>3</sup> This can be accomplished in both group and individual sessions. It is ineffective to have the entire facility population convene in the cafeteria for a group session that is a didactic session. In one observed group session of 33 patients, 11 slept throughout the presentation.

A troubling clinical concern is the care given to women at this program. The patient population is overwhelming male and there is no evidence of a clinical track available to engage addicted women. The unique treatment needs of addicted women are simply underplayed. There is an empirical literature available that argues forcefully for gender specific treatment for addicted women.

This is a clinical program that was not set up properly from the start. It has no internal quality assurance process in place for self-correction, reflective practice, or to identify and integrate modern medical and clinical practices. Modern practice protocols need to be established.

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<sup>3</sup> See: SAMSA, *Detoxification and Substance Abuse Treatment, A Treatment Improvement Protocol, Tip 45*, 2006

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Patient Population and Individuals Served

This is the analysis of one week of admissions to the APRA Detoxification Center. The time period is October 1, 2008 - October 7, 2008.

A one-week period was selected for evaluation as part of the data strategy to ensure valid information from the program's non-standardized patient information system. It was thought that the time frame, October 1 – 7, would also guarantee that all patients would have completed the program, dispositions would be recorded, vouchers issued, and potentially re-authorized. Finally, the time frame anticipated that all patient records (charts) would be readily available.

The first section summarizes referral characteristics and demographics of the individuals admitted, their discharge status and referrals, and prior contact with the system. A discussion of the data follows:

- 68 individuals were admitted to the Detoxification Center (Center) during the evaluation period.
- 33 individuals (49%) were admitted after evaluation at the Assessment and Referral Center (ARC). During the evaluation period the ARC referred 39 individuals to the Center. Six (6) or 15% never made it from ARC to the Center for admission.

- Only 60 of 68 patient records were located for data extraction (88%). However, a discharge disposition for 63 patients was secured by piecing together data from multiple sources.

- Discharges for the patients during the evaluation period (N = 63):

Referred back to CSOSA	13 (21%) <sup>4</sup>
Referred to Treatment, Voucher Issued	28 (44%)
Recommended Treatment, No Voucher	16 (25%)
Left Against Medical Advice (AMA)	6 (10%)

- Discharged patients:

Average age	44
Male	82%
Average Length of Stay, All Discharges	8.2 days
Average Length of Stay, AMA's	4.6 days
Average Length of Stay, No AMA's	8.6 days

- 52% of individuals admitted to the Center had been seen previously at the ARC on average for 2.3 evaluations (range 1 – 10 visits).

- 40% of individuals admitted to the Center had an average of almost 2 prior Center admissions (1.8 admissions, range 1 – 7).

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<sup>4</sup> CSOSA: Court Services and Offender Supervision Agency

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- From the patient records it is impossible to determine what admission criteria are used for the Center. There are standard guidelines in the field published by the American Society of Addiction Medicine (ASAM) but they do not seem to be in use at the facility.<sup>5</sup>

#### Discussion

- Only 60 of 68 patient records could be located for review despite 3 days of searching.
- The average age of patients (44) and the average length of stay (8.6 days, when AMA's are excluded) suggests that the program is less a medical detoxification program and more a social model detoxification/stabilization, or shelter program. This is reinforced by the fact that 52% of the admissions have been seen multiple times at the ARC and 40% of admissions have had an average of almost 2 prior admissions to the Center. The frequent re-referrals and re-admissions also speak to the inadequacy of the clinical program and the smooth transfer and retention of patients in the community continuum of care.
- 21% of the admissions originated from CSOSA. Dispositions did not include any clinical recommendations for further substance abuse treatment, but simply a return to CSOSA. This merits further exploration. APRA is expending resources,

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<sup>5</sup> ASAM: *American Society of Addiction Medicine Patient Placement Criteria II Revised*

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but its clinical input appears to be negligible, if it exists at all, for CSOSA patients.

- 25% of the individuals recommended for treatment were never issued a voucher authorizing treatment. When combined with the individuals who left against medical advice (AMA), 35% of the individuals admitted never received additional services beyond detoxification. This is a significant systems issue and certainly contributes to the high rate of re-referral to ARC for evaluation and to the Center for readmission. As a point of contrast, AMA's from the comparable Maryland facility were below 1%.<sup>6</sup>
- Another system issue to explore is the relatively high percentage of individuals referred to the Center from ARC, but who never make it there for admission (15%). This is especially interesting given the door-to-door transportation service provided by APRA from ARC to the Center.

ACIS is yet to be fully implemented and there is no systematic, reliable data collection mechanism in place. Executing this study was challenging and required going to hand written nursing admission logs to get basic information. Equally challenging was understanding how data is aggregated and reported. Data that does exist suggest there are

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<sup>6</sup> The program is the Avery Road Treatment Center (ARTC) in Rockville, Maryland. ARTC is a publicly funded, contractor-operated program in a public facility leased to the contractor.

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as few as 1,880 individuals admitted to the facility in a year, or as many as 3,400. It is not possible to know.

What is certain is that the average length of stay for individuals, derived from a sample of admissions, was over 8 days. The average for a facility that functions as a non-hospital detoxification program is 4 days. Again, it is a fair observation that the Center functions more as a shelter, a very expensive shelter, than as a non-hospital detoxification program.

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Budget and Expenditures

The budget allocated to the Center is not the problem. The \$5.6 million expended in FY 2008 for 80 beds is more than sufficient to provide an excellent program of detoxification services.

At the current budget level, the cost to maintain a bed is \$70,000 per year.

A comparable 60-bed program that includes an intermediate care program with a length of stay of 21 – 28 days is \$3.1 million.<sup>7</sup> At that budget level, the cost to maintain a bed is \$51,167; 27% less per bed. It should also be noted this facility requires more hours of clinical programming per week than does the Center.

Under the current business model for the Center, APRA is overpaying for detoxification services in the range of \$2 million to \$2.5 million per year.

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<sup>7</sup>The program is the Avery Road Treatment Center (ARTC) in Rockville, Maryland. ARTC is a publicly funded, contractor-operated program in a public facility leased to the contractor.

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Recommendations

- The program of services should be re-designed and re-sized to a maximum of 60 beds with an average length of stay of 4 – 5 days, which is consistent with lengths of stay reported from similar programs. At an average length of stay of 5 days and a 90% occupancy, the program would admit over 3,900 individuals per year.
- The service should not be directly operated by APRA. Directly operated services by the Single State Authority are incompatible with the mission of planning, funding, implementing and regulating services.
- It is recommended that APRA specify a scope of services required of a public non-hospital detoxification program and issue a competitive procurement to select an entity to operate and manage this level of care. Performance based compensation should be included as part of the solicitation for services. A sample solicitation to illustrate a program re-design, and performance contracting will be submitted to APRA as an addendum to this report.
- The problems at the Center are unrelated to funding. The available funding (\$5.6 million) is more than sufficient to operate an efficient, cost effective and clinically effective non-hospital detoxification program.

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- An efficient and effective non-hospital detoxification service should cost approximately \$3.1 million a year and save a minimum of \$2 – 2.5 million a year of the current funds budgeted. These savings are then available to be re-directed within the system.
  
  - Improvements at the Center must begin as soon as possible. It is recommended that an outside expert in addictions treatment and specifically, program operations, be brought into the Center and lead the staff in developing up to date management, administrative, and clinical policies and procedures. The goal should be to certify the Center as if it was any other program within the APRA continuum of care.

**APPENDIX 5**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health  
Addiction Prevention and Recovery Administration



Office of the Senior Deputy Director  
for Substance Abuse Services

December 19, 2008

[Redacted]  
Addiction Prevention and Recovery Administration  
Detoxification Center  
1905 E Street, SE, Bldg. 12  
Washington, DC 20003

Dear [Redacted]

You are hereby notified that APRA Detoxification Center Program has been granted full certification for a period of one (1) year based on compliance with "*Certification Standards for Substance Abuse Treatment Facilities and Programs*" (Chapter 23 of Title 29 of the DCMR) and acceptance of your corrective action plan to aggressively remedy the corrective actions planned. This certification authorizes you to provide ***Level III Residential Sub-Acute Non-Hospital Medically Monitored Detoxification for Adults***. Please frame and post the enclosed Certificate in a place of prominence.

Full one (1) year certification has been granted in accordance with Chapter 23, Sections 2301.2 through 2301.4.

APRA Detoxification Center Program's certification will expire on **May 12, 2009**. It applies only to the program located at the address given, for the type of services specified. It is not transferable or renewable. Review Section 2310 **NOTICE REQUIREMENTS – Operation Changes** for reporting changes to the Department that may affect the status of your certification. Also note that the Department may conduct inspections and investigations annually and/or at any time during the certification period (Sections 2306.1 and 2306.4).

Application for re-certification must be made not less than 90 days prior to the expiration date of your current certification (Section 2305.1) or prior to other planned changes (Section 2305.3).

If you have any questions regarding the above, you may contact [Redacted]  
[Redacted]

33 N Street, NE, Suite 209, Washington, DC 20002 (202) 727-7590 (tdd) (202) 727-7789 (fax)

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Sincerely,



Sr. Deputy Director

Enclosure

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1500 17<sup>th</sup> Street, N.W., Washington, DC 20002 (202) 727-8944 (tel) (202) 727-8092 (fax)

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health  
Addiction Prevention and Recovery Administration  
Office of Certification and Regulation



**CERTIFICATE OF AWARD**

Pursuant to Title 29 (Public Welfare),  
Chapter 23 of the District of Columbia Municipal Regulations (DCMR),  
"Certification Standards for Substance Abuse Treatment Facilities and Programs"

*Full Certification* is granted to:

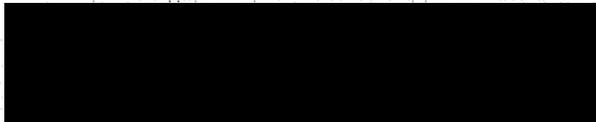
Addiction Prevention and Recovery Administration  
Detoxification Center

To Operate: Level III Residential Sub-Acute Non-Hospital  
Medically Monitored Detoxification for  
Adults

Location: 1905 E Street, SE, Building 12  
Washington, DC 20003

For a period of: One (1) Year  
May 13, 2008 – May 12, 2009

**Certificate Number: 102500DX-010**



12/19/08  
Date

Sr. Deputy Director for Substance Abuse Services

This certificate is required to be posted in a conspicuous place, preferably framed under clear glass or plastic. It is valid only for the licensee(s), location(s) and services named above, for the period specified, and is not transferable. This certificate is the property of the District of Columbia Department of Health and is valid only when the facility or program is in compliance with 29 DCMR Chapter 23.