

Residential Treatment Center Review Results

Improving the Quality of Services in Residential Treatment Centers: A Consultative Model

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Why the reviews?

- County director hearing anecdotal evidence of questionable treatment practices used in congregate care facilities
- Over \$40 million in county resources being directed to residential treatment with little oversight
- Concerns related to capacity of local office to monitor treatment practices
- Concerns related to the length of stay in congregate care

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Review Methodology I

- Random sampling of 20 percent of cases for review
- Introductory overview of agency
- Interviews with clinical staff
- Interviews with direct care staff
- Interviews with children

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Review Methodology II

- Review of records
 - Treatment plans
 - Progress notes
 - Medication logs/nursing notes
 - Evaluations/assessments
- Exit Summary Report
 - Summary of findings
 - Technical assistance provided related to best/evidence-based practice

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Review Methodology III

- Written report drafted by consultative review team members
 - Summarized findings
 - Written technical assistance provided for required plan of correction
- Report reviewed and forwarded to provider by child welfare office

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Early findings I

- Reviewer visits to one facility found that the psychiatric diagnosis of children was posted on their bedroom door
- In another early visit, reviewers found the facility with complete lack of supervision as most of the staff were at an in-house training

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Early Findings II

- Questionable medication practices throughout the provider system
 - Psychotropic medications being stored on window sills in bright daylight
 - Adult dosages of psychotropic medications being given to children as young as 9 years old
 - Unsecured medications
 - Lack of required blood monitoring for some prescribed medications

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Early Findings III

- Reviewers noted questionable disciplinary procedures
 - Lack of justified use of mechanical restraints
 - Excessive use of prolonged isolation and lack of adequate documentation
 - Humiliating disciplinary practices
 - Staring at the wall in the hall for 24 hours

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Early Findings IV

- Lack of coordinated care by many providers in the system
 - Scheduled therapies
 - Inadequate progress notes
 - Many facilities did not keep progress notes
 - Lack of advocacy related to educational needs
 - IDEA services not provided
 - Lack of family engagement

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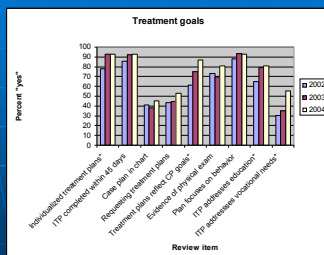
Early findings V

- General lack of sophistication around confidentiality issues
 - Notations in chart listing names of other residents
 - Staff sharing information about residents to other residents
- Length of stay
 - Reviewers noted that usual length of stay was usually at least a year with some being as long as four plus years

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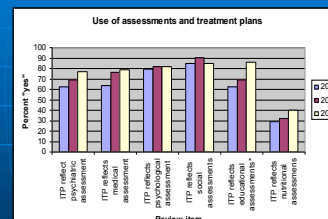
Individualized Treatment Plans



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Use of Assessments

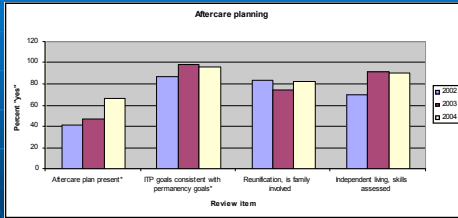


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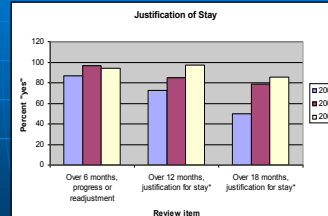
Aftercare Planning



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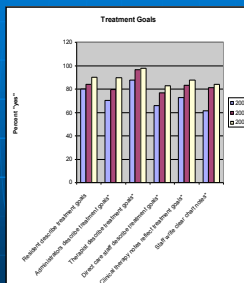
Justification of Stay



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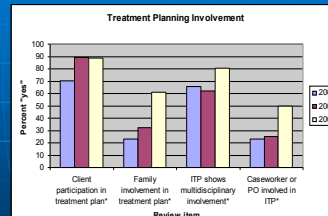
Treatment Goals



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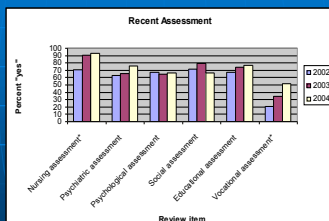
Treatment Planning Involvement



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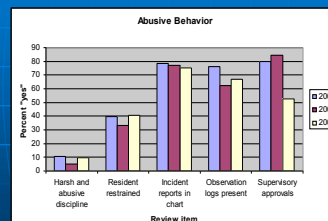
Recent Assessment



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Agency Disciplinary Practice

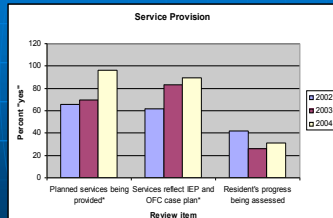


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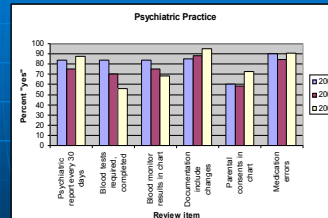
Service Provision



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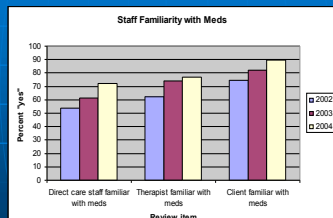
Psychiatric Practice



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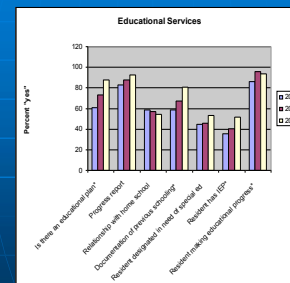
Familiarity with Medications



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Educational Services



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Where are we now? I

- Generally improved processes around medication use and psychiatric practice
 - Specific language inserted into contract related to psychotropic medication use
 - Use of institutional pharmacies by providers
 - Professionalization of medical services within facilities
 - Staff training about medications
 - Issues continue to persist related to parental consent and blood level monitoring

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Where are we now? II

- Improved treatment process
 - Most providers now complete scheduled therapies
 - Most providers have developed a means to document the treatment process through their use of progress notes
 - Treatment planning has improved and has become more multi-disciplinary and family inclusive

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Where are we now? III

- Increased congruence between case plans and treatment plans
 - Increased PO and FCM involvement
- Reduction in prolonged stays without justification...length of stay less of an issue
- Agencies are now addressing educational needs more consistently
 - Increased advocacy
 - Working more closely with their local educational systems

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Continued Challenges I

- Persistent occurrence of abusive practice by providers
- Persistent problems with medication errors/documentation and lack of blood monitoring
- Increased PO and FCM involvement in treatment planning
 - Case plans
 - Treatment plan reviews

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Continued Challenges II

- Improved educational services for children in congregate care facilities
 - Procurement of IDEA services
 - Accredited schools
 - Transition planning to home schools
- Improved vocational services
 - Vocational assessment for youth over age 16
 - Provision of vocational opportunities
 - Jobs
 - Skill certification
 - Linkage to college and continued support

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Continued Challenges III

- Continued/improved capacity of placing agencies to monitor service practice
 - Creation of feedback loops that enable problem solving
 - Enhancing the skills of staff to monitor quality issues
 - Training of new staff related to quality assurance processes
- Establishing uniform processes around unusual incident reporting
- Capacity to assist provider organizations in making necessary changes

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Continued Challenges IV

- Use of decision support guidelines to support appropriate placement recommendations
 - Using CANS data appropriately
 - Making treatment recommendations based upon clinical presentation
- Family engagement
 - Increased levels of family involvement especially in reunification cases
 - New treatment modalities that support the development of caregiver capacity

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Next Steps

- Challenge policymakers in Indiana to implement a quality assurance approach across the entire state
- Conduct a review of all 50 states to determine the quality assurance approaches implemented in each state

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