



# PROVIDER ALERT

---

Alert # 01-2003-02-10 HCAL

## **Performance Improvement Plan for Residential Treatment Facilities Allegheny County 2/10/03**

As a result of the outcome of the 2001 External Quality Review completed by IPRO, Community Care Behavioral Health collaborated with the Residential Treatment Facility Group of Allegheny County to develop a Performance Improvement Plan to address the identified quality of care concerns. The interventions identified in this Performance Improvement Plan are intended to facilitate and support Residential Treatment Facilities in improving the overall quality and documentation of care, as well as actively intervening to promote improved performance on all indicators identified in the IPRO study. CCBH has incorporated these performance indicators into our quality and care management processes to work toward the achievement of targeted indicators from the IPRO study. In particular, we will strive to improve scores related to family involvement, coordination of outpatient follow-up care and documentation of rationale for medications.

Community Care Behavioral Health and the RTF group are committed to working collaboratively with providers to promote the delivery of high quality residential treatment services as evidenced during medical records reviews at each RTF site. Community Care completed medical record reviews at each network provider site as planned by December 2002. CCBH Quality Record Reviews focused on the following documentation:

- Documentation that each member's **parent/guardian was in attendance for a meeting at the RTF within seven days** of admission to the RTF.
- Documentation that providers promote **family participation in the treatment planning and delivery process**. Providers will be expected to demonstrate their assertiveness, creativity and flexibility in encouraging family participation in RTF treatment.
- Documentation that the **family participated in the therapeutic process required before and after all therapeutic leaves**.
- Documentation of **the rationale and parent permission for initiating, adjusting and/or discontinuing medication**. Providers are also expected to provide documentation that the **parent and member received education concerning the benefits and possible side effects of medications**. This documentation will be contained in the member's medical record.
- Documentation that **medications are thoroughly discussed at each Individual Services Planning Team meeting** to ensure that all team members are updated on the current medication regimen.
- Documentation that **providers communicate and collaborate with all involved systems**, using appropriate release of information forms.
- Documentation of a **discharge planning policy** which includes a protocol for discharges including family involvement in RTF treatment, medication rationale and coordination of RTF coordination of outpatient follow-up care. Providers are required to document that staff are trained on all discharge policies and documentation requirements and Best Practice Standards on an annual basis.
- Providers are required to **notify CCBH and the RTF Group if a discharge is unplanned or if a member is Absent Without Leave**. It is imperative that communications and collaboration occurs to coordinate essential services to continue to support the member and family.

- Providers are expected to coordinate **ISPT meetings 45 days prior to the expiration of the authorized placement period**, to determine if reauthorization will be requested or if discharge planning is appropriate. When planning for discharges, RTF providers are expected to coordinate follow-up care and linkages to more informal, supportive services. **Discharge plans** must be documented and include follow-up care, community linkages and team members/persons responsible for implementing the discharge plan, to ensure that services and supports are in place prior to the member's discharge. Providers will fax a discharge summary or the "RTF 7-Day Discharge Form" to Community Care and the RTF group seven days prior to discharge. CCBH expects that discharge information and follow-up treatment recommendations be faxed to the follow-up provider at least 7 days prior to discharge.

Providers will be required to perform quarterly self-assessments utilizing the RTF Quality Management Form to monitor adherence to the Best Practice Standards and RTF State regulations.

Providers will no longer be required to complete the CCBH 30-day review form. Care Managers will continue monitoring treatment during the 45-day review process. CCBH Care Managers may request a telephonic review at anytime during the authorization period.

Results of the recent CCBH Quality Medical Records Reviews at RTF facilities reveal improvement in the following areas:

- 100% of records reviewed demonstrated documentation of parent/guardian involvement in treatment at the RTF.
- 100% of records reviewed documented parent/guardian participation in the therapeutic leave process.
- 85% of records reviewed documented rationale for medication changes.
- 81% of records reviewed documented that parent/guardian was in attendance for a meeting at the RTF within 7 days of admission.

Results of the recent CCBH Quality Medical Records Reviews at RTF facilities revealed the following areas are still in need of improvement. Providers are expected to return corrective action plans related as requested by Becky William, Quality Clinician, on or before 2/17/03.

- 0% of records reviewed had documentation that parent/guardian participated in medication changes
- 0% of records reviewed indicated that parent/guardian received education about medication changes
- 19% of records reviewed indicated that discharge information was faxed to the follow-up provider 7 days prior to discharge.
- 46% of records reviewed had documentation that medication changes were discussed during treatment team meetings.
- 54% of records reviewed had documentation that the member received education about his/her medication changes