



# Performance Standards

## Residential Treatment Facility

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

**Disclaimer:** These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

## RESIDENTIAL TREATMENT FACILITIES

### PERFORMANCE STANDARDS

As defined by the Office of Mental Health and Substance Abuse Services (OMHSAS), residential treatment facilities (RTF) are child care facilities that are licensed under Chapter 3810 of 55 PA Code and certified by OMHSAS, after a site visit, as required by OMHSAS and Medical Assistance (MA) Bulletins. Residential treatment facilities provide 24 hour living arrangements *and* mental health treatment for children/adolescents whose needs are such that they can only be served in a 24 hour residential setting.

Services at this level of care are intended to address the intensive treatment needs of children and adolescents. An RTF provides a setting in which a child/adolescent is expected to receive intensive reassessment, re-training, and skill-building opportunities. RTFs also offer the opportunity for the optimization of a psychotropic regime, when psychotropic intervention is an integral part of a child's treatment. During this course of treatment, the child is supported to enhance his/her capacity and skills for interpersonal communication and relationship building. Treatment planning is individualized to promote positive change that will allow a child to succeed in his/her community upon discharge.

These performance standards are the result of a series of meetings facilitated by Community Care, with representatives from network RTF providers and other stakeholders. The goal of the meetings was to develop standards to expand upon the work of the Department of Public Welfare (DPW) and the statewide CASSP initiative. These standards are intended to clarify expectations and define the parameters of reasonable standards of practice for the provision of residential treatment. The standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performance standards. In some instances, the standards set the bar higher than baseline performance standards. Overall, this is reflective of the current level of quality within the network and the commitment of all involved stakeholders to continually strive to improve the quality of residential treatment services.

These standards should not be interpreted as regulations, nor will they be utilized as a means of requiring or prohibiting specific interventions for specific individuals. Each child or adolescent receiving residential treatment is to have a uniquely developed treatment plan which identifies strengths and addresses needs.

Additional input was sought from members and family stakeholders prior to the issuance of these standards in final form.

To improve the readability of the document, "child" is the term that will refer to the child, adolescent, member, or resident of the RTF.

## ACCESS STANDARDS

- For a child to access an RTF, the child must receive a psychiatric evaluation no more than 30 days prior to submission of the request for authorization of the RTF admission to the behavioral health managed care organization (BH-MCO), and the evaluating psychiatrist must recommend this level of care as medically necessary (*Note: Psychological evaluations performed by licensed psychologists are acceptable for admission to non-JCAHO facilities*). An evaluator is only to arrive at a recommendation for residential treatment after a complete evaluation of the child's strengths and needs, review of past treatment trials, and full consideration of the full continuum of care available to children and adolescents. Documentation as to why this level of care is medically necessary and why alternative less intensive, less restrictive services are not expected to adequately meet the identified needs must be included in the referral packet.
- Referral packets must be submitted to available RTF providers within 30 days of the psychiatric evaluation. That psychiatric evaluation will continue to provide the necessary current "prescription" for residential treatment for an additional 30 days.
- Several standards were identified to expedite access:
  - RTF providers are expected to communicate to referral sources on a monthly basis about current bed availability.
  - In Allegheny County, the RTF Group will submit individual referral information to multiple RTF providers to ensure that access is as timely as possible. In other counties, lead case managers are expected to submit referrals to multiple RTF providers to expedite access. Referring entities are expected to maintain contact with all RTFs considering a referral to keep all involved parties informed as to the status of a referral and to maintain documentation of such contact.
  - RTF providers are expected to update referral sources as to action they have taken upon receipt of a referral, on at least a weekly basis, in order to facilitate timely access to care.
  - RTF providers are expected to inform referral sources as to their current "skill sets", identifying program strengths and the profiles of children they can most effectively serve. RTF providers are expected to maintain up-to-date service descriptions (reviewed every six months and updated as needed; document the review process) inclusive of this information in order for referral sources and families to make informed choices. Document distribution of this information to referral sources.
  - Upon receipt of a referral and the determination that the referral will be considered for admission, RTF providers are expected to contact families, invite families to visit their facilities prior to placement, and provide families with as much program information as possible to assist them in deciding what program best meets the needs of their child and family. RTF providers should document all outreach and educational efforts extended to families to assist families through the pre-admission and admission process.

- While awaiting acceptance into an RTF, the identified lead (typically a case manager) of the current interagency team is responsible for collaborating with the family to develop an interim plan for services and to oversee the implementation of the interim service plan. The prescribing evaluator is expected to contribute to this process.

## **SERVICE ENGAGEMENT/RE-ENGAGEMENT STANDARDS**

Providers are expected to demonstrate reasonable efforts to engage a child and family in the treatment process. There are a variety of reasons why at first attempt, a child or family may appear to be uninterested in participating in treatment. However, providers are expected to repeatedly try a variety of interventions to engage them in treatment and to *document all efforts*.

The importance of interventions aimed at increasing the level of child and family involvement in the residential treatment services cannot be overstated. The extent to which a provider is able to engage the child and his/her family in treatment positively impacts the outcomes of treatment. The greater the degree of member and family involvement in treatment, the more effective the treatment, and the more positive the outcomes. Providers are expected to be creative and flexible in all outreach to a child and his/her family. Cultural issues are to be considered fully so as to engage in outreach efforts that are culturally sensitive and respectful.

The following represents a sample list of interventions that RTF providers are expected to employ to engage a child and family to the fullest extent possible throughout the treatment process. All interventions and attempts to engage a child and his/her family in services are to be documented in detail. Providers are not to be limited by this list and are encouraged to develop creative ways of enhancing partnerships with families and to improve the overall level of family participation in programming. Providers are expected to demonstrate multiple types of interventions throughout the course of treatment to fully engage a child and family or to maintain a maximum level of participation.

Expected interventions include:

- **Offering telephonic therapy sessions to accommodate families.** When families are unable to attend family sessions at the RTF, for whatever reason, RTF providers are expected to offer participation in family sessions by phone as one way of maintaining involvement while obstacles to face-to-face sessions are being addressed.
- **Offering family sessions in the family home as opposed to requiring the family to come to the RTF.** Providers are encouraged to outreach to families in this manner when unable to resolve obstacles that prevent families from being able to participate in family sessions at the RTF. If a family has been unable to attend scheduled meetings at the RTF for a two month period, the RTF provider is expected to offer to go to the family home for a session. If this offer is not made, reasons why must be clearly documented.

- **Openly reviewing treatment goals with the family on a monthly basis to ensure that the goals accurately reflect the family’s goals; modifying treatment goals to be consistent with those of the family.** When reviewing or developing treatment goals with the family, it is important that the goals are meaningful to the family.
- **Addressing transportation issues.** Document all efforts to address transportation obstacles, including education provided to the family regarding transportation options and collaboration with case management to identify possible solutions.
- **Making multiple attempts to reschedule appointments cancelled by families; one attempt to reschedule is inadequate.** Within one week of an appointment cancelled by a family, the RTF provider is expected to contact the family and offer a choice of alternatives to get the appointment rescheduled. All attempts to reach the family are to be documented. If a family cancels several appointments, the RTF provider is expected to inquire as to additional reasons than those stated why the family is canceling. The RTF provider is expected to attempt to resolve any identified obstacles to family participation and to document such efforts.
- **Maintaining general “family-friendly” communication standards as evidenced in program policies and procedures.** Examples of “family-friendly” communication standards include providing a family with easy access to treatment and program staff; encouraging contact between the family and the children through phone calls, flexible family visits and home passes, continually empowering the family throughout the course of treatment to be critically involved in decisions and informed of events affecting the child. Providers are expected to document how the family is informed about their access to program staff and invited to contact staff on a regular basis. Providers are expected to consistently demonstrate efforts to encourage and support contact between the resident and his/her families.
- **Convening an interagency team meeting to review the current plan and identify, as a larger team, other ways to engage the family.** When an RTF provider has been unable to engage a family in treatment over the course of two months, they are expected to convene an interagency team meeting. There may be resources within the team that can address identified barriers to family participation in treatment. The interagency team is also a resource when progress in treatment appears to be stalemated. Providers are encouraged to convene interagency team meetings to openly address lack of progress in treatment and to use the resources within the team to propose interventions that may promote treatment progress.
- **Maintaining monthly contact with the family to assess the level of satisfaction with services to date and inquire as to how to better engage the family in the process when involvement to date has been minimal.** Progress notes should document the occurrence of this monthly discussion with families:
  - RTF providers are expected to notify the involved BH-MCO within one week when they are experiencing difficulties engaging a family over the course of a one month period of time.
  - RTF providers are expected to maintain telephonic contact with the child and family if they require inpatient care during their residential treatment. RTF providers are also expected to attend (by phone or in person) treatment team meetings on the inpatient unit when appropriate. Evidence of this contact should

be documented in progress notes. This contact is necessary to maintain continuity of care in the event that the child is returned to the RTF or to successfully transfer or transition the child to another provider or level of care.

## **ASSESSMENT STANDARDS**

Following are performance standards regarding the assessment process, content, and qualifications of evaluators.

### **Assessment process prior to the initiation of residential treatment**

- Lead case managers or lead clinicians are expected to give pertinent historical information from all involved child serving systems to the evaluator prior to the completion of a psychiatric or psychological evaluation, to determine the most appropriate, least intensive and restrictive level of care required to adequately address current needs of the child.
- Other involved service providers are expected to gather relevant information for submission and review by the evaluating psychiatrist/psychologist. The evaluator can incorporate this information into the written evaluation. Such efforts support the effective management of limited physician availability.
- Evaluators are expected to be available to the interagency team through participation in interagency team meetings (by phone or in person) or review and consideration of input from the interagency teams following meetings.
- Every effort is to be made to include other involved services and systems throughout the assessment and treatment process. Input is to be sought from the educational system, extended family, supportive community members, juvenile probation services (when applicable), child protective services (when applicable), and any others identified by the child and family as a resource.
- The family is to be supported to participate in the assessment process to the fullest extent possible. Examples of such support include educational efforts to the family to explain what to expect from the assessment process, scheduling accommodations to obtain full family participation when possible and actively seeking and valuing the information the family provides to assist with the assessment process.
- RTF providers, case managers, and BH-MCOs all assume responsibility for continually educating referral sources about expectations of the prior assessment process.

## **CONTENT OF THE EVALUATION**

- Evaluations are expected to adhere to the “Life Domain Format for Psychiatric/Psychological Evaluations” as published by OMHSAS in *Guidelines for Best Practice in Child and Adolescent Mental Health Services*.
- Priority assessment areas include:
  - In-depth description of current strengths and presenting problems and symptoms; hypothesis as to what is maintaining the current problematic behaviors.
  - History of previous treatment and responsiveness.

- Family assessment.
- Adequate clinical information to substantiate the medical necessity for recommended services.
- Global as well as specific treatment recommendations; identification of goals for recommended services.
- In instances in which medical necessity for RTF has been substantiated (admission is to be pursued), but the evaluation lacks sufficient information to be considered comprehensive, several steps will be taken. BH-MCO staff will contact the evaluator to obtain additional information by phone or to request additional information in writing to support the medical necessity for this level of care. BH-MCOs will track the production of inadequate evaluations through provider profiling and will intervene with evaluators as appropriate. RTF providers may also contact evaluators and other members of the interagency team directly when assessing the appropriateness of a referral if additional clinical information is needed. The lead case manager or lead clinician is expected to assist with the process of gathering additional clinical or referral information when necessary to facilitate an admission.

## **QUALIFICATIONS OF EVALUATORS**

- For placement in JCAHO approved RTFs, a licensed physician must complete a psychiatric evaluation.
- For placement in non-JCAHO RTFs, a licensed psychologist or a licensed physician must complete a psychiatric or psychological evaluation.
- Evaluators are expected to have knowledge of:
  - The child serving systems.
  - The continuum of care available to children/adolescents.
  - Family systems theory and principles.

## **EARLY ASSESSMENT FOLLOWING ADMISSION TO AN RTF**

RTF providers are expected to:

- Engage the family very early upon admission to the ongoing assessment and treatment planning process. Documentation of communication and collaboration with the family during the first week of admissions is expected.
- Help to educate the family as to what to expect from the residential treatment experience for themselves and their child.
- Continue assessing the child and making the appropriate additions/revisions to the comprehensive, individualized treatment plan during the first month of treatment. Providers are expected to partner with the family to the fullest extent possible throughout the assessment and treatment planning process.
- Meet within the first 30 days of treatment with the treatment team, including the child and family, to thoroughly review the treatment plan and revise as necessary. Maintain documentation of treatment team meetings and revisions to the treatment plan.

- Hold an interagency team meeting approximately one month prior to the expiration of the current authorized service period to review progress toward goals, responsiveness to residential treatment and to clinically review the need for continuing stay at this level of care (Note: In Allegheny County, the RTF provider must convene an interagency team meeting no later than 45 days into the service period to review progress to date and the need for continuing stay at this level of care).

## **SERVICE PLANNING ELEMENTS**

Successfully “matching” the child to an RTF that can best address his/her needs can be expected to lead to better outcomes. The child/family should be given information indicating why particular RTF providers are being suggested to them based on the providers’ abilities to meet the identified individual and family needs. Ideally, the child/family should be given a choice of RTF providers and adequate information on how to decide what provider is the best “match” for the child/family. As referral sources engage in the service planning process, it is important to understand the strengths and “skill sets” of each available residential treatment facility. Accurate and current service descriptions by facility are one way of keeping informed of the unique strengths of each facility.

## **SERVICE DESCRIPTIONS**

Each RTF provider is expected to review (every six months) and update (as needed) their current service description and distribute it to referral sources (including BH-MCOs and families as requested).

Updated service descriptions are to include:

- Treatment specializations offered by the facility.
- Description of the primary treatment models of the facility.
- Policy regarding transportation.
- Frequency and type of treatment interventions.
- Frequency of family work.
- Education capacity: identify how the facility works to ensure that the educational needs of its residents are addressed.
- Information about whether home based services are a typical part of the treatment approach of the facility.
- Special populations that the facility is equipped to treat.

Key elements to the successful development of an individualized treatment plan or ISP (Individualized Service Plan) are also identified under this topic of service planning elements. A standardized “service plan” template is used throughout the HealthChoices Southwest Zone.

## **ELEMENTS OF THE TREATMENT PLAN/ISP AND THE SERVICE PLANNING PROCESS**

The treatment plan, or ISP, and the service planning process are expected to:

- Link to the assessment of strengths and needs by life domains, and to identify the initial priorities for services.
- Establish a progressive course for treatment; identify how services will be holistic, addressing the “total” needs of the child and family.
- Identify how services from several sources will be coordinated and integrated to best address the needs of the child and family. The ISP is to “guide” the delivery of services.
- Be developed collaboratively, with the child and the child’s family participating to the fullest extent possible.
- Include a discussion of discharge planning very early in the service planning process and on an ongoing basis.
- Identify an anticipated length of stay. The treatment team is to anticipate discharge placement, identify possible barriers to discharge, and include preparations for transition throughout the course of treatment. RTF is a temporary treatment program as opposed to a long term placement option.
- Develop individualized crisis plan/relapse plans. The family needs to be included in the development of this crisis/relapse plan and knowledgeable of it. When an acute inpatient stay occurs, there should be communication and collaboration with the inpatient team about the relapse plan to enhance the continuity of care. All systems and providers involved in providing services to the child are to be made aware of the crisis/relapse plan. A crisis/relapse plan should address, at minimum; a) identification of prior precipitants to crises, b) delineation of interventions to address precipitants, c) a means of assessing the outcome of the interventions, d) specific alternatives to be tried prior to consideration of inpatient treatment (given that the situation can be safely managed in current level of care), and e) plan for communicating significant events in the child’s life to members of the treatment team. The RTF is also expected to have an internal crisis plan for each resident. For example, for a resident for whom running away behavior is common, the RTF provider is expected to develop a proactive plan of action that ensures the resident’s safety to the greatest extent possible in the event of this crisis.
- Identify how the child’s educational needs will be met. The service plan needs to be well coordinated and integrated with a child’s Individualized Education Programs (IEP). Effective service planning addresses transitional issues and continuity of care issues between approved private schools, public schools, and on-campus RTF based schools. Systems need to continue to work toward greater flexibility to ensure that a child receives the best possible educational plan that is well coordinated with his/her treatment plan in as least restrictive and intrusive setting possible.
- Be individualized, despite the fact that there are some “core” treatment components to residential treatment.
- Identify specific, measurable goals and objectives. The goals need to reflect the strengths/needs, diagnosis, overall level of functioning, and priorities identified throughout the assessment process.

- Include activities that promote community based integration and utilization of natural supports.
- Include family involvement in the treatment process to the greatest extent possible. It is expected that family goals be included in each child's treatment plan where appropriate.
- Include skill development goals.
- Consider new assessment information from psychiatric/psychological re-evaluations required by regulations.
- Include psychiatric follow up and medication management interventions.
- Include a monthly progress report and an update of the ISP with each continued stay request packet.
- Include use of standardized tool(s) to measure changes in overall levels of functioning throughout the course of treatment such as the CAFAS or CBCL.

## **PROGRAM ACTIVITIES**

The following bullets highlight the general expectations on what program activities are routinely provided in residential treatment facilities. RTF programs are expected to:

- Identify the primary clinical orientation of the program, as evidenced in program policies and procedures. Staff should be clear about the facility's core clinical orientation, as evidenced by staff training curriculum.
- Provide an orientation to the family prior to or shortly after admission. The family needs to be supported to be fully involved in the treatment process from the beginning of services. The family needs to be informed about what to expect from this service. The family should be informed about the different types of services/therapies that will be offered to the child. The orientation is to include an open discussion about the importance of family participation in assisting the child to achieve his/her goals. Providers are expected to document orientation activities or interventions.
- Provide all of the following treatment and therapeutic activities options (in some situations, a service may be offered but not provided. It is essential that providers document reasons why expected program activities are not delivered or why alternative activities are more clinically appropriate):
  - Therapeutic Milieu: Milieu therapy is expected to be an integral part of the daily program at residential treatment facilities. The therapeutic environment is expected to provide regular opportunities for both treatment and therapeutic activities.
  - Individual Therapy: Each child is expected to be provided with the opportunity for weekly scheduled one-on-one interaction with a master's level clinician, and spontaneous individual therapy as opportunities for intervention arise. Individual therapy is expected to be included in the treatment plan for every RTF resident. Providers will document clinical reasons for any deviations from this performance standard.
  - Family Therapy: Each child is expected to participate in a family focused therapy session on at least a weekly basis. RTF staff will document all attempts to fully engage family members in family therapy. Such approaches as arranging for

telephone participation, or community based family sessions closer to the family's home are encouraged. Contact with the family on a weekly basis is not sufficient to satisfy the expectation that family therapy be provided on a weekly basis. If a less intense schedule for family therapy is developed with the family, the provider is expected to document that decision and the reasons for the less intense family treatment plan.

- Opportunities for Therapeutic Leaves: Therapeutic leaves, prescribed as part of the child's individual treatment program, are very effective in helping a child and family prepare for discharge from the RTF setting. Providers are expected to maintain documentation of the physician's order for the therapeutic leave, a description of the desired outcome, the date and time of the leave and a written evaluation resulting from interviews with both the child and family/guardian after the leave period. Plans for therapeutic leaves are to be individualized, as reflected by observing flexible use of this intervention across residents (in terms of days, hours. Note: therapeutic leave is not limited to overnight visits, but includes planned day therapeutic visits). Providers are expected to document educational efforts with the family to emphasize the therapeutic goals of leave time and the importance of not creating a "holiday" environment that excludes work toward goals. In preparation for therapeutic leaves, the provider is expected to review the child's crisis or relapse prevention plan with the child and family. The RTF provider maintains clinical responsibility for residents while on leave.
- Group Therapies: Group therapy is a core component to daily programming. The following core psychoeducational group topics were identified: Anger Management, Self-Awareness, Social Skill Development, Developing Positive Relationships with Peers and Family, Conflict Resolution, and Anxiety Management. Specialized groups to address issues such as substance abuse and sexual abuse are to be offered as needed. If unavailable at the RTF yet needed, the RTF provider is expected to arrange for the child to receive such services outside of the RTF setting. Traditional process groups to review progress on daily/weekly goals are also seen as useful therapeutic tools.
- Skill building opportunities within the RTF setting and within community settings: Residents are to be provided with opportunities to practice skills being developed in formal groups and in therapy in natural informal settings.
- Opportunities for community participation on a weekly basis.
- Regular contact with the interagency team: RTF providers are expected to provide monthly updates to members of the interagency team.
- Medication administration and monitoring on a daily basis and at least monthly monitoring by a psychiatrist.

## **ROLE OF THE PSYCHIATRIST**

Psychiatrists serve an important role and provide important program activities within residential treatment facilities. Psychiatrists are expected to have regular and ongoing contact with residents, especially those receiving medications. Psychiatrists are also expected to have regular and ongoing contact with treatment staff within the RTF to assist with treatment plan development, implementation, and monitoring. Maintaining

regular contact with external members of interagency teams is also an important role for psychiatrists. Psychiatrists are expected to provide psychoeducation, especially regarding diagnostic implications and psychotropic interventions, to members, families, staff, and interagency teams. Psychiatrists are encouraged to attend interagency team meetings for residents. Psychiatrists are also expected to have regular and ongoing contact with the residents' families, both face-to-face and by telephone.

## **DISCHARGE PLANNING AND FOLLOW UP PRACTICES**

The goal of residential treatment is to prepare the child for return to the least restrictive, least intrusive, most natural setting possible. Discharge planning is not a discrete activity, but an ongoing process that begins at admission. Effective discharge planning requires participation by the child, family, and the full interagency team, including representatives from all of the involved child serving systems. The following standards are expected to lead to timely, comprehensive discharge planning. In collaboration with the interagency team, RTF providers are expected to:

- Include discharge planning as an integral aspect of the treatment planning process and document discussion of discharge criteria.
- Educate and communicate to the family and other service providers about the shared responsibilities involved in successfully planning for discharge (as evidenced in interagency or treatment team meeting notes and progress notes). Other involved systems are expected to remain actively involved with the child while receiving an RTF treatment episode of care.
- Identify and begin to address barriers to discharge at the onset of treatment. Maintain a child centered focus throughout the discharge planning process, challenging systems to overcome any barriers within their system that detracts from a child centered focus.
- Develop realistic goals for completion prior to discharge, in collaboration with the interagency team, and include the discharge criteria on the treatment plan or ISP. Residential treatment is not intended to “fix the child”, but rather is an intervention intended to stabilize the child and promote successful community reintegration.
- Incorporate child and family strengths and address needs in the discharge plan.
- Begin home visits early in the treatment process to assist with discharge planning. Utilize home visits as opportunities for treatment and preparation for discharge. Plan for home visits during weekdays as well as weekends to emphasize the therapeutic value of such visits. RTF staff may conduct a few family sessions in the family home prior to the discharge date to better prepare the child and family for discharge.
- Identify what interventions work for a child, and ensure that this information is integrated into the discharge plan. Educate the family/caregiver about what interventions have proven to be most helpful to the child.
- Prepare the family/caregiver as to what to expect during discharge transitions, e.g., honeymooning, anxiety, ambivalence, or testing of limits.
- In situations in which discharge is being considered because an RTF determines that it is unable to successfully address the needs of a resident, the RTF provider should convene an interagency team meeting to openly address this issue,

determine if individualized program modifications may enable the resident to continue in treatment, or openly discuss alternative treatment options.

## **DISCHARGE PLANNING IS EXPECTED TO INCLUDE ALL OF THE FOLLOWING COMPONENTS**

- Discharge planning meetings within 45 days of a projected date of discharge.
- Identification of a lead agency post discharge 45 days prior to discharge.
- Identification of legal guardianship and post discharge residential arrangements.
- Identification of triggers for relapse and a plan to prevent relapse.
- Identification of family supports. The RTF provider is expected to schedule appointments for all follow up services rather than just offering families referrals. The RTF provider is expected to ensure that follow up medication management arrangements are complete.
- Arrangements are complete for an appropriate educational placement.
- Initiation of follow up services 30 days prior to discharge when possible.

## **FOLLOW UP PRACTICES:**

All RTF providers are expected to:

- Send written discharge summaries to all involved systems within 15 days of discharge.
- Monitor the implementation of the discharge plan by following up with the child/family or caregiver by phone at approximately 15 days after discharge and one month after discharge.
- Contact the lead agency to address any concerns that the discharge plan is not being implemented as planned by the interagency team.
- Be available for consultation with the interagency team to share knowledge about what has been helpful to a child in the past, to assist the team in addressing any problems the child may be experiencing post discharge.

## **Comprehensive Provider Evaluation Process (CPEP)**

Community Care continues to develop the CPEP. This process offers a comparison of one network provider's performance singularly to 1) an aggregate of network providers, 2) a goal or standard determined over time and provided through committee meetings that identify trends, and 3) national standards when available. Community Care includes in this process, information from the following quality sources:

- Complaints
- Medical necessity denials/impartial reviews
- Grievances
- Administrative denials
- Incidents
- Member events
- Record reviews

- Treatment plan submissions
- Access notification
- Utilization information
- Clinical outcomes
- Satisfaction measures
- Initially, Community Care will look at claims data for the following four general outcome indicators:
  - Discharge planning: time to an outpatient follow up appointment for every child discharged from residential treatment.
  - Hospitalization utilization while receiving residential treatment.
  - Rate of hospital admissions within 24 hours and four, 14, and 30 days following discharge from an RTF.
  - Inpatient readmission data.

As Community Care continues to further develop the CPEP, providers expressed interest in obtaining comparative data about average lengths of stay and the impact of length of stay on outcomes. They are also interested in receiving data about the implementation of discharge plans and the effect of follow up interventions on enhancing implementation of discharge plans, and the relatedness to long term functional improvements in children.

## **OUTCOME MEASURES**

All RTF providers are expected to have an outcomes measurement plan that is directly related to the overall quality improvement plan for their facility. Providers will be expected to share the program outcomes measurement plan during regularly scheduled quality audits by the BH-MCO.

The outcomes measurement plan should:

- Evolve from asking questions such as “Who did we serve?” “What services were provided,” and “What were the results.” The plan should produce useful, actionable data that provides the necessary feedback loop to continually improve the overall quality of care.
- Collect data on standard issues over intervals of time (such as admissions, discharge, post discharge).
- Identify the specific outcome indicators to be measured, to include a combination of process indicators, e.g., costs, demographics, length of stay, number of hospitalizations, functional indicators, e.g., educational status, school attendance, restrictiveness of living environment, clinical indicators, e.g., symptom reduction, CAFAS and satisfaction measures.
- The following list of outcome indicators pertinent to residential treatment was identified. This is intended to be a sample of outcome indicators. Each facility is expected to design an outcomes measurement plan that serves their overall program goals and agency mission.

RTF providers are not expected to include every indicator listed in their outcomes measurement plan, but must include at a minimum at least one functional indicator, one clinical indicator, and one satisfaction measure:

- Post discharge level of care
- Inpatient recidivism
- Restrictiveness of educational placement
- Restrictiveness of living environment
- Stability of living environment
- Child serving systems involvement following discharge
- Community involvement following discharge
- Safety assessment post discharge and extent of engagement in at-risk behaviors
- Length of stay
- Number of parent contacts by RTF provider during treatment
- Regularity of job or school attendance post discharge
- AMA discharge rates
- AWOL rates

## **SATISFACTION MEASURES**

All RTF providers are expected to assess child and family satisfaction on a routine basis.

- Satisfaction is to be measured at admission (satisfaction with intake and admission process), during the stay (satisfaction with treatment, accessibility, communication, implementation of CASSP principles, facility, food, and staff interaction) and post discharge (supported through transition, adequate discharge planning, and implementation of the plan).
- Results of the satisfaction measures are to be incorporated into program continuous quality improvement efforts.

## **CULTURAL COMPETENCE AND SENSITIVITY**

All RTF providers are expected to support the development of cultural competence within their programs through:

- Ongoing staff training.
- Open, respectful communication the child and family/caregiver about culturally based values and belief systems that need to be considered when intervening with a child.
- Programming that recognizes the extent of cultural diversity among residents.
- Respecting the wishes of families in the celebration of holidays, special social activities, and gift giving.
- Providers are expected to maintain documentation of all initiatives to further develop the cultural competence and sensitivity of staff and interventions to improve the overall cultural competence of their programs.
- One means of assessing the cultural competence of a program is through member complaints.