

TRICARE/CHAMPUS STANDARDS FOR RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS (RTCs)

I. ORGANIZATION AND ADMINISTRATION

A. Definition

A Residential Treatment Center (RTC) is a facility or a distinct part of a facility that provides to beneficiaries under 21 years of age, a medically supervised, interdisciplinary program of mental health treatment. Qualified mental health professionals provide a program of individualized treatment that addresses the psychiatric needs of patients and their families. Skilled milieu services are provided by trained personnel who are supervised by qualified mental health professionals on a 24-hour-per-day, seven-day-per-week basis.

An RTC is appropriate for patients whose predominant symptom presentation is essentially stabilized, although not resolved, and who have persistent dysfunction in several major life areas. The extent and pervasiveness of the patient's problems requires a protected and highly structured therapeutic environment.

Residential treatment is differentiated from acute psychiatric care, which requires medical treatment and 24-hour availability of a full range of diagnostic and therapeutic services. Continuous physician involvement and direct daily contact with a psychiatrist are provided. Intensive nursing care renders constant monitoring and assessment of the patient's condition and response to treatment. The focus of treatment is to establish and implement an effective plan of care which will reverse life-threatening and/or severely incapacitating symptoms.

Residential treatment is differentiated from partial hospitalization, which provides a less than 24-hour-per-day, seven-day-per-week structured, interdisciplinary program of therapeutic services. Partial hospitalization programs serve patients who continue to exhibit psychiatric problems but can function with support in some of the major life areas. Medical participation is required to evaluate the extent of dysfunction and to determine the appropriate intensity and type of care required.

An RTC is differentiated from a group home, which is a professionally directed living arrangement with the availability of psychiatric consultation and treatment as needed. A group home serves a broad and varied patient population with significant family dysfunction and/or chronic but stable psychiatric disturbances.

An RTC is differentiated from a therapeutic school, which is an educational program supplemented by psychological and psychiatric services. Therapeutic schools serve a varied population of students who have significant difficulties in social and academic areas. These programs usually do not provide 24-hour-per-day, seven-day-per-week therapeutic

services to all students.

An RTC is differentiated from facilities that treat patients with a primary diagnosis of chemical abuse or dependence.

An RTC is differentiated from facilities providing care for patients with a primary diagnosis of mental retardation or developmental disability.

NOTE: An RTC provides medical care. Although an RTC may provide a less restrictive environment than an acute care hospital, it is nevertheless an institutional provider of medical care. The RTC must be both physically and programmatically distinct if it is a part or subunit of a hospital.

B. ELIGIBILITY

1. To be eligible for TRICARE/CHAMPUS certification, the facility is required to be licensed and fully operational for six months with a minimum average daily census of 30 percent of total bed capacity and to operate in compliance with state and federal regulations.

2. The facility is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the current edition of the *Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services*.

3. The facility has a written participation agreement with TMA. The RTC is not a TRICARE/CHAMPUS-authorized provider and TRICARE/CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director, TMA or a designee. Retroactive approval is not given.

4. Where different certification, accreditation, or licensing standards exist, the more exacting standard applies. Regulations take precedence over standards and standards take precedence over participation agreements.

C. GOVERNING BODY

1. A governing body is responsible for the policies, bylaws, and activities of the facility. If the RTC is owned by a partnership or single owner, the partners or single owner are regarded as the governing body. As required by the participation agreement, the facility shall notify the TMA of changes in the governing body or in ownership.

2. The governing body or chief executive officer provides written notification to TMA no later than 30 days prior to any significant changes in: chief executive officer; medical director, clinical director, purpose or philosophy, volume of services, licensure, certification, accreditation status, and location.

3. The governing body provides leadership and sufficient resources to ensure that appropriate and adequate services are delivered to all patients. To accomplish this, the governing body:

- a. Specifies the qualifications, authority, and responsibilities of its members;

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- b. Establishes bylaws, rules, regulations, policies, and procedures in accordance with legal requirements and TRICARE/CHAMPUS standards;
 - c. Conducts regular meetings and maintains minutes of all deliberations and actions;
 - d. Conducts business based upon its rules, regulations, and defined responsibilities;
 - e. Establishes a mission statement that provides the basis for strategic planning;
 - f. Adopts a plan of operation consistent with the mission statement with goals and objectives that reflect the long-range direction of the facility;
 - g. Appoints a chief executive officer (CEO) to implement policies and procedures and oversee the day-to-day operation of the facility;
 - h. Appoints a medical director to oversee all of the medical care provided;
 - i. Appoints a clinical director to oversee the clinical program;
 - j. Authorizes the establishment of a medical or professional staff organization to oversee and direct patient care services;
 - k. Establishes bylaws, rules, and regulations to govern the activities of the medical or professional staff organization;
 - l. Ensures that sufficient clinical staff are available to provide necessary and appropriate patient care services;
 - m. Ensures that sufficient administrative and support staff are available to maintain the administrative, health, and safety aspects of the facility;
 - n. Oversees the system of financial management and accountability;
 - o. Ensures that the physical, financial, and staffing resources of the facility are adequately insured;
 - p. Approves the initiation, expansion, or modification of programs, services, and resources; and
 - q. Evaluates the performance of the CEO, the clinical director and medical director on an annual basis, using specific performance criteria.
4. The governing body is responsible for the continuing development and improvement of patient care. To accomplish this, the governing body:

- a. Reviews, revises, and updates the plan of operation on at least an annual basis;
 - b. Approves all policy changes for the facility as documented in the minutes of the governing body meetings;
 - c. Appoints members to the medical or professional staff and grants clinical privileges on the basis of verified expertise and practice;
 - d. Reappoints medical or professional staff and renews clinical privileges on the basis of continued competence, adherence to staff rules and regulations, and quality of care reviews;
 - e. Approves a system to ensure that direct care staff are supervised by a qualified mental health professional;
 - f. Approves a system of quality assessment and improvement which evaluates the efficiency, appropriateness, and effectiveness of programs and services provided;
 - g. Approves admission criteria that clearly reflect the medical and/or psychological necessity for treatment at a residential level of care;
 - h. Reviews reports from various evaluation activities to determine that identified problems are appropriately addressed and that care is improved;
 - i. Ensures that the facility maintains continued compliance with state licensing regulations and national accreditation standards; and
 - j. Establishes an organizational structure to facilitate communication between the CEO, clinical director, medical director, administrative staff, medical or professional staff, and the governing body.
5. If a business relationship exists between a governing body member and the facility, a conflict-of-interest policy defines the member's authority, responsibility, and restrictions.
 6. Orientation and continuing education programs are provided to members of the governing body to enhance their awareness of the facility and its services.
 7. The governing body conducts an annual review of its documented performance in meeting its purposes, responsibilities, goals, and objectives.

D. CHIEF EXECUTIVE OFFICER

1. The chief executive officer (CEO) is appointed by the governing body and meets the following minimum qualifications:
 - a. Has a master's degree in business administration, public health, hospital administration, nursing, social work, or psychology; or

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- b. Meets similar educational requirements as prescribed by TMA; and
 - c. Has five years' administrative experience in the field of mental health.
 2. The CEO assumes overall administrative responsibility for the operation of the facility according to governing body policies.
 3. The CEO plans, develops, and implements programs and services, recruits and directs staff, and ensures the appropriate utilization of resources. The CEO:
 - a. Implements an organizational structure that facilitates communication, delineates responsibility, and specifies lines of clinical and administrative supervision;
 - b. Prepares a manual of policies and procedures which is reviewed annually and revised as necessary;
 - c. Develops a strategic plan that specifies the facility's long- and short-term goals and objectives. The plan is evaluated annually and the results reported to the governing body;
 - d. Ensures the development of an effective evaluation program to analyze and report patterns and trends in clinical performance and service delivery; and
 - e. Prepares detailed reports for the governing body regarding the facility's operations including pertinent findings related to the quality of care.
 4. The CEO, along with the clinical director and the medical director, establishes a plan of operation that is approved by the governing body, reviewed annually, and revised as necessary. The plan provides an overview of service delivery and differentiates between child and adolescent programs. The plan describes the:
 - a. Theoretical orientation of the RTC;
 - b. Clinical characteristics of the population served;
 - c. Admission, continued-stay, and discharge criteria;
 - d. Process for determining the eligibility and medical necessity for admission;
 - e. Interdisciplinary treatment planning, review, and revision processes;
 - f. Specific services provided;
 - g. Therapeutic modalities offered;
 - h. Outside resources providing services that are not available within the facility;
 - i. Qualifications of staff for each service and therapeutic modality;

- j. Responsibilities of each professional discipline and their relationships with each other;
- k. Supervision provided to staff who are not eligible to practice independently;
- l. Methods to involve family members; and
- m. Processes for transition, discharge, and follow-up care.

E. MEDICAL DIRECTOR

1. The medical director is appointed by the governing body and meets the following qualifications:

- a. Is a graduate of an accredited school of medicine or osteopathy who is licensed to practice medicine in the state where the facility is located; and
- b. Has completed an approved residency in psychiatry and has a minimum of five years' clinical experience in the treatment of children and adolescents.

2. The medical director is responsible for:

- a. Overseeing all medical care provided;
- b. Planning, development, and implementation of all activities related to medical treatment of patients;
- c. Serving as a liaison to the medical or professional staff to ensure that matters of medical importance are conveyed to the CEO and the governing body;
- d. Developing, in conjunction with the clinical director, medical and professional staff, the behavior management plan;
- e. Submitting regular reports to the governing body about medical affairs, including unusual occurrences;
- f. In conjunction with the clinical director, develops and implements a peer review system, that monitors professional practice; and
- g. Developing, in consultation with the clinical director, medical and professional staff, an effective quality assessment and improvement program.

F. CLINICAL DIRECTOR

1. If qualified, the medical director may also serve as clinical director. The clinical director is appointed by the governing body and meets the following qualifications:

a. Is a psychiatrist or doctoral level clinical psychologist who meets applicable TRICARE/CHAMPUS requirements for individual professional providers and is licensed to practice in the state where the residential treatment center is located; and

b. Possesses requisite experience and credentials applicable under state practice licensing laws appropriate to the professional discipline; and

c. Has a minimum of five years' clinical experience in the treatment of children and adolescents.

2. When the medical director and clinical director are separate positions, the governing body shall establish their individual responsibilities.

3. The clinical director is responsible for:

a. Overseeing the clinical program;

b. Participating in the planning, development, and implementation of the clinical programs and services;

c. Developing, in conjunction with the medical director, medical and professional staff, the behavior management plan;

d. Developing and implementing a peer review system, in conjunction with the medical director, that monitors professional practice; and

e. Developing, in consultation with the medical director, and the medical and professional staff, an effective quality assessment and improvement program.

f. May submit regular reports to the governing body about clinical affairs, including unusual occurrences;

g. May serve as a liaison to the medical or professional staff to ensure that matters of clinical importance are conveyed to the CEO and the governing body;

G. MEDICAL OR PROFESSIONAL STAFF ORGANIZATION

1. The medical or professional staff organization is established by the governing body. The organized staff is accountable for patient care and is responsible for:

a. Making recommendations to the governing body concerning appointments and reappointments to the medical or professional staff;

b. Determining the specific clinical privileges that may be granted and the training and experience required for each;

c. Defining clinical privileges based upon the services provided and the ages, disabilities, and clinical needs of the patients served; e.g., specialty groups for trauma victims;

- d. Maintaining rules and regulations that support the goals and objectives of the RTC;
- e. Ensuring the ethical conduct of individual staff members;
- f. Establishing position requirements and verifying the qualifications of all staff providing direct patient care;
- g. Implementing a system to evaluate the performance and current competence of its members; and
- h. Overseeing the patient care responsibilities of staff who are not members of the medical or professional staff.

H. PERSONNEL POLICIES AND RECORDS

1. The facility maintains written personnel policies, updated job descriptions, and comprehensive personnel records.
2. Job descriptions for full-time, part-time and contracted employees are criteria-based and contain:
 - a. Position title, required education and training, prior work experience, and other qualifications;
 - b. Lines of supervision, responsibility, authority, and communication;
 - c. Duties and responsibilities corresponding to education, training, and experience; and
 - d. Annual performance appraisals with objective evaluation criteria, ratings, and comments.
3. Individual personnel records contain:
 - a. Application for employment;
 - b. Verification of the qualifications for the position;
 - c. Criteria-based job description;
 - d. Pre-employment reference checks;
 - e. Signed acknowledgment that the employee understands policies on patient abuse and neglect and confidentiality;
 - f. Pre-employment health examinations to ensure that all employees are able, physically and mentally, to perform their duties;

- g. Annual performance appraisals;
- h. Documented attendance at educational and training programs, including orientation and in-service courses;
- i. Any complaints, allegations, inquiries or findings of patient abuse or neglect; and
- j. Warnings or disciplinary actions.

I. STAFF DEVELOPMENT

1. The facility provides appropriate training and development programs for administrative, professional, support, and direct care staff.
 - a. Orientation and training programs are relevant to the care and treatment of children and adolescents. The programs are specific to the skills, responsibilities, and duties of the staff.
 - b. Instruction in life safety, disaster planning, and fire safety including the proper use of fire extinguishers, is provided at orientation and annually thereafter.
 - c. Instruction in cardiopulmonary resuscitation is required to maintain current certification.
 - d. All direct care staff receive relevant in-service education in emergency first aid, human growth and development, behavioral management, clinical observation, and clinical record documentation.
 - e. Staff training and development activities are provided by individuals who are qualified by education, training, and experience.
 - f. Staff training and development programs are influenced by the results of evaluation activities and are documented on a regular basis.

J. FISCAL ACCOUNTABILITY

1. The facility maintains complete and accurate financial records of income and disbursements which are open to inspection upon reasonable notice by the United States government or its authorized agents. The facility:
 - a. Has a schedule of public rates and charges for all services provided, and makes this available to all referral sources and families.
 - b. Has an independent audit performed at least annually.
 - c. Maintains insurance coverage on all buildings, equipment, physical resources, and vehicles. Adequate comprehensive liability insurance protects patients, staff, and visitors.

K. DESIGNATED TEACHING FACILITIES

1. Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university or medical school.

2. The teaching program is approved by the Director, TMA or a designee. To be an approved teaching program the facility has:

a. A written contract or letter of agreement between the accredited university and the governing body. The contract or letter of agreement designates:

(1) The qualified mental health professional providing supervision;

(2) The nature and extent of supervision required; and

(3) The supervisor's medical and legal responsibilities for all clinical care provided by the student, resident, intern, or fellow.

b. A description of the training program within the plan of operation, specifying the assignments, supervision, and documentation required;

c. A medical or professional staff organization to recommend the privileges granted, under supervision, to students, interns, residents, or fellows; and

d. A medical director or clinical director, as appropriate, to oversee the training program and provide regular reports to the governing body.

L. EMERGENCY REPORTS AND RECORDS

1. The facility notifies TMA of any serious occurrence involving any TRICARE/CHAMPUS beneficiary.

a. Reportable occurrences include a life-threatening accident, a patient death, a patient disappearance, a suicide attempt, cruel or abusive treatment, physical or sexual abuse, or any equally dangerous situation.

b. The occurrence is reported by telephone to the Director, TMA or a designee, on the next business day; a full written account is sent within seven days.

c. The occurrence and contact with TMA are documented in the patient's clinical record.

d. Notification is provided to the next of kin or legal guardian and, if required by state or commonwealth law, the appropriate legal authorities.

2. When a TRICARE/CHAMPUS beneficiary is absent without leave and is not located within 24 hours, the incident is reported by telephone to TMA on the next business

day. If the patient is not located within three days, a written report of the incident is made to TMA.

3. Any disaster or emergency situation, natural or man made, such as fire or severe weather, is reported by telephone within 72 hours, followed by a written report within seven days, to TMA.

4. All of the facility financial and clinical records are available for review by TMA during announced or unannounced on-site reviews and inspections. The on-site review includes an examination of any clinical records, regardless of the source of payment.

II. TREATMENT SERVICES

A. Staff Composition

1. A written plan describes the composition and number of staff required to meet the medical and clinical needs of patients.

a. Staffing patterns are based upon the characteristics and special needs of the population served, the patient census, and the type(s) and intensity of services required.

b. Sufficient full-time professional staff provide clinical assessments, active therapeutic interventions, and ongoing program evaluation.

c. Clinicians providing individual, group, and family therapy meet TRICARE/CHAMPUS requirements for professional providers of care, and operate within the scope of their license.

d. To meet the identified medical and clinical needs of patients, on-site professional staff coverage is provided 24 hours a day, seven days per week.

(1) Physicians are available 24 hours a day, seven days per week to respond to medical and psychiatric problems.

(2) A registered nurse (RN) is on duty every shift to plan, assign, supervise, and evaluate nursing care.

(3) RNs and other treatment staff are assigned depending upon the number, location, and acuity level of the patients.

(4) Medical and professional consultation and supervision are readily available during service hours.

(5) Liaison relationships are maintained with other psychiatric and human service providers for emergency services.

e. The authority for medical management of care is vested in a physician. A psychiatrist is actively involved in developing and implementing individualized treatment.

(1) A physician member of the active duty military medical corps or the United States Public Health Service does not meet this requirement.

(2) A resident or intern does not meet this requirement.

f. The authority for planning, developing, implementing, and monitoring of all clinical activities is vested in a psychiatrist or doctoral level psychologist.

g. Professionals who perform assessments and/or treat children and adolescents understand human growth and development and can identify age-related treatment needs.

h. The qualifications, training, and experience necessary to assume specific clinical responsibilities are specified in writing and verified prior to employment.

B. STAFF QUALIFICATIONS

1. Within the scope of its programs and services, the facility has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided. Qualified mental health providers meet state licensure, registration, or certification requirements in their respective disciplines.

a. RTC staff meet the following educational and experience requirements:

(1) a physician, other than a psychiatrist, has a medical or osteopathic degree from an accredited university, and is licensed by the state in which he/she is practicing;

(2) a psychiatrist has a medical or osteopathic degree from an accredited university, is licensed by the state, and has completed an approved psychiatric residency;

(3) a psychologist has a doctoral degree from an accredited university, and has two years of clinically supervised experience in psychological health services, with one year postdoctoral and one year in an organized psychological services program;

(4) a certified psychiatric nurse specialist has a master's degree from an accredited school of nursing with a specialty in psychiatric or mental health nursing, or addiction treatment. The nurse has two years of post-master's degree practice in the field of psychiatric or mental health nursing;

(5) a social worker has a master's degree in social work from a graduate school accredited by the Council on Social Work Education, and has two years of post-master's degree, supervised clinical social work practice;

(6) a staff nurse has a minimum of a diploma or an associate degree in nursing, and is licensed by the state in which he/she is practicing;

(7) a professional counselor, marriage and family counselor, or pastoral counselor has a master's degree in mental health or behavioral sciences from an accredited

university, has two years of supervised, post-master's degree practice;

(8) an occupational therapist, recreational therapist, or expressive art therapist has at least a bachelor's degree from an accredited college or university, is nationally registered or certified, and is licensed or certified in his/her respective field when this is offered or required by the state where the facility is located;

(9) a teacher has a bachelor's degree from an accredited university and is certified as a teacher in the respective state;

(10) an addiction therapist has a master's degree in mental health or behavioral sciences from an accredited university, and three years of experience in alcohol/drug abuse counseling;

(11) an addiction counselor has a bachelor's degree from an accredited university, five years of experience in alcohol and/or drug abuse counseling, and is supervised at least weekly by a qualified member of the professional staff; and

(12) direct service staff, e.g., patient care assistants, have at least a high school diploma or equivalent. These staff offer support and assistance to patients but do not provide therapy, e.g., individual, family, couples, or group. They receive documented supervision from qualified health care professionals.

2. RTCs that employ master's or doctoral level staff who are not qualified mental health providers have a supervision program to oversee and monitor their provision of clinical care.

a. All care provided is the responsibility of a licensed or certified mental health professional, as previously defined in this section.

b. To provide services, nonlicensed clinicians:

(1) Have a master's or doctoral degree in a mental health discipline;

(2) Practice under a licensed or certified mental health professional for up to two years during which time the nonlicensed clinician is actively working toward licensure or certification; and

(3) Meet the credential requirements of the facility to provide clinical services;

c. Supervision provided to nonlicensed clinicians is specified in writing and meets the following requirements:

(1) The supervisor is employed by the facility and provides clinical supervision only in privileged areas;

(2) The supervisor meets at least weekly on an individual basis with the supervisee and provides additional on-site supervision as needed;

- (3) Supervisory sessions are regularly documented by the clinical supervisor;
- (4) Clinical documentation meets clinical records and quality assessment and improvement standards; and
- (5) All clinical entries by the supervisee are reviewed and countersigned by the supervisor.

C. PATIENT RIGHTS

- 1. The facility protects all individual patient rights, including civil rights, under applicable federal and state laws.
 - a. Policies and procedures clearly describe the rights of the patients and the facility's methods to guarantee these rights.
 - b. Patients and families are informed of their rights in language that is easily understood.
 - c. All patients are treated with dignity and respect, and are afforded full protection of their basic personal and privacy rights.
 - (1) The right to privacy is based on individual developmental and clinical requirements.
 - (2) Patients may contact an attorney.
 - (3) Patients may send and receive mail without hindrance unless clinically contraindicated and restricted by the responsible physician's or clinical psychologist's order.
 - (4) Patients may have private telephone contact with members of their immediate family or guardian unless clinically contraindicated and restricted by the responsible physician's or clinical psychologist's order.
 - (5) Patients may have private visits with their family or guardian unless clinically contraindicated and restricted by the responsible physician's or clinical psychologist's order.
 - (6) All orders to restrict patient rights are supported by a written justification of clinical need and are reviewed every seven days.
 - (7) Mail, telephone calls, and family visits are not restricted by treatment philosophy, level, phase, or milieu program design.
 - (8) Patients are not required to dress in distinctive clothing for behavioral control purposes or as a consequence for misconduct.
 - (9) Except at admission, body searches for the detection of contraband

require a written physician's order. The order and the justification are documented in the clinical record.

(10) The facility provides opportunities for patients to attend religious services and to seek religious counsel unless clinically contraindicated.

d. The facility maintains a safe environment; patients are protected from physical or emotional harm by other patients, staff, and visitors.

e. The facility protects the right of confidentiality for all patients, their families, and significant others. Personal pictures, videotapes, or audio recordings are not obtained without written permission.

f. Informed consent is obtained from the patient, family, or legal guardian authorizing emergency medical care, including surgical procedures.

g. Parents or guardians are informed of the patient's treatment progress at regular intervals, and at least monthly.

h. The patient, family, or legal guardian have the right to present complaints or grievances about the facility or the care received. The facility has procedures for responding to these complaints.

i. The patient and family are provided with written descriptions of the principles, methods, and interventions used in behavior management. If a level or phase system is implemented:

(1) Level achievement is not considered to be an objective of the interdisciplinary treatment plan;

(2) Level achievement or lack thereof does not affect the provision of therapeutic services, including passes when clinically indicated;

(3) Level achievement or lack thereof does not negate a timely discharge once the therapeutic goals and objectives have been attained; and

(4) The level or phase system is not used to compromise the basic rights of the patient.

j. When food services are provided, patients receive adequate and nutritious meals with accommodations for special diets, and are not denied food as a method of behavior management.

k. The patient and family receive education regarding all medications prescribed, including benefits, side effects, and risks.

l. Patients have the right to refuse treatment and medications. If a patient or family refuses treatment, the facility:

(1) Makes documented, reasonable efforts to understand the issues involved and resolve the conflict. If the issue cannot be resolved, the facility:

(a) Terminates treatment on reasonable notification of patient, family, or legal guardian; or

(b) Seeks legal alternatives to ensure that the patient's safety and treatment needs are met.

m. Any research involving TRICARE/CHAMPUS beneficiaries has prior approval from TMA and complies with the regulations protecting human subjects of the Department of Health and Human Services (45 CFR 46).

2. The facility has a written policy regarding patient abuse and neglect.

a. All facility staff, patients, and families as appropriate, are informed of the policy.

b. All incidents of suspected abuse and neglect are reported promptly to the appropriate state agencies.

3. Facility marketing and advertising meets professional standards.

D. BEHAVIOR MANAGEMENT

1. Behavior management is based on a comprehensive, written plan that describes a full range of interventions using positive reinforcement methods and clear implementation guidelines.

2. Policies and procedures for behavior management are developed by the medical director or clinical director and medical/professional staff and approved by the governing body. They are implemented on the basis of the following considerations:

a. Behavior management is individualized to ensure appropriate consideration of the patient's developmental level, psychological state, cognitive capacity, and other clinically relevant factors.

b. Time-out is a brief, voluntary separation from program, activities, or other patients, and is initiated by the patient or at the request of staff to help the patient regain self-control.

c. Physical holding is a brief, involuntary procedure that is initiated by trained staff to help the patient regain self-control.

d. Restraint is the use of physical holds or mechanical devices which inhibit the voluntary movement of the whole or a portion of the patient's body.

e. Seclusion is the restriction or confinement of a patient to a room or other area until released with a staff member's approval or assistance.

f. If any part of a facility is locked to ensure patient safety, the rationale is based on clinical or medical needs and the security measures are consistent with the treatment philosophy, mission statement, and admission criteria.

3. Restraint and seclusion are considered extraordinary interventions to be used only by professional staff in an emergency, after less restrictive methods have been attempted unsuccessfully.

a. A psychiatrist conducts an assessment of the patient providing the rationale and clinical justification for the intervention.

b. The psychiatrist evaluates the appropriateness of the patient's continued treatment at the residential level of care.

c. The assessment and justification for the use of restraint or seclusion are documented in the clinical record for each episode and include the consideration of less restrictive interventions.

d. Each written order for restraint or seclusion is time limited, and does not exceed four hours. PRN orders are not used.

e. Restraint or seclusion is not used as a punishment, or for staff convenience.

f. All restraint or seclusion incidents are reported daily to the medical director or physician designee.

4. Only trained and clinically privileged RNs or qualified mental health professionals may implement seclusion and restraint procedures in an emergency situation.

a. The psychiatrist is provided with a clear assessment of the patient's current condition.

b. The psychiatrist writes or gives a telephone order within 30 minutes of implementation.

(1) The psychiatrist's written order and clinical assessment are entered into the clinical record within 24 hours of the telephone order.

(2) Seclusion or restraint procedures exceeding eight hours require continued authorization by the medical director or physician designee.

(3) If seclusion or restraint procedures exceed 24 hours, the patient is assessed by the medical director to determine the appropriateness of treatment at the residential level of care.

(4) An RN or qualified mental health professional may release a patient from seclusion or restraint prior to the time specified. The assessment and rationale for ending the procedure is documented in the clinical record.

c. Appropriate attention is given to patients in seclusion or restraint.

Observations occur at least every 15 minutes and care is regularly documented in the clinical record.

(1) Observations by an RN or a qualified mental health professional occur every hour with documentation of the appropriateness of continuing or discontinuing use.

(2) Documented care includes, at a minimum, rest room breaks every two hours, fluids every hour, and regularly scheduled meals and snacks.

(3) For mechanically restrained patients, range of motion and circulation checks are done every hour, and vital sign monitoring occurs every two hours.

5. The facility maintains an aggregate log on the use of special treatment procedures including the patient's name, date of the occurrence, type of intervention used, and the duration of the intervention.

6. On a daily basis, the medical director or clinical director reviews all incidents involving time-outs, physical holds, restraints, and seclusions, and investigates unusual or unwarranted patterns of use.

E. ADMISSION PROCESS

1. The admission process helps the patient to fully use the medical, clinical, and program services of the RTC. The patient, family and significant others as appropriate, are familiarized with the treatment program and how the facility addresses patient capabilities and medical/clinical needs.

a. Preadmission information is obtained to evaluate the medical and/or psychological necessity for admission. Recent psychiatric, psychological, and psychosocial evaluations are reviewed.

b. Written admission criteria describe the extent and complexity of the disorders appropriate for residential treatment.

c. A qualified mental health professional, who meets TRICARE/CHAMPUS requirements for individual professional providers and who is permitted by law and by the facility to refer patients for admission, shall render medical and/or psychological necessity determinations for admission.

d. The facility accepts only those patients who meet the conditions outlined in the admission criteria, and for whom the RTC has an operational program.

e. The facility observes and maintains compliance with the conditions of licensure under which it operates, including age, sex, type, and number of patients accepted.

f. No one is denied admission on the basis of race, religion, national origin, or sexual orientation.

g. Patients and families who are not accepted for treatment are provided with alternative recommendations and referrals as needed.

(1) Referral policies and procedures include statements about the special needs and services the facility cannot provide.

(2) Referrals for examination, assessment, and consultation are discussed with the patient and family prior to admission.

h. During the admission process, the patient and family are clearly apprised of the expectations for treatment and the services provided.

(1) Written and signed documentation verifies that patients and family members understand the clinical care that will be provided.

(2) The policies and procedures for emergency medical or psychiatric care are explained, including transfer or referral and the means of transfer, e.g., family, facility staff, or ambulance service.

i. All admissions are planned and approved by a qualified mental health professional, who meets TRICARE/CHAMPUS requirements as an individual professional providers and is permitted by law and by the facility to refer patients for admission.

j. All admissions are preauthorized by TMA.

F. ASSESSMENTS

1. Professional staff are responsible for current assessments of all patients. Consideration is given to the fundamental clinical needs of patients including, but not limited to their physical, psychological, social, spiritual, developmental, family, educational, environmental, and recreational needs.

2. All required clinical assessments are completed prior to the development of the master treatment plan. Assessments conducted within 30 days prior to admission may be used if reviewed and approved for treatment planning by the responsible psychiatrist.

a. A physical examination is completed on all patients by a qualified physician, qualified physician assistant, or nurse practitioner within 24 hours of admission. When the physical examination is completed by a physician assistant or nurse practitioner, a physician must countersign. The physical examination includes: a complete medical history; a general physical examination; sensorimotor development and functioning; physical development; vision and hearing; immunization status; serology, urinalysis, and other routine laboratory studies as indicated; and a tuberculin test with results or a chest X-ray to rule out tuberculosis. A physical examination is conducted every 12 months, or sooner if indicated.

b. A mental health assessment is completed on all patients by a qualified psychiatrist or doctoral level psychologist within 24 hours of admission. The psychiatric evaluation includes: the reason for admission; current clinical presentation; psychosocial

stressors related to the present illness; current potential risk to self or others; history of present illness; past psychiatric history; developmental assessment; presence or absence of physical disorders or conditions affecting the presenting illness; alcohol and drug history; and mental status examination. A diagnosis on all five axes is given, based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. A repeat psychiatric evaluation is conducted every six months, or sooner if indicated.

c. A nursing assessment is completed on all patients by a registered nurse within 24 hours of admission. The nursing assessment documents a general history of the patient's and family's health and includes a history of current medications, allergies, pertinent medical problems requiring nursing attention, current risk and safety factors, nutritional patterns, immunization status, and sleep patterns.

d. A social history is completed on all patients by a qualified mental health professional. The social history includes: presenting problems; developmental history; history of significant losses; physical or sexual abuse; family substance abuse; family constellation; parents' military service history; family dynamics and relationships; peer group influences; physical description of current and past home environment; impact of any medical conditions upon the patient; and the impact of financial, religious, ethnic, and cultural influences upon the patient or family. Goals and recommendations for family involvement in treatment are also indicated. A social history completed within the past 12 months may be included in the patient's clinical record if reviewed and approved by the responsible psychiatrist or qualified mental health professional.

e. A psychological evaluation is completed by a doctoral level licensed clinical psychologist. The psychological evaluation includes a comprehensive clinical assessment and recommendations for the multidisciplinary treatment plan. Testing may include: intellectual, cognitive, and perceptual functioning; stressors and coping mechanisms; neuropsychological functioning; and personality assessment. Psychological testing completed within the past 12 months may be included in the patient's clinical record if reviewed and approved by the responsible physician or clinical psychologist. The psychological evaluation is repeated every 12 months, or sooner if indicated.

f. A skills assessment is completed on all patients by a licensed or certified activity, occupational, or rehabilitation therapist. The assessment includes activity patterns prior to admission, aptitudes and/or limitations, activities of daily living, perceptual-motor skills, sensory integration factors, cognitive skills, communication skills, social interaction skills, creative abilities, vocational skills, and the impact of physical limitations. The skills assessment is repeated every 12 months, or sooner if indicated.

g. An educational assessment is completed on all patients by a certified teacher. The educational assessment includes an evaluation of the patient's educational history, current classroom observations, achievement testing, and identification of learning disabilities and needs. An educational assessment completed within the past 12 months may be included in the patient's clinical record if reviewed and approved by the facility's director of education.

h. Additional assessments may include, as appropriate, speech, hearing and language evaluations, neuropsychological evaluations, neurological evaluations, vocational assessments, nutritional assessments, legal assessments, and other assessments that are clinically indicated.

G. CLINICAL FORMULATION

1. A clinical formulation is developed on all patients by a qualified mental health provider. The clinical formulation is reviewed and approved by the responsible physician or doctoral level licensed clinical psychologist. The clinical formulation is generally organized into a Descriptive Section including the nature, severity, and precipitant of the individual's mental health disorder; an Explanatory Section including the rationale for the development and maintenance of the symptoms and dysfunctional life patterns; and the Treatment-Prognostic Section serving as the explicit blueprint governing treatment interventions and prognosis. The clinical formulation:

- a. is completed prior to the development of the master treatment plan;
- b. incorporates significant clinical interpretations from each of the multidisciplinary assessments;
- c. identifies patient strengths and limitations, current psychosocial stressors, present level of functioning, developmental issues to be considered, degree of risk to self or others, and significant treatment issues;
- d. interrelates the assessment material and indicates the focus of treatment strategies;
- e. clearly describes the clinical problems to be addressed in treatment, including plans for discharge; and
- f. substantiates Axes I through V diagnoses, using the current *Diagnostic Statistical Manual of Mental Disorders* of the American Psychiatric Association.

H. TREATMENT PLANNING

1. A qualified mental health professional shall be responsible for the development, implementation, supervision, and assessment of an individualized, interdisciplinary treatment plan.

- a. A preliminary treatment plan is completed within 24 hours of admission and consists, at a minimum, of a physician's admission note and orders.
- b. A comprehensive treatment plan is completed within 10 days of admission to the RTC. The comprehensive treatment plan:
 - (1) Clearly articulates the clinical problems that are the focus of treatment;
 - (2) Identifies individual treatment goals that correspond to each identified

problem;

(a) Goals are specific outcome statements based on the anticipated response to treatment.

(b) Treatment goals and clinical needs are discussed with the patient and family.

(3) Identifies individualized and observable or measurable objectives that represent incremental progress toward attaining goals;

(4) Describes strategies of treatment, responsible clinicians, and interventions that address individual needs and assist the patient in achieving identified objectives and goals;

(5) Includes specific, individualized discharge criteria, which identify essential goals and objectives to be met prior to termination of treatment;

(6) Identifies needed services that are not provided directly by the facility; and

(7) Specifies goals, objectives, and treatment strategies for the family. If geographically distant family therapy is indicated:

(a) A therapist is identified to provide family therapy on behalf of the facility.

(b) A designated staff member serves as a liaison with the therapist to ensure treatment coordination.

(c) The therapist provides the facility with a monthly report regarding patient/family progress in treatment.

c. The treatment plan is reviewed for effectiveness and revised at least every 30 days, or when major changes occur in treatment. Objectives and strategies are modified to reflect the patient's response or lack of response to the individualized treatment program. The results are recorded in the clinical record.

I. DISCHARGE AND TRANSITION PLANNING

1. Discharge and transition planning is based upon the anticipated needs of the patient at the time of discharge. The planning involves: determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources to maintain therapeutic stability following discharge.

a. During the treatment planning process, the patient's living situation, ongoing treatment needs, and educational and/or vocational needs are assessed.

b. The treatment plan is modified to anticipate termination, address the temporary regression of the patient, and facilitate re-entry into the home environment or a less intensive level of care.

c. Community and therapeutic resources are identified to help the patient and family to maintain previous therapeutic gains.

d. If the patient is not returning home, the RTC is responsible for facilitating alternative discharge plans.

J. CLINICAL DOCUMENTATION

1. Clinical records are maintained on each patient to plan care and treatment and to provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following:

a. Demographic data, including the patient's name, date of birth, sex, next of kin, occupation of parents or guardian, school and grade, date of initial contact, legal status, legal documents, religion, current home address, telephone number of the family, source of referral, and reason for referral;

b. Other information, including consent forms and pertinent legal documents; reports of all assessments and clinical formulation; treatment plans and treatment plan reassessments; consultation and laboratory reports; physician orders; progress notes; and a discharge summary.

K. PROGRESS NOTES

1. Progress notes clearly document the course of treatment for the patient and family. The entries provide information for review, analysis, and modification of the treatment plan. Progress notes include:

a. a description of the interventions made by the provider in accordance with the treatment plan and the patient's response in measureable, observable and/or quantifiable behavioral terms;

b. interpretations of the responses to treatment;

c. justification, implementation, and interpretation of the effectiveness of interventions for behavior management;

d. justification for changes in medication, and a description of any side effects and adverse reactions; and

e. date and length of the therapy session.

2. All clinical entries are legible, contemporaneous, sequential, signed, and dated. At a minimum, the following are required:

- a. A weekly note by a registered nurse evaluating the patient's progress in treatment;
- b. A weekly note by the responsible psychiatrist or doctoral level clinical psychologist and a monthly evaluation of the patient's response to all treatment provided;
- c. The interdisciplinary treatment plan and monthly treatment plan reviews;
- d. Progress notes on individual therapy within 24 hours of each session including the name of the clinician providing the therapy, when it was provided, and the duration of the session;
- e. Weekly progress notes on group and therapeutic activity services;
- f. Progress notes on family therapy including the name of the person providing the therapy, when it was provided, and the duration of the session after each contact; and
- g. A discharge summary including a plan for continuing care is entered in the record within 15 days following discharge.

L. THERAPEUTIC SERVICES

1. A range of therapeutic services are provided to address the assessed clinical needs of patients. These include, at a minimum: psychotherapy; educational services; therapeutic activities; and physical health, dietary, emergency, pharmacy, and other services as clinically indicated. Cognitive, behavioral, and other therapies are administered on an individual and group basis. A seven-day-a-week program integrates milieu activities and clinical services. Services that are clinically contraindicated are documented in the clinical record.

2. *Psychotherapy Services* Individual, group, and family psychotherapy are provided to all patients. The type of psychotherapy and its primary purpose is included in each patient's treatment plan.

a. Individual psychotherapy is provided by a privileged qualified mental health provider, practicing within the scope of his/her license or by a practitioner under the supervision of a licensed mental health provider, as discussed in [Section II.B.](#) and is offered as indicated in the treatment plan.

b. Group psychotherapy is provided by a privileged qualified mental health provider, practicing within the scope of his/her license or by a practitioner under the supervision of a licensed mental health provider, as discussed in [Section II.B.](#) and is offered as indicated in the treatment plan.

c. Family psychotherapy is provided by a privileged qualified mental health provider, practicing within the scope of his/her license or by a practitioner under the supervision of a licensed mental health provider as discussed in [Section II.B.](#) and is offered as indicated in the treatment plan.

(1) If geographically distant family therapy is required, the facility makes arrangements to engage a qualified therapist who provides the psychotherapy.

(2) Telephone contacts with the family or guardian do not meet the compliance requirement of this standard.

3. *Therapeutic Activities* A range of therapeutic activities are offered to help the patient meet the goals of the treatment plan.

a. The activities program is directed and staffed by a licensed, registered, or certified activity therapist.

b. The facility provides the staff and resources necessary to support the program.

(1) A structured skills program is provided for all patients.

(2) A leisure and social program is provided. Patients participate in the planning and scheduling of daytime, evening, and weekend activities.

(3) If indicated by the skills assessment, the patient receives a vocational assessment and the necessary vocational training.

(4) If the facility has an organized vocational training program, the program is state certified and staffed by qualified vocational teachers.

4. *Therapeutic Educational Services* Therapeutic educational services appropriate to the patient's educational and therapeutic needs are provided or arranged.

a. If the facility provides educational services, the necessary resources and equipment are available to meet the educational needs of children and adolescents.

b. Each patient receives a complete educational assessment. The results of the assessment are incorporated into the clinical formulation and the interdisciplinary treatment plan.

c. The therapeutic educational services are integrated into the individual treatment plan, coordinated with the milieu program, and documented in the clinical record.

d. Educational services are provided by qualified teachers. Teachers have a bachelor's degree from an accredited university and are certified by the state in which the facility is located.

(1) If the teachers are not certified in special education, the facility retains a special education teacher to provide consultation and supervision.

(2) If the therapeutic school program is not accredited by a state agency, the facility makes this information clear in its policies, brochures, and information given to all applicants.

(3) If the facility has a school program accredited or approved by a state agency, documentation of this accreditation or approval is made available to TMA for review.

e. Local schools may be used by patients for the transitional phase of treatment. This transition is individualized, coordinated with the school, and progress is documented.

M. ANCILLARY SERVICES

1. *Emergency Services* Policies and procedures for emergency services define the facilities to be used and the qualified and responsible staff who assess the situation and arrange transfers, as indicated.

a. A written agreement is maintained with each facility providing emergency services.

b. Appropriate information is exchanged between the referring and receiving facilities.

c. In accordance with written policy and legal requirements, parents, legal guardians, or significant others are notified in an emergency.

2. *Physical Health Services* Physical health services are available 24 hours per day, seven days per week, either directly or through contractual arrangement. The physical health services necessary for patient evaluation and treatment are provided.

a. Physical health services include, but are not limited to: complete medical history and physical examinations; pathology and laboratory services; vision, hearing, and dental services; and radiology services.

b. Contractual agreements include a description of the services provided and the reporting requirements.

3. *Pharmacy Services* The facility provides, or contracts for, all pharmacy services. Written policies and procedures govern the safe storage and administration of drugs and meet applicable federal, state, and local laws and regulations.

a. A registered pharmacist is responsible for:

(1) Developing written policies and procedures that govern safe storage, preparation, distribution, and administration of drugs in accordance with applicable laws and regulations;

(2) Dispensing drugs and chemicals;

(3) Developing a formulary in conjunction with the medical staff;

(4) Recording monthly inspections of all drug storage units, including emergency boxes, emergency carts, and stock medications; and

(5) Approving a medication administration program and participating in staff development activities.

b. The emergency box is stocked with drugs as indicated by the attending physician's list. The pharmacist checks the emergency box monthly and after each use.

c. All medications administered are documented.

(1) Only authorized physicians write medication orders.

(2) The prescribing physician signs telephone orders within 72 hours.

(3) Medications are administered by authorized physicians, registered nurses, or licensed practical nurses under the supervision of a physician or registered nurse.

(4) If self-administration of medication is ordered, the patient is supervised by a qualified staff member.

d. Medications prescribed in a manner not approved by the Food and Drug Administration require approval by the medical director, and are justified in the clinical record.

e. A qualified physician, nurse, or pharmacist informs the patient and family or legal guardian as appropriate, of the benefits, side effects, and risks associated with prescribed medications.

4. *Dietary Services* Dietary services are under the supervision of a registered dietician. The dietician develops a diet manual and approves menus that are nutritionally and calorically adequate, taking into consideration patients' special needs.

a. Dietary personnel comply with federal, state, and local laws concerning food preparation and handling.

b. The dietary services meet all applicable local, state, and federal regulations concerning the handling, preparation, and distribution of food.

(1) Supplies are clearly labeled and nonfood supplies, including cleaning materials, are stored separately.

(2) Food is protected from contamination and spoilage.

(3) Food preparation areas, utensils, and equipment are thoroughly cleaned and sanitized after each period of use.

(4) All food items are stored above floor level in covered containers that are insect and vermin proof.

(5) Perishable foods are stored at proper temperatures.

(6) All reusable eating and drinking utensils are sanitized after use. Broken or chipped dishes, glasses, and cooking utensils are discarded.

(7) Garbage is disposed of in a sanitary manner to prevent the transmission of disease.

(8) Dining areas are attractive and clean, and the furnishings are in good repair.

III. PHYSICAL PLANT AND ENVIRONMENT

A. Physical Environment

1. The buildings and grounds of the facility are maintained, repaired, and cleaned so that they are not hazardous to the health and safety of the patients, staff, and visitors.

a. All space, supplies, equipment, motor vehicles, and facilities, both within and outside the facility, meet applicable federal, state, and local requirements for safety, fire, health, and sanitation.

b. Equipment and furnishings are of safe and sturdy construction. Furniture is comfortable, attractive, and age appropriate.

c. Sufficient staff and resources are provided to carry out preventive maintenance and regular housekeeping services.

d. Repair and replacement of broken items is done promptly.

e. Windows and doors used for ventilation are screened.

f. Sleeping rooms have windows or skylights.

2. The physical environment is appropriate to the nature of the services provided and the patients served.

a. Indoor and outdoor areas are provided where patients can gather for reading, study, relaxation, entertainment, or recreation.

b. Recreational areas and equipment meet the developmental and clinical needs of the patients.

c. Resources such as toys, books, and games are age appropriate and accessible.

3. All sleeping areas meet state licensure requirements, promote comfort and dignity, and provide adequate space and privacy for the patients.

a. No more than four patients are housed in a sleeping room unless provisions are made for adequate privacy.

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- b. Each patient has his/her own bed consisting of a level bedstead and a clean mattress in good condition.
 - c. All mattresses are fire retardant and have water repellent covers or protectors.
 - d. Linens, blankets, pillows, and towels are furnished by the facility. Linens and towels are changed at least weekly.
4. Storage areas are provided for each patient's clothing and personal possessions.
 - a. Adequate, secure personal storage space is available to each patient.
 - b. Storage space is accessible and within easy reach.
 5. The facility makes appropriate provisions for personal hygiene.
 - a. All toilets have secured seats, are kept clean, are in good working order, and have partitions and doors.
 - b. All bathtub and shower areas are appropriately partitioned for privacy.
 - c. Bathrooms are cleaned thoroughly each day.
 - d. Toothbrushes, toothpaste, soap, and other items of personal hygiene are provided if necessary.
 - e. Nondistorting mirrors are furnished in each bathroom.
 6. Separate areas and adequate space are provided for therapeutic services including educational, rehabilitative, and vocational services.
 7. A comprehensive smoking policy is established for patients, staff, and visitors.

B. PHYSICAL PLANT SAFETY

1. The facility is of permanent construction and maintained in a manner that protects the lives and safety of patients, staff, and visitors.
2. The facility complies with all applicable building codes, fire, health and safety laws, ordinances, and regulations in the state in which it is located. Current inspection reports are retained for TMA review.
 - a. The fire inspection meets or exceeds the regulations set by the local fire marshal (as governed by local ordinances), and may never be less than those regulations set by the state fire marshal.

b. Buildings in which patients are housed overnight or receive treatment are in compliance with the appropriate provisions of the *Life Safety Code of the National Fire Protection Association* or equivalent protection is provided and documented.

c. The health inspection meets or exceeds the regulations set by the local health ordinances (where applicable) but may never be less than those regulations set by the state health department.

d. Levels of lighting are maintained throughout the facility that are appropriate for the purpose of the designated area.

3. The number, type, capacity, and location of fire extinguishers and/or smoke detectors comply with all applicable local or state fire regulations. All staff are instructed in the use of fire extinguishers. Fire extinguishers are inspected and serviced as required.

4. All fire safety systems are kept in good operating condition. Fire safety systems are inspected regularly and records are kept on file. An electronic fire alarm system automatically notifies the fire department. If such a system is not available, an alternative method is implemented.

5. Regular safety inspections are conducted by a safety committee. The personnel responsible for safety evaluations receive appropriate training. Monthly safety inspections are documented and maintained on file.

6. Specific safety measures are provided for areas of the facility that present unusual hazards to patients, staff, or visitors. Special consideration is given to building and campus features that may cause harm such as “invisible glass doors” and recreation equipment. All stairways have handrails.

C. DISASTER PLANNING

1. The facility has written plans and policies for taking care of casualties arising from internal and external disasters. The plans are rehearsed at least every six months.

2. The facility is prepared to handle internal and external disasters such as explosions, fires, or tornadoes. The plan incorporates evacuation procedures approved by qualified fire, safety, and other appropriate experts.

3. The plans for internal and external disasters include instructions on the use of alarm and smoke detection systems, methods of fire containment, plans for notifying appropriate personnel, and posted evacuation routes.

4. Disaster plans are made available to all facility personnel, and evacuation routes are posted in appropriate areas within the facility.

5. Records are maintained regarding the disaster training offered to employees.

6. Regular fire drills are conducted for each shift and on each patient unit. At least one drill is conducted monthly.

7. An evaluation of all drills concerning internal and external disasters is made at least every six months.

IV. EVALUATION SYSTEM

A. Evaluation Activities

1. The facility has a written plan of evaluation to examine the overall quality of patient care and services. Evaluation activities include, but are not limited to, quality assessment and improvement, utilization review, patient records, drug utilization review, risk management, infection control, safety, and facility evaluation.

2. The system of evaluation meets guidelines set forth by accrediting bodies, such as the JCAHO, and regulatory agencies of local, state, and federal government.

B. QUALITY ASSESSMENT AND IMPROVEMENT

1. The facility has a program that monitors the quality, appropriateness, and effectiveness of the care, treatment, and services provided for patients and their families.

2. Quality assessment and improvement activities include, but are not limited to, clinical peer review, outcome studies, incident reporting, and the attainment of programmatic, clinical, and administrative goals.

a. The evaluation system involves all of the disciplines, services, and programs of the facility, including administrative and support staff activities.

b. The evaluation system identifies opportunities for improving the effectiveness and efficiency of patient care.

3. The quality monitoring process uses explicit clinical indicators, i.e., well-defined, measurable variables related to the provision and outcome of patient care.

a. The clinical indicators identify high-volume, high-risk, and problem-prone areas of clinical practice.

b. The clinical indicators focus on structural, process, and outcome measures.

c. Each clinical indicator requires the establishment of a threshold to determine when a problem or opportunity to improve care exists.

4. The clinical director, in consultation with the medical director and the medical and professional staff organization, is responsible for developing and implementing quality assessment and improvement activities throughout the facility. A similar methodology is applied to services, departments, disciplines, programs, and patient populations.

C. UTILIZATION REVIEW

1. The RTC shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration, and the governing body.
2. Utilization review activities include, but are not limited to, concurrent and retrospective studies examining the distribution of services as well as the clinical necessity of treatment.
3. The utilization review process identifies the appropriateness of admission, continued stay, and timeliness of discharge as part of the effort to provide quality patient care in a cost-effective manner.
4. The utilization review process identifies the under-utilization, over-utilization, and inefficient use of the facility's resources, both concurrently and retrospectively.
5. A conflict-of-interest policy applies to all staff involved in the utilization review process.
6. A confidentiality policy protects both the patients and clinical staff involved in the utilization review activity and maintains the confidentiality of the findings and recommendations.
7. The source of payment is not used as the basis for determining patient reviews.
8. Review information is reported to the applicable departments, services, and disciplines for further recommendations and corrective actions as appropriate.
9. The findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.
10. The CEO is responsible for the development and implementation of the utilization review process.

D. PATIENT RECORDS

1. Clinical records are maintained and controlled by an appropriately qualified records administrator or technician.
 - a. Written policies and procedures ensure that records are current, accurate, confidential, and safely stored.
 - b. Current records are kept in patient care areas and are immediately accessible to staff.
 - c. Policies and procedures adhere to federal guidelines for the release of confidential information specific to residential treatment.

2. The facility monitors and evaluates the completeness of patient records, including timeliness of entries, appropriate signatures, and the pertinence of clinical entries, particularly with regard to the regular recording of progress/non-progress in treatment.

3. Qualified health care professionals review a representative sample of patient records on a monthly basis.

4. Conclusions, recommendations, actions taken, and the results of actions are monitored and reported.

E. DRUG UTILIZATION REVIEW

1. The facility establishes objective criteria for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs.

2. The monitoring of drug usage ensures that medications are administered appropriately, safely, and effectively.

3. Data are collected on the drugs most frequently prescribed, those prescribed for other than FDA-approved use, and those with known or suspected adverse reactions or interactions with other drugs.

4. The review process involves physicians, nurses, pharmacists, administrative and management staff, and other personnel as needed.

5. Minutes document the classes of drugs reviewed, and the findings, conclusions, recommendations, and actions taken.

6. The results of drug evaluations are disseminated to nursing and medical staff, and are incorporated into other data in the evaluation system involving practice patterns, clinical performance, and staff competence.

7. The medical or professional staff is responsible for the drug utilization review process.

F. RISK MANAGEMENT

1. A risk management program is implemented to prevent and control risks to patients and staff, and to minimize costs to the facility associated with patient care and safety.

2. Risk management activities are coordinated with other evaluation programs including safety monitoring, utilization review, infection control, drug utilization review, and patient record reviews.

3. The risk management findings are reviewed quarterly to identify clinical problems or opportunities to improve patient care.

a. Minutes are maintained that include conclusions, recommendations, and the corrective action(s) taken to reduce patient/staff risk and cost.

b. The findings related to risk management are included in the facility evaluation.

c. A summary report is submitted to the governing body indicating the findings and results of risk management activities.

G. INFECTION CONTROL

1. The facility implements policies and procedures for the surveillance, prevention, and control of infections.

2. A qualified staff person is assigned responsibility for the management of infection surveillance, prevention, and control.

3. All staff involved in direct patient care and patient care support are involved in infection control activities.

a. Training is provided for all new employees on infection control, personal hygiene, and their responsibility to prevent and control infection.

b. Education on the prevention and control of infection is provided at least annually for staff in all the departments, services, and programs involved in patient care.

4. Records and reports of actual and potential infections among patients and staff are documented. Patterns and trends are monitored through the use of aggregated data.

H. SAFETY

1. The facility implements a safety monitoring system as described below:

a. An incident reporting system reviews all accidents, injuries, and safety hazards. Incidents are investigated and evaluated, and follow-up actions are documented and tracked.

b. Disaster training, safety orientation, and continuing safety education are monitored through a review of reports and an evaluation of drills.

c. A continuous safety surveillance system exists that detects and reports safety hazards related to patients, staff, or visitors.

d. A multidisciplinary safety committee evaluates the safety monitoring activities, with the authority to take action when conditions pose a threat to people, equipment or buildings.

I. FACILITY EVALUATION

1. The CEO and other administrative staff develop a strategic plan with specific goals and objectives to evaluate the various functions of the RTC.

2. The annual goals and objectives for each program component or service are related to the patient population served.

3. The strategies to meet the objectives are defined.

4. The criteria by which the programs and services are to be evaluated are specified.

5. The programs, services, and organization are evaluated annually.

a. An explanation is given of any variance or failure to meet the goals and objectives.

b. The findings of this evaluation are documented and reported to the governing body.

