MENTAL HEALTH, ADDITION AND RECOVERY SERVICES
BOARD OF LORAIN COUNTY

REQUEST FOR QUALIFICATIONS (RFQ)

FOR ARCHITECTURAL, ENGINEERING AND RELATED SERVICES

FOR THE LORAIN COUNTY CRISIS RECEIVING CENTER

Issue Date: March 14, 2022

Submission Due: April 8, 2022

Contact Person:

Owner's Representative – Hill International, Inc.
Mr. Todd Cooper, Project Manager
9100 South Hills Blvd
Broadview Heights, OH 44147
toddcooper@hillintl.com

REQUEST FOR QUALIFICATIONS (RFQ)
FOR ARCHITECTURAL & ENGINEERING SERVICES
FOR THE LORAIN COUNTY CRISIS RECEIVING CENTER

TABLE OF CONTENTS

I. PURPOSE OF RFQ 3

II. LOCATION 3

III. PROJECT DESCRIPTION 3

IV. GENERAL DESCRIPTION 3

V. STATEMENT OF SPECIFIC DESIGN SERVICES REQUIRED 4

VI. PROJECT BACKGROUND 4-5

VII. PROJECT QUALIFICATIONS – CRITERIA 5-6

VIII. SELECTION PROCESS 6

IX. PRELIMINARY SCHEDULE 6-7

X. INSTRUCTIONS, NOTIFICATIONS & INFORMATION 7

XI. SUBMITTAL INSTRUCTIONS 7-8

XII. CONTENT OF SUBMITTAL 8-9

LORAIN COUNTY COMMISSIONERS
REQUEST FOR ARCHITECTURAL SERVICES

I. PURPOSE OF RFQ

The MENTAL HEALTH, ADDITION AND RECOVER SERVICES BOARD OF LORAIN invites the submittal of responses to this Request for Qualifications (RFQ) from qualified firm(s) interested in providing architectural services required for the Lorain County Crisis Receiving Center as herein outlined.

II. LOCATION

The BOARD is currently in process of performing acquisition of its preferred site. This site will be reviewed during contract negotiations with the firm determined to be most qualified. The project is anticipated to be new construction on a greenfield site.

III. PROJECT DESCRIPTION

The Mental Health, Addition & Recovery Services Board of Lorain County (MHARS Board-Owner) in partnership with Lorain County Commissioners, foundations and private donors have made available funding to support the development of a 32-bed Lorain County Crisis Receiving Center (LCCRC). The anticipated project budget is $10 Million.

The overall role of the MHARS Board is to:

- Assure a unified system of behavioral health services
- Create a community support system
- Protect personal liberty & least restrictive environment (Client Rights)
- Ensure high quality, cost effective, culturally competent services
- Maintain comprehensive services based on local needs – severely ill & special population priorities
- Ensure services meet (minimum) standards
- Develop continuum of care
- Require consumer involvement

For more information on the duties and responsibilities of the MHARS Board, please go to Ohio Revised Code (ORC) Chapter 340 (click on link Here).

IV. GENERAL DESCRIPTION

The MHARS Board proposes to retain a highly qualified, capable firm(s) to act as Architect to assist in planning, schematic design, design, competitive bidding and construction of this new building project. Firm(s) who participate in this RFQ process are sometimes referred to as "Firm" and "Architects". The BOARD will give prime consideration to Architects with significant and current experience in the development, design and construction of recovery facilities, medical facilities and clinic space.

Previous work experience shall be for projects that comply with the State of Ohio Board of Health Rules and Regulations or other similar regulatory authorities.

V. STATEMENT OF SPECIFIC DESIGN SERVICES REQUIRED

A. The selected Architect(s) will be required to perform basic architectural and engineering services to be specified more fully in a contract agreement to be negotiated after selection. Services desired include all A/E tasks necessary to fully complete the development and construction of this facility, including, but not limited to,

1. Project development and programming,
2. Schematic design
3. Production of computer generated renderings
4. Cost estimates
5. Design development
6. Construction documents
7. Preparation of specifications/bidding documents
8. Review of bids received
9. Construction contract documents
10. Project/Construction administration, including preparing reports to the Board as requested, meeting with other approving agencies as required and other tasks as may be deemed necessary.

B. The BOARD reserves the right to include additional project elements in the initial or subsequent professional services agreements, as the BOARD may (in its sole discretion) deem appropriate. The BOARD may decide not use the standard AIA contract documents to secure the professional services herein described. The Architect will be required to retain and be responsible for all basic engineering disciplines as appropriate for the Scope of Work negotiated. The Architect is also required to identify and select the appropriate sub-consultants; however, the BOARD reserves the right to approve proposed sub-consultants that will be associated with the Project.

VI. PROJECT BACKGROUND

In 2018, the BOARD commissioned RI International to perform a study focused on optimizing the mental health crisis system in Lorain County (Attachment A). This study recommended the BOARD consider the development of a 32 bed crisis center consisting of a 16 bed receiving center and a 16 bed sub-acute treatment facility.

This concept was further developed in 2019 when a conceptual test fit of what such a facility might look like was prepared for the BOARD to identify a project budget and potential site location (Attachment B). It should be noted that this was a very preliminary concept and that it is expected the selected firm will undertake their own independent

programming and schematic design effort to identify the needs and requirements of the BOARD.

We would also encourage interested firms to review the following videos as the BOARD believes that they capture what the BOARD is looking to achieve.

The Recovery Response Center and the Fusion Model

The Fusion Model

VII. PROJECT QUALIFICATIONS - CRITERIA

Statement of qualifications must include information regarding:

A. (25 points) Previous experience designing efficient medical clinic space, living and work areas, include a list of similar projects completed. Provide the project cost and schedule for each project and indicate if the project was completed on time and within budget. Provide a list of non-owner requested change orders.

B. (20 points) Firm's history of construction and project administration and management. Provide information of architects experience with value engineering, coordination of multiple prime contractors, and communicating with a public entity. Include an example of creative problem solving.

C. (30 points) Firm's lead and key technical personnel's qualifications and expertise. List of proposed sub-consultants, along with qualifications. (MEP, structural, security, data/telecommunications, acoustical, fire protection, etc.). Availability of staff members assigned to this project.

D. (15 points) Firm's technical approach to the project. Include discussion on the team's experience working together and how the team members will integrate together in the delivery of the project.

E. (10 points) Experience with similar projects with ligature-risk environments with healthcare accreditation and certification requirements.

F. (0 points) List of references of previous clients.

VIII. SELECTION PROCESS

The statements of qualifications shall be timely reviewed and evaluated by an evaluation committee using the RFQ criteria. Proposing firms shall not contact members of the evaluation committee prior to announcement of the short list, except as prescribed in this RFQ.

The evaluation/interview committee consists of the following members:

Michael Doud, Executive Director, MHARS Board of Lorain County
Don Schiffbauer, Executive Director, The Nord Center
Dan Haight, Executive Director, The LCADA Way
Karen Perkins, Facilities Manager, Lorain County Commissioners
Jeff Kamms, Executive Director, Road to Hope
Barry Habony, Chief, Business Operations, MHARS Board of Lorain County
Todd Cooper, Owner's Representative, Hill International, Inc.

At the conclusion of the evaluation process, scores shall be tallied and a short-list of up to three (3) viable firms will be determined as most qualified to perform the required services. A scope clarification meeting may be conducted with the short-listed firms. The discussions shall be designed to further explore the scope and nature of the services required, the various technical approaches the firms may take toward the project, unique project requirements, the project schedule and the project budget. Any questions of the firms shall be answered at this meeting and shared with all participants.

Interviews to select the successful firm and/or team, at a location to be determined, will most likely occur within 2 weeks of the submission date. The interview committee may interview each of the short-listed firms and each member shall rank the firms from most to least qualified to provide the required services based on their interview and statement of qualifications. The rankings of the interview committee members shall be combined to determine the overall ranking of the short-listed firms.

The BOARD shall announce the firm determined to be the most qualified to perform the required services, request a fee proposal and enter into contract negotiations with the selected firm in accordance with section 153.69 of the Revised Code.

Records that are maintained by the BOARD during the selection process are public, to the extent permitted by sections 149.43 and 149.433 of the Revised Code, and shall be available for inspection.

The BOARD has a right to accept or reject any or all professional design firms' statements of qualifications or technical proposals in whole or in part.

IX. PRELIMINARY SCHEDULE

RFQ Issued	March 14, 2022
Deadline for the Submission of Questions (5:00 pm) E-mail questions to toddcooper@hillintl.com E-mail Subject Must Read LCCRC AE RFQ Question	March 21, 2022
BOARD Responds to Questions (Posted to Website)	March 28, 2022
RFQ Responses Due to BOARD by 4:00 pm	April 8, 2022
Proposals Reviewed	April 11-15, 2022

Interviews	April 25-29, 2022
Notification of Most Qualified Firm	May 2, 2022
Fee Negotiations	May 2-May 13, 2022
Approval of AE Contract by BOARD	May 19, 2022
Bidding of Construction Contracts	January 1, 2023
Substantial Completion	January 1, 2024

X. ADDITIONAL INSTRUCTIONS, NOTIFICATIONS AND INFORMATION

A. All Information True – By submitting a response, Architects represent and warrant to the BOARD that all information provided in the response submitted shall be true, correct and complete. Architects who provide false, misleading or incomplete information, whether intentional or not, any of the documents presented to the BOARD for consideration in the selection process may be excluded.

B. Cost of Responses - The BOARD will not be responsible for the costs incurred by anyone in the submittal of responses.

C. Contract Negotiations – This RFQ is not to be construed as a contract or as a commitment of any kind. If this RFQ results in a contract offer by the BOARD the specific scope of work, associated fees, and other contractual matters will be determined during contract negotiations.

D. Professional Liability Insurance – Any person rendering professional design services to a public authority, including a criteria architect or engineer and person performing architect or engineer of record services, shall have and maintain, or be covered by, during the period the services are rendered, a professional liability insurance policy or policies with a company or companies that are authorized to do business in this state and that afford professional liability coverage for the professional design services rendered. The insurance shall be in an amount considered sufficient by the BOARD.

XI. SUBMITTAL INSTRUCTIONS

Submit five print copies and a digital copy, via at least one flash drive, following the aforementioned instructions. The copies and flash drive should be mailed or delivered in person during regular business hours (Monday through Friday from 8 a.m. to 4:30 p.m.) to the MHARS Board offices:

MHARS Board of Lorain County
Attn: Mr. Michael Doud, Executive Director
1173 N. Ridge Road East
Lorain, Ohio 44055

RESPONSE ARE DUE on or before 4:00 pm on April 8, 2022. All submittals must be labeled:

REQUEST FOR QUALIFICATIONS FOR
ACHITECTURAL & ENGINEERING SERVICES
FOR LORAIN COUNTY CRISIS RECEIVING CENTER

To enable the BOARD to efficiently evaluate the responses, it is important that the Architects follow the required format when preparing their responses. Responses that do not conform to the prescribed format may not be evaluated.

Please use a minimum font size of 12-point and maintain margins of 1" on all four (4) sides. Bind the proposal by stapling at the upper left-hand corner only. Do not use any other binding system. Do not provide tabbed inserts or other features that may interfere with machine copying. Pages shall be no larger than letter size (8 ½ " x 11") or, if folded to that dimension, twice letter size (11" x 17"). Each section (defined below) shall be separated by a divider page. Elaborate covers are not required.

XII. CONTENT OF SUBMITTAL

Each response shall be submitted as outlined in this section. Please include an outside cover and/or first page, containing the name of the Project.

A table of contents should be next, followed by dividers separating each of the following sections:

Section 1: A letter transmitting the response to the BOARD.

Section 2: Firm Information

- Firm name, address, email and telephone number of all firm offices
- Structure of firm (sole proprietorship, partnership, corporation) and size of firm
- Number of years firm has been in business
- Name of principals
- Primary contact
- Organizational chart
- List of all projects currently under contract and their proposed finish dates.
- Firm's lead and key technical personnel's qualifications and expertise.

Section 3: Previous experience designing medical, clinical, living and working space within one facility.

- Project name and location
- Year Completed
- Short description – include size of project
- Name, address and phone number of owner and contact person tasked with daily responsibilities of the project

- Name, address and telephone number of general contractor
- Design cost
- Construction cost
- List of non-owner requested change orders
- Project start date (design) and finish date (construction complete)
- Firm's lead architect assigned to the project

Section 4: Firm's history of construction / project administration and management

- Provide firm's philosophy regarding value engineering and buildable design. How were these philosophies applied during construction administration and management of a project?
- Provide a list of projects that architect performed coordination of multiple prime contractors
- Describe how architect will approach communication with the BOARD and contractors
- Describe a creative solution to a problem implemented by your firm during the administration or management of a public project

Section 5: Proposed project teams qualifications and expertise

- Organization chart that explains team member responsibilities and chain of command
- Name of the project team leader in charge of project
- Resumes of all persons to be assigned to the project
- Current and upcoming job assignments for each team member

Section 6: List of sub-consultants with qualifications

- Project name and location
- Year Completed
- Short description – include size of project
- Name, address and phone number of owner or name, address and phone number of design firm
- Name, address and telephone number of contractor specific to sub-consultants scope of work
- Firm's lead and key technical personnel's qualifications and expertise.

Section 7: Technical Approach

Section 8: Experience with similar projects with ligature-risk environments with healthcare accreditation and certification requirements.

Section 9: List of references of previous clients. Provide at least five.

Attachment A

RI International Study

I.	[illegible] Consultation	page [illegible]
II.	Stakeholder Meetings	page 2
III.	Crisis [illegible] Capacity Model	page 3
IV.	Nord Site Visit	Page 4
	a. Crisis Call Center	Page 5
	b. Mobile Teams	Page 6
	c. Crisis Stabilization Unit	Page 7
V.	Final Thoughts	page 8

Crisis System Optimization

RI International Consulting

Jamie Sellar

6/15/18

Empowering people to recover, succeed in accomplishing their goals, find meaning and purpose in life, and reconnect with themselves and others.

I. Goals of Consultation

Goals of consultation between the Lorain County Board of Mental Health focused around optimizing the crisis system. RI International is a leader in the use of crisis system best practices from across the country. The specific outcomes desired for the consultation, focused on the creation of a capacity model utilizing the *Crisis now* model as well as reviewing the Crisis Services of the Nord Center to determine how to support that agency in streamlining crisis services.

II. Stakeholder Meetings

In order to get a better understanding of the needs of the community in order to meet the goals of consultation, meetings with several key stakeholders were held. The Stakeholders included:

- Elyria Police Department
- Cleveland Clinic
- Lorain County Board of Mental Health Crisis Liaison Program
- University Hospital
- Firelands
- The Nord Center
- Mercy Health
- Lorain County Sheriff's Office
- PEGS Foundation

Key concepts that emerged from these meetings centered around the growing need for crisis services throughout the county. The current model relies heavily on Emergency Rooms and Law Enforcement. The Nord Center was frequently recognized as a crisis stabilization unit, yet many stakeholders reported that access into the Nord Center Beds were difficult with many roadblocks and hurdles. Mobile team response times to Law Enforcement calls were high. Both Law Enforcement Agencies questioned whether they should be looking at co-responder programs. When Law Enforcement Agencies believe that they need to create internal solutions to community behavioral health problems, it is an indicator that mobile teams are not currently meeting community need. A fully trained and responsive mobile crisis service can offer 24/7 support regardless of the number of crisis occurring simultaneously. This is generally preferred to a co-responder model that offers limited availability. Additionally, Mercy Regional Medical Center currently has what they call the "Behavioral Access Center (BAC)" to respond to patients in the midst of a behavioral health crisis in the Emergency Departments. This again is an internal solution to a community behavioral health problem that indicates that the current crisis system is missing components.

Based on these stakeholder meetings, it is evident that there is strong support for optimizing the crisis system in Lorain County. There is faith in the LCMHB as a leader in the community and a desire from all

parties to support initiatives designed to improve access to care. From a readiness perspective, Lorain County demonstrates the traits needed to move into a more evolved crisis system.

III. Crisis Now Capacity Model

Crisis Now: Transforming services is within our reach. Is a white paper that was sponsored by the National Action Alliance for Suicide Prevention's Crisis Services Task Force in 2016. The paper focused on learning from the best crisis practices throughout the United States. It is the current model that is supported by the National Association of State Mental Health Program Directors (NASMHPD). The whitepaper demonstrates the importance of an integrated crisis system that has four strong components. Those components are:

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. Short-term, "sub-acute" residential crisis stabilization programs; *and*
4. Essential crisis care principles and practices.

Based on population data, data collected in over 100,000 crisis episodes in other parts of the country, and Lorain County stakeholder interviews, RI International was able to create a capacity model for Lorain County based on the *Crisis Now* recommendations. Below is the model as created by RI Internationals Capacity Algorithm and adjusted based on community resources.

Crisis Now Capacity Model

	Baseline	Evolving	Evolved	Lorain County Currently
Inpatient beds	143	53	34	83
Sub-Acute beds	0	12	14	0
23 hour Observation Recliners	0	6	17	12
Mobile Teams	0	2	3	6
Respite	0	NA	NA	12

As the model shows, Lorain County has components of an evolving crisis system. Mercy Regional Medical Center currently operates the Behavioral Access Center (BAC) that functions as a combination 23-hour Observation Unit / Sub-Acute unit. The goal of optimizing a crisis system is to decrease the need for inpatient acute beds that are often over-utilized as a result of lack of capacity in lower levels of care. The

data clearly shows that Lorain County has an overabundance of inpatient beds. The Crisis Now model would estimate that Lorain County has 49 more inpatient beds than capacity would require in a fully evolved system. Estimates of the cost for an inpatient bed is $1,000 per day. Lorain County would be well served by shifting the costs of those additional inpatient beds into supporting the creation of more 23 hour observation recliners and Sub-Acute beds. Currently Mercy Regional Medical has a plan and opportunity to move their current BAC out of the Emergency Department and into another area of the hospital. Based on cost and utilization factors, it is believed that Mercy Regional should pursue this course of action. Based on typical crisis utilization needs for a community of Lorain County's size, the opportunity for respite level services at the Nord Center, as well as economies of scale, it would be recommended that Mercy increase their plans for total bed count and provide 12 observation recliners and 10 sub-acute beds. This would get closer to an evolved model and provide an opportunity for further optimization.

Lorain County currently offers Mobile Team Services through the Nord Center. Modeling indicates the need for about 4 calls per day. The Nord Center is currently taking about 6 calls per day. However, the majority of these calls are not true crisis calls as defined in the crisis now model. These calls are frequently are utilization management assessments at local facilities to help determine if placement criteria has been met. While the current number Mobile Teams is above what the capacity model would indicate is necessary, it is recommended that the number currently remain the same and the scope of mobile teams be adjusted to serve more community need in the areas of prevention and follow up from residential or inpatient levels of care. This is based on the belief that Mercy Regional Medical Center will not be able to increase the Sub-Acute and Observation capacity enough to truly be evolved This would require a more proactive community approach to crisis prevention to ensure that planned capacity is not saturated. Additionally, it is recommended that the Mobile Teams pivot away from doing the utilization management screenings at local EDs and that function be served through The Nord Center Crisis Line based on clinical review with the ED Clinician. This would optimize their availability for true crisis mobile work.

IV. The Nord Center Site Visit

The Nord Center Site Visit Focused on Crisis Services in three specific areas:

- Crisis Call Center
- Mobile Crisis Teams
- The Crisis Stabilization Unit

There is a significant benefit to a crisis network that employs the same provider in the provision of the services listed above. The Nord Center currently offers all three. The Nord Center is currently the largest provider of community based mental health services in Lorain County. Based on interviews and a review of publicly available financial records, the Nord Center is currently stabilizing its operations. It has a new Executive Director who is open and responsive to ideas and suggestions around improving current crisis programs. Additionally, he has forward thinking ideas of his own that align strongly to best practices identified in other states. They would benefit from analysis around all service lines and the creation of a plan to optimize services to ensure a margin. The biggest risk that is facing The Nord Center in relation to crisis

system is recent changes in Medicaid reimbursement rates. The rates for many services have dropped an estimated 40%. This makes evaluation of efficiencies in services even more crucial. Nationally, changes in reimbursement rates/models are putting agencies at risk if they don't have adequate days of cash on hand as a cushion to protect against these changes.

Crisis Call Center:

The Crisis Call Center currently averages approximately 2,500 calls per month based on self report. Based on population statistics, this per capita volume is slightly higher than the majority of large crisis call centers in metropolitan areas across the country. Review with The Nord Center leadership and community stakeholders finds that the Crisis Call Center currently meets community need, and has a good reputation in the community. From a staffing viewpoint, the call center manages its capacity by utilizing mobile crisis team members and clinicians from other service lines to take calls in an overflow capacity. Outcome measures that the Crisis Call Center analyzes, match up well with national benchmarks. However, the data collection methods that the Crisis Call Center employs rely heavily on call center personnel tracking their own data. Frequently, smaller call centers employ this model of data collection. There is an inherent risk due to the cadence of crisis work that some calls are not documented as a result, actual numbers may be slightly different. Off all three crisis programs at the Nord Center, the Crisis Call Center is functions the closest to optimized. They would certainly benefit from using technology to enhance process and ensure accuracy of data collection as outlined in recommendations below.

Recommendations:

1. Ensure alignment of staffing model with incoming calls using predictive modeling of call volume. The Erlang C model is a useful tool in predictive modeling and is used in various high volume call centers. A calculator based on the Erlang B and C models for reference is here, http://www.erlang.com/calculator/call/
2. Consider the use of advanced telephony equipment to ensure data collection is accurate and support the predictive model above in accuracy. The telephony systems can easily track drop rates, average time on calls, disposition and other useful call stats. It improves efficiency on the actual calls themselves. With an average of 2,500 calls per month, the Crisis Call Center has about the right volume to consider this.
3. Continue to ensure that staff that without a full-time dedication status to the Crisis Call Center meet the same standards in regards to training and supervision as the full-time staff. The use of overflow staff is appropriate for times of high call volume in a smaller call center. However, with staff that are not trained and supervised as well, the potential for an adverse outcome magnifies.
4. Continue to follow the National Suicide Prevention Lifeline Best Practice Model.

Mobile Teams:

Mobile teams are currently being dispatched at an approximate average of 8 times per day. It is important to note that the Mobile Teams in Lorain County operating under The Nord Center purview respond to an additional situation that are not in the scope of work of a traditional mobile team. Approximately 25% of the

calls that they take are for level of care evaluations at Emergency Departments in order to grant authorization for admission into the State Hospital. This Utilization Management function in other states is frequently handled via phone consultation between the authorizing agency and hospital employed Social Workers. These calls in some ways artificially inflate the numbers of people served and in part warrant the need for a higher number of teams than the *Crisis Now* model would indicate. Stakeholder meetings with Law Enforcement relate that the current Mobile Teams system does not meet their needs. Response times are slower than desired and frequently the teams do not relieve the officer on scene but require them to stay in addition to team members. As a result, Law Enforcement departments are inquiring about creating co-responder programs to internally meet the needs that are not getting met through The Nord Center Mobile Teams. The benefits of fully engaged/trained/available community-based mobile teams outweigh the benefits of the co-responder model due to the 24/7 availability and ability to handle more than one call at a time due to more Mobile Teams than co-responders. Currently, the majority of calls taken by Mobile teams involve one person teams based on the current staffing model. Two-person teams that employ a clinician and a certified peer or bachelor's level mental health technician is a superior model as it adds flexibility, an increased ability to engage those in crisis and improves safety of the team members themselves. Mobile Teams are currently utilizing the Columbia Suicide Severity Rating Scale (C-SSRS) as its risk management tool. This is a strong evidenced based practice regarding risk assessment. Decreased reimbursement rates for crisis intervention is the biggest current risk to the Mobile Teams. Based on current payment structure, it may be difficult to continue to run mobile teams utilizing the traditional fire house model. Recommendations for optimization are below:

Recommendations:

1. Move toward a staffing model of two-person teams that employ a licensed clinician and a Certified Peer Specialist or Bachelor's Level Mental Health Technician. The benefits in flexibility outweigh the minimal extra salary and employment related expenses in safety, engagement and flexibility.
2. Evaluate whether the Hospital Utilization Review Component yields a significantly different result than would a phone consultation between a crisis call center worker and the Hospital Social Worker.
3. If it is determined that the Utilization Management function is still required, consider co-locating a Mobile team out of the ED of Mercy Regional medical Center or University Hospital to decrease response time. These teams would still go on community based calls as needed if they are closer than the Nord Center based teams. This substation or satellite approach should decrease drive time by allowing the Crisis Call Center to dispatch whichever team is closest. Decreasing drive time has the biggest impact on optimization.
4. With a two person team. Evaluate ability to transport clients needing facility-based support in company vehicles. This is the most efficient, economical, and client-centered mode of transportation. The Nord Center would need to create protocol around who/when to transport to ensure those that are at the highest risk are safe to transport in this manner.
5. Work with funders on true cost of Mobile Crisis Services to ensure that the fire house model can continue. Current reimbursement rates are inadequate to ensure capacity. This should be an issue with all mobile crisis providers.

6. Begin to explore with the extra teams above and beyond the number determined in the *Crisis Now* algorithm the ability to provide follow-up services for those getting released from inpatient and crisis centers. Reimbursement may be an issue. Evaluate re-imbursement and pilot a program that connects with patients in the 24 hours following discharge for reassessment and support. The first 72 hours post-discharge is a historically dangerous time for people stabilizing from a crisis.

Crisis Stabilization Unit:

The Nord Center currently operates a facility based crisis center that is identified as a crisis stabilization unit. The expectation in the community is that this facility acts as a receiving center for persons in the midst of a mental health crisis. A walk through of the unit and review of the staffing model quickly identifies that this program does not meet the standards of a crisis stabilization unit. A true crisis stabilization unit has the ability to accept guests from the community regardless of acuity, keep them safe and begin the process of triage, assessment, and stabilization. The current unit from a facility standpoint would be unable to ensure the safety of patients. It has many ligature points, areas with obstructed views and a floorplan that increases the risk of self harm or harm to others by segregating spaces. A true receiving center would have the ability to utilize a seclusion and restraint room for guests that cannot remain safe without its use. The current facility does not have this option. The staffing model does provide adequate staffing to handle guests of a high acuity. The current unit operates more as a crisis residential or crisis respite level of care in both layout, and staffing model. As a result, the program denies admission to a large number of potential patients that meet the criteria for needing a crisis stabilization unit. It is understandable that there are a large number of denials as acceptance of patients with higher acuities would be unsafe. However, the discrepancy between community understanding of the "Crisis Stabilization Unit" and the reality of the program model causes understandable community frustration. In the evaluation of current community resources and needs, it is suggested that the Crisis Stabilization Unit move toward a level of care most suited to the level that it is currently providing. This level would be a Crisis Respite or short term Crisis Residential Facility (CRF). The facility itself would need a significant amount of tenant improvements in order to be anti-ligature, decrease the number of blind spots and hidden areas, employ cameras and rework the positioning of the nursing stations. The Program itself would require reworking. This would include changes in protocols, admission criteria, staffing model, therapeutic schedule and a host of other program changes. Lorain County needs a receiving center. Mercy Regional Medical Center seems in a stronger position to be able to offer this service. After revamping the CSU program to a Crisis Respite Level of Care, there should be a strong crisis network approach to utilize this new and improved service to act as a crisis prevention program, and an inpatient diversion and/or a step down program. RI International would be supportive of The Nord Center coming to Peoria Arizona and touring our Crisis Respite while learning our program model. All recommendations around the Crisis Stabilization Unit focus on the above recommended changes.

Recommendations:

1. Immediately assess and plan to make the unit completely anti-ligature.
2. Convert the Crisis Stabilization Unit to true Crisis Respite/Residential Program.
3. Rework all protocols, policies, and procedures to match new service.

4. Rework therapeutic program to match level of care. Visit RI International Crisis Respite program if questions around milieu management exists or as an educational opportunity around best practices.
5. Ensure that billing codes match service and that funding is going to match budget. The current rate does not offer sufficient reimbursement to ensure program sustainability.
6. Secure funding for tenant improvements to further ensure physical safety for patients and staff as well as improve workflow and create a more recovery oriented atmosphere.
7. Once the unit is ready for the new level of care, adjust the staffing model.
8. Create a community communication and marketing plan to ensure community awareness of changes being made.
9. Implement above communication and marketing plan.
10. Create joint protocols with EDs and local jail on referral process.

Ultimately, the Crisis Stabilization Unit needs to be completely reworked. At best in its current format, it does not meet current community needs. At worst it is at risk for an adverse outcome based on staffing model and physical plant limitations. Leadership currently tries to manage safety concerns by adhering to exclusionary criteria and strong triage decision points. This however leaves the community frustrated as there is discord between the promotion of the program and the reality of the program.

IV. Final Thoughts

Lorain County is poised to have a strong *Crisis Now* model of crisis services. Community, Provider, Hospital and Law Enforcement Leadership are in a high level of readiness in regards to change. Overall in regards to these services, Lorain County is still evolving. Movement toward a more evolved level will focus on shifting from a predominantly Inpatient model of mental health crisis services to a creation of a fuller more vibrant menu of crisis services between mobile teams and inpatient care. The other "rungs in the crisis continuum ladder' should decrease current reliance on EDs as being the primary caregiver to people in the midst of crisis. The ideas stated in this report would increase access to appropriate care in a much more cost-effective manner, saving community resources. The biggest take away from this report should be that the current CSU needs to change to a crisis residential or respite level of care. Additionally, it needs to evaluate the safety of its facility with an eye toward anti-ligature immediately. While Sub-Acute and 23 hour Observation facilities are often better served in community settings, it is believed that Mercy Regional Medical Center is in the best position to currently serve that need with its plans to move the BAC to a different part of the hospital. Finally, crisis service reimbursement rates are decreasing in the state. The estimated 40% decrease in Mobile Team reimbursement significantly puts the sustainability of this program in question. The payment model as it is currently is geared toward outpatient services and not true crisis programs.

Thank you for the opportunity to spend a few days in beautiful Lorain County. If I can be of any service in the future, please let me know.

Jamie Sellar MA, LPC
Director of Consulting and Development
RI International

From Psychiatric Times:

What Psychiatrists Need to Know: Patients in the Emergency Department

- Scott Zeller, MD

Aug 16, 2018

If you're having a psychiatric emergency, hang up and dial 911, or go to your nearest emergency room." Most psychiatric patients are all too familiar with this voicemail message. And those who follow this advice, even calling 911, will still likely find themselves at the nearest emergency department (ED).

What many psychiatrists do not realize is that the majority of EDs in the US are inadequately equipped to treat psychiatric crises. As a result, many patients who seek emergency psychiatric care are mostly held for transfer to inpatient facilities. In fact, patients who present to the ED with mental health and substance abuse complaints are 2.5 times as likely to be admitted as those with purely physical problems.[1]

Unfortunately, the demand for inpatient psychiatric beds far exceeds supply. The Treatment Advocacy Center reported that the number of inpatient beds dropped by 95% from 1955 to 2005, going from 340 beds per 100,000 people to 17 beds per 100,000 people—and the number is still dropping.[2] Because of this shortage, admitted patients must often wait many hours in the ED without treatment. This practice is known as *psychiatric boarding*.

The number of patients in the US presenting to the ED with psychiatric complaints has increased by more than 50% since 2006. One in eight ED visits now involves a psychiatric emergency.[3] Meanwhile, the number of psychiatric inpatient beds continues to diminish.

A main driver of boarding is the belief that most patients experiencing psychiatric emergencies require inpatient admission. However, like physical complaints, mental health and substance abuse crises can often be stabilized in the ED. Imagine, for example, that we admitted everyone who presented to the ED with chest pain. If that were the case, we would be lamenting a national shortage of general hospital beds as well. (Fortunately, only 18% of chest pain patients are admitted from the ED to the hospital.[4])

Research strongly suggests that if an appropriate treatment is started promptly, the majority of psychiatric emergencies can be resolved within 24 hours without inpatient hospitalization.[5] To end boarding for this vulnerable population, we must implement effective ways to deliver timely psychiatric care in the ED.

An important clarification: it is completely appropriate for emergency psychiatric patients to come to medical EDs. In fact, the federal Emergency Medical Treatment and Active Labor Act categorizes psychiatric emergencies as equivalent to medical emergencies like trauma and heart attacks. Patients in psychiatric crisis therefore have the same legal requirements for prompt evaluation and stabilizing treatment.

Unfortunately, many systems have sought to divert psychiatric patients from the ED as if they do not belong there. However, psychiatric emergencies like suicidality and psychosis are life-threatening and require the highest level of care available. Thus, instead of looking for ways to avoid it, hospitals need to embrace and prepare for these patients' urgent care needs, providing proper ~~staff~~ training, and putting systems and procedures in place to provide an effective care environment for them.

Even where community resources are available, like mental health urgent care centers and crisis intervention programs, most of these sites cannot accept patients who are acutely agitated, actively suicidal, have a history of violence, are presently intoxicated or in substance withdrawal, or who have comorbid medical issues. This means sizable numbers of excluded patients will still need to go to hospital EDs for care. But because most EDs typically provide very limited psychiatric treatment, commonly the highest acuity psychiatric patients in any region are ironically the most underserved. (To put things in perspective, only about 16% of emergency physicians report having access to an on-call psychiatrist.[6])

Many psychiatrists may not realize that the average ED duration of stay for psychiatric patients ranges from seven to 34 hours in the US[7]—three times longer than patients presenting with physical illnesses and injuries.[8] Boarding exacerbates ED crowding, reducing the department's capacity to care for people experiencing things like heart attack, stroke, or trauma. It also leads to longer wait times, care delays, and ambulance diversions that affect all patients.

The good news is that with the right processes in place, most of these care delays can be effectively eliminated. When appropriately managed, the majority of patients in psychiatric crisis can be stabilized, treated, and discharged within 24 hours. This greatly improves ED capacity while also saving precious inpatient psychiatric beds for those who truly have no alternative.

New approaches to ED psychiatry

A number of health systems around the US have recently pioneered alternative care models to address psychiatric emergencies while ensuring that all psychiatric patients

presenting to the ED receive timely assessment and treatment. In many cases, this can mean the difference between boarding and timely discharge with targeted follow-up.

RESEARCH SUGGESTS that the following three approaches can greatly improve care quality:

1. EmPath Units. The noisy, hectic ED can be an upsetting place for psychiatric patients. A long stay without treatment will often worsen symptoms rather than alleviate them. It is therefore beneficial to move medically cleared patients into a calmer environment staffed with trained mental health personnel. One model that follows this philosophy is the EmPath Unit (Emergency Psychiatric Assessment, Treatment and Healing Unit).

An EmPath Unit is a standalone unit or section of the ED dedicated solely to the treatment of high-acuity psychiatric conditions. These units offer a calm, home-like, supportive milieu reminiscent of drop-in crisis programs. But because EmPath Units are hospital-based and ED-affiliated, they are able to treat high-acuity, dangerous, intoxicated/in withdrawal, and/or medically comorbid individuals who normally would be excluded from community-based programs.

EmPath Unit patients receive prompt psychiatric assessment and early initiation of treatment, with ongoing involvement and re-evaluations for up to 24 hours. The calm, supportive environment dramatically reduces levels of agitation and aggression, and use of coercive treatments and restraints is rare, typically in less than one percent of patients. Decisions about hospitalization or disposition are not made until providers have time to observe the patient's response to treatment. All told, about 75% of EmPath patients who would have been hospitalized in traditional EDs are able to avoid inpatient admission and are discharged to a less-restrictive level of care.[9]

EmPath Units have recently launched or are planned in multiple states. Most are currently located in large cities like Los Angeles and Chicago. However, the Billings Clinic in Montana launched the first regional EmPath Unit serving a largely rural catchment area in April.

2. On-demand telepsychiatry. Not every ED sees a sufficient volume of psychiatric patients to justify a separate unit for psychiatric crisis care. However, smaller-volume EDs still benefit from access to an experienced emergency psychiatrist, especially for complex cases. Many are now meeting this need with on-demand video conferencing.

Telepsychiatry programs provide EDs with around-the-clock access to board-certified emergency psychiatrists for patient assessments and consultations. When an emergency provider requests a consult, a psychiatrist responds quickly and is often evaluating a patient within an hour. The psychiatrist interviews and assesses the patient via a secure two-way video platform and advises the emergency physician on diagnosis, treatment, medications, and disposition planning.

This process provides earlier diagnosis and therapeutic intervention for patients while decreasing ED duration of stay and improving outcomes. Research suggests that telepsychiatry programs save hospitals an estimated $1,000 to $,500 per patient and can also reduce readmissions by up to 62% in some settings.[10]

3. Training for ED teams. Emergency physicians are experts at treating physical illnesses and injuries, but they are often less confident addressing psychiatric emergencies because of minimal psychiatric training. Psychiatrists can therefore play a vital role in helping to train emergency physicians to manage mental health and substance abuse crises. One simple way to get involved is to offer Grand Rounds or an in-service training for local ED providers. ED teams are especially interested in education on suicidality, medication management, de-escalation, and the benefits of avoiding restraints.

Training empowers ED physicians to intervene earlier to relieve psychiatric patients' suffering, which can decrease the need for coercive treatments, improve outcomes, and reduce both boarding times and the demand for inpatient admissions. Collaborating with ED providers in this way also helps psychiatrists to understand the challenges and realities of crisis care in the ED. This quid-pro-quo benefits everyone involved— most of all, vulnerable and underserved patients who rely on the ED when emergencies arise.

Conclusion

While the challenges cannot be solved overnight, awareness is the first step to leading change. As psychiatrists, it is our duty to understand the care landscape and advocate for psychiatric patients by partnering with the EDs to ensure access to timely, appropriate and compassionate care. Implementing a better care infrastructure in our EDs and utilizing best practice solutions such as EmPATH Units, telepsychiatry and physician training can help EDs to transform the health care experience for all patients who walk through the emergency room doors.

Disclosures:

Dr Zeller is Vice President of Acute Psychiatry at Vituity, a multispecialty partnership of physicians, advanced providers, and industry professionals, and is an Assistant Clinical Professor, University of California-Riverside. Dr Zeller reports reports no conflicts of interest concerning the subject matter of this article.

References:

1. Owens PL, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits Among Adults, 2007. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf. Accessed July 5, 2016.

2. Torrey EF, Entsminger K, Geller J, et al: The Shortage of Public Hospital Beds for Mentally Ill Persons, 2008. http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf. Accessed July 5, 2018.

3. Weiss AJ, Barrett ML, Heslin KC, Stocks C. Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013. 2016. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf Accessed July 5, 2018.

4. Venkatesh AK, Dai Y, Ross JS, et al. Variation in US hospital emergency department admission rates by clinical condition. *Med Care*. 2015;53:237-244.

5. Zeller SL. Treatment of psychiatric patients in emergency settings. *Prim Psychiatry*. 2010;17:35-41.

6. Waits for Care and Hospital Beds Growing Dramatically for Psychiatric Emergency Patients [press release]. Las Vegas, NV: American College of Emergency Physicians; October 17, 2016.

7. Weiss AP, Chang G, Rauch SL, et al. Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. *Ann Emerg Med*. 2012;60:162-171.e165.

8. Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int*. 2012. https://doi.org/10.1155/2012/360308. Accessed July 5, 2018.

9. Zeller S, Calma D, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West J Emerg Med*. 2014;15:1-6.

10. Conn J. Telehealth reduced readmissions, hospital days. *Modern Healthcare*. February 5, 2013. http://www.modernhealthcare.com/article/20130205/NEWS/302059954. Accessed July 5, 2018.

	RI International fiscal study					
	Lorain County, OH - Crisis Center					
	Phase I - 8 chair Receiving Center and 8 bed Sub-Acute	FTE			FTE	
	Year 1	39.00	31.00	Year 2	39.00	31.00
	Operating Expenses	RRC	Living Room		RRC	Living Room
	Salaries & Wages	1,895,098	1,272,907		1,942,475	1,304,730
	Registry Services	23,500	23,500		23,500	23,500
	Employee Benefits	395,606	266,423		407,474	274,416
	Travel	3,540	3,540		3,540	3,540
	Office Occupancy	108,000	108,000		108,000	108,000
	Client Occupancy	-	-		-	-
	Program Services	38,161	38,161		40,069	40,069
	Program Supplies	40,240	40,240		40,240	40,240
	Office Supplies & Equipment	12,750	12,750		12,750	12,750
	Insurance	18,033	17,401		18,033	17,401
	Telephone	7,800	7,800		7,800	7,800
	Other Expenses	3,500	3,500		3,500	3,500
	Capital Expenditures	-	-		-	-
	Operating Expenses	**2,546,228**	**1,794,222**		**2,607,381**	**1,835,946**
	Direct Allocations					
	Billing Services & Data Reporting	72,666	49,073		74,846	50,545
	Quality & Compliance	47,210	31,882		48,626	32,838
	Electronic Health Record	-	-		-	-
	Operating Expenses, including Direct Allocations	**2,666,103**	**1,875,177**		**2,730,853**	**1,919,329**
	Indirect Allocations					
	Executive	156,209	105,491		160,114	108,128
	Finance	82,154	55,480		84,208	56,867
	HR	68,038	45,947		69,739	47,096
	MIS Network	39,110	26,412		40,088	27,072
	Non Reimbursable - Contra	-	-		-	-
	Non Reimbursable	-	-		-	-
	Total Indirect	**345,511**	**233,331**		**354,148**	**239,164**
	Total Expenses, including all Allocations	**3,011,614**	**2,108,508**		**3,085,002**	**2,158,493**

RI International fiscal study

Codes	Rate Case	Year 1	RRC	Living Room	Year 2	RRC	Living Room
			1.5	2.5	ALOS	1.5	2.5
	Census Bed Days Billable		**2007**	**2482**		**2336**	**2628**
	% of total available		69%	85%		80%	90%
Codes	Professional fees	Billing Rate			Billing Rate		
90791	Psyc Evaluation	$ 261.44	$ 349,806	$ 259,557	$ 261.44	$ 407,149	$ 274,825
90835	Professional Follow-up	$ 224.54	$ 150,217	$ 334,384	$ 224.54	$ 174,841	$ 354,054
	Total Professional Fees		**$ 500,023**	**$ 593,941**		**$ 581,990**	**$ 628,879**
S9484	RRC Per Diem	$ 1,251.42	$ 2,511,591		$ 1,071.49	$ 2,503,012	
114	Sub-Acute Per Diem	$ 610.22		$ 1,514,567	$ 582.04		$ 1,529,614
	Total Prof Fees and Per Diem	**$ 896.89**	**$ 3,011,614**	**$ 2,108,508**	**$ 812.37**	**$ 3,085,002**	**$ 2,158,493**
				$ -			
	Start up Costs	$ 386,000	$ 202,000	$ 184,000		$ -	$ -
	Total State & County	11%	$ 331,278	$ 231,936	11%	$ 339,350	$ 237,434
	Total Medicaid		*$ 2,680,336*	*$ 1,876,572*		*$ 2,745,651*	*$ 1,921,059*
	Total Funding Needed		**$ 3,213,614**	**$ 2,292,508**		**$ 3,085,002**	**$ 2,158,493**

Notes

1 Office Occupancy - 8,000 sq. ft. building for both programs
(Rent = $20...Utilities = $3...Janitorial $3...Repairs & Maintenance $1...costs are per square foot)

2 Electronic health record will be charged depending on MCO contract and provider system bid.

3 Program Supplies - Food costs are $9 per bed, per day for 3 meals and snack

4 No in-house kitchen anticipated

RI International fiscal study

Lorain County, OH - Crisis Center

Phase II - 16 chair Receiving Center and 16 bed Sub-Acute

	FTE			FTE	
Year 1	**51.00**	**45.00**	**Year 2**	**51.00**	**45.00**
Operating Expenses	**RRC**	**Living Room**		**RRC**	**Living Room**
Salaries & Wages	2,653,518	1,965,173		2,719,856	2,014,302
Registry Services	47,000	47,000		47,000	47,000
Employee Benefits	543,670	409,484		559,980	421,769
Travel	3,540	3,540		3,540	3,540
Office Occupancy	229,500	229,500		229,500	229,500
Client Occupancy	-	-		-	-
Program Services	61,527	61,527		64,603	64,603
Program Supplies	58,750	58,750		58,750	58,750
Office Supplies & Equipment	14,950	14,950		14,950	14,950
Insurance	20,107	19,509		20,107	19,509
Telephone	15,600	15,600		15,600	15,600
Other Expenses	2,750	2,750		2,750	2,750
Capital Expenditures	-	-		-	-
Operating Expenses	**3,650,911**	**2,827,783**		**3,736,635**	**2,892,273**
Direct Allocations					
Billing Services & Data Reporting	101,867	76,040		104,924	78,321
Quality & Compliance	66,181	49,402		68,167	50,884
Electronic Health Record	-	-		-	-
Operating Expenses, including Direct Allocations	**3,818,960**	**2,953,224**		**3,909,726**	**3,021,478**
Indirect Allocations					
Executive	218,983	163,462		224,457	167,548
Finance	115,169	85,969		118,048	88,118
HR	95,379	71,197		97,764	72,977
MIS Network	54,827	40,926		56,197	41,949
Non Reimbursable - Contra	-	-		-	-
Non Reimbursable	-	-		-	-
Total Indirect	**484,357**	**361,553**		**496,466**	**370,592**
Total Expenses, including all Allocations	**4,303,317**	**3,314,778**		**4,406,192**	**3,392,070**

RI International fiscal study

Codes	Rate Case	Year 1	RRC	Living Room	Year 2	RRC	Living Room
			1.5	2.0	ALOS	1.5	2.0
	Census Bed Days Billable		**3869**	**5000**		**4672**	**5256**
	% of total available		66%	86%		80%	90%
Codes	Professional fees	Billing Rate			Billing Rate		
90791	Psyc Evaluation	$ 261.44	$ 674,340	$ 653,600	$ 261.44	$ 814,298	$ 687,064
90835	Professional Follow-up	$ 224.54	$ 289,581	$ 561,350	$ 224.54	$ 349,683	$ 590,091
	Total Professional Fees		**$ 963,921**	**$ 1,214,950**		**$ 1,163,981**	**$ 1,277,155**
S9484	RRC Per Diem	$ 863.12	$ 3,339,396		$ 693.97	$ 3,242,211	
114	Sub-Acute Per Diem	$ 419.97		$ 2,099,828	$ 402.38		$ 2,114,915
	Total Prof Fees and Per Diem	**$ 613.28**	**$ 4,303,317**	**$ 3,314,778**	**$ 539.60**	**$ 4,406,192**	**$ 3,392,070**
	Start up Costs	$ 474,000	$ 246,000	$ 228,000		0	0
	Total State & County	11%	$ 473,365	$ 364,626	11%	$ 484,681	$ 373,128
	Total Medicaid		$ 3,829,952	$ 2,950,152		$ 3,921,511	$ 3,018,942
	Total Funding Needed		**$ 4,549,317**	**$ 3,542,778**		**$ 4,406,192**	**$ 3,392,070**

Notes

#1 Office Occupancy - 17,000 sq. ft. building for both programs
(Rent = $20...Utilities = $3...Janitorial $3...Repairs & Maintenance $1...costs are per square foot)

#2 Electronic health record will be charged depending on MCO contract and provider system bid.

#3 Program Supplies - Food costs are $7 per bed, per day for 3 meals and snack

#4 FTE's - This includes 1 chef (Split 50%) and 2 Kitchen Aides (36 hrs. per location) as well more staff due to size increase

Attachment B

2019/2020 Conceptual Test Fit Prepared by Clark and Post

24'-0" 36'-0" 28'-8" 10'-0" 52'-0"

STAIRS
6 PATIENT RM.
7 PATIENT RM.
SECLUSION & RESTRAINT
8 PATIENT RM.
9 PATIENT RM.
HEALING COURTYARD
5 PATIENT RM.
5 PATIENT RM.
4 PATIENT RM.
3 PATIENT RM.
2 PATIENT RM.
1 PATIENT RM.
YOUTH RESPIT
NURSE STATION
TR
GROUP THERAPY
LINEN STOR.
LAUNDRY
UTILITY
STAFF BREAK
ADULT RESBIT
RESTRM.
SHOWER
MENS
SENSORY ROOM
WOMENS
RECEPTIONIST
MOBILE CRISIS
SERVING KITCHEN
LOBBY
RESTRM.
SHOWER
SHOWER / RR2
STORAGE
INTERVIEW
INTERVIEW
ELEV.
VESTIBULE
OFFICE
JANITOR
EMS 2
EMS 1
PR. 3' DOORS
GARAGE/SALLYPORT
LIFE CARE MINI STATION

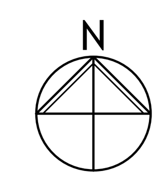
26'-4" 60'-4" 30'-0" 116'-8" 86'-8" 30'-0"

68'-0" 52'-0" 30'-8"

150'-8"

FIRST FLOOR PLAN

1/8" = 1'-0"



GROSS SECOND FLOOR AREA: 13,728 SF

TOTAL GROSS BLDG AREA: 25,445 SF

CLARK & POST
architects inc.
E: clarkpost@clarkandpost.com
6125 So. Broadway Lorain, Ohio 44053
T: (440) 233-8487 F: (440) 233-8658

dates/ revisions
March 10, 2020

sheet description
First Floor Plan

project name
Annex Building for
The Nord Center

6140 S. Broadway
Lorain, Ohio 44052 project number 1843

sheet
2

STAIRS

5 DETOX RM. | 6 DETOX RM. | 7 DETOX RM. | 8 DETOX RM. | 9 DETOX RM. | 10 DETOX RM. | COUNSELOR | STORAGE | ROOF

4 DETOX RM. | 3 DETOX RM. | 4 DETOX RM. | 3 DETOX RM. | RESTROOM | ADA RESTROOM | LAUNDRY | ADA RESTROOM | RESTROOM

LOUNGE | (ESS / DETOX) | DAY ROOM | NURSE STATION | INTAKE EXAM | DRUGS | STORAGE | KITCHENETTE

MECHANICAL / ELECTRICAL | RESTROOM | RESTROOM | IT | CONFERENCE

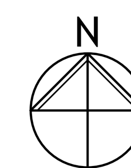
11 DETOX RM. | 12 DETOX RM. | 13 DETOX RM. | 14 DETOX RM. | 15 DETOX RM. | 16 DETOX RM. | COUNSELOR | MACHINE RM. | ELEV. | LOBBY | OFFICE | OFFICE | OFFICE | OFFICE

26'-0" | 60'-8" | 86'-8" | 150'-8"

ROOF

SECOND FLOOR PLAN

1/8" = 1'-0"



GROSS SECOND FLOOR AREA: 11,717 SF

TOTAL GROSS BLDG AREA: 25,445 SF

CLARK & POST
architects inc.
E: clarkpost@clarkandpost.com
6125 So. Broadway Lorain, Ohio 44053
T: (440) 233-8487 F: (440) 233-8658

dates/ revisions
March 10, 2020

sheet description
Second Floor Plan

project name
Annex Building for
The Nord Center

6140 S. Broadway
Lorain, Ohio 44052
project number 1843

sheet
3