Residential Treatment Center Review
Results

Residential Treatment Center Evaluation
Project

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

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

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

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

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
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

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

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

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

Individualized Treatment Plans

Use of Assessments

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Aftercare Planning

Justification of Stay

Treatment Goals

Treatment Planning Involvement

Recent Assessment

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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

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
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

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

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

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

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

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