INTRODUCTION

Nevada children's mental health services in concept and philosophy are based upon System of Care values and principles. System of Care incorporates a comprehensive spectrum of mental health and other necessary services for children with emotional and behavioral disorders. These services are organized into a coordinated network to meet the multiple and changing needs of children and their families. Mental health services offered under System of Care need be responsive to the cultural context and characteristics of the populations they serve. It is imperative that the Nevada Division of Child and Family Services (DCFS) knows the children and families for whom it cares and the perceptions they have regarding the adequacy and quality of the mental health services they receive.

QUALITY ASSURANCE / PROGRAM QUALITY IMPROVEMENT

Over the past year, the DCFS Planning and Evaluation Unit (DCFS/PEU) has initiated and/or continued several key components of its expanding system for monitoring populations entering service, service recipient satisfaction and service delivery compliance.

Admission Population

Descriptive Study of Mental Health Services

A detailed Descriptive Study was completed this past year that looked at all 1608 children admitted to the DCFS Children's Mental Health Services in Fiscal Year 2007 (July 1, 2006 through June 30, 2007). Demographic and assessment information were carefully documented in portraying the individuals entering our care.

Of the 1608 children admitted to DCFS programs, 1121 (69.7%) were served in the southern region (Clark County), 419 (26.1%) were served in the northern region (Washoe County), and 68 (4.2 %) were served in the rural counties.

Community based outpatient programs accounted for 84.4% of the admissions statewide. The remaining 15.6% of admissions went to residential and inpatient treatment settings.

59% of the youngsters admitted were 12 years of age or less and 59.5% of all admissions were male. Over 91% of admissions were Caucasian or African-American.

Two-thirds (66.3%) of the children admitted to mental health services statewide in FY07 were in the custody of their parent or family. 28.9% were in Child Welfare custody and 1.75% were in Youth Parole custody. 2.99% were in "Other" custody status**.**

The two most frequent admitting complaints statewide were Adjustment Problems and Depression. Physical Aggression is the third most frequently reported problem in the

Southern Region while Parent-Child Problems was the most frequently reported problem in the Northern Region.

This population's Functional Assessment ratings, incidence of Post Traumatic Stress Disorder and additional diagnostic/other information breakout can be found in the DCFS Mental Health Services Descriptive Study SFY08 (Attachment A).

Service Recipient Satisfaction

It is the policy of DCFS that all children, youth and their families/caregivers receiving mental health services have an opportunity to give feedback and information regarding those services while still being served and later at the time of their discharge from treatment.

Satisfaction Surveys

DCFS/PEU conducted four separate client and family satisfaction surveys during SFY 2008.

DCFS Community-based Children's Mental Health Programs

A youth version and a parent/caregiver version of the DCFS Outpatient Mental Health Satisfaction Survey were administered. Five Neighborhood Family Service Center sites were polled in Las Vegas and three were polled in Reno. Survey results indicated a statewide average 88% youth approval rating and an 84% parent/caregiver approval rating for the program areas targeted for review. Results of the parent/caregiver survey were reported to the federal Center for Mental Health Services as a requirement for Nevada's participation in the Community Mental Health Services Block Grant.

A summary of the youth survey results is found in DCFS Outpatient Youth Satisfaction Survey (Attachment B). A summary of the adult survey results is found in DCFS Outpatient Parent/Caregiver Satisfaction Survey (Attachment C).

DCFS Residential and Psychiatric Inpatient Mental Health Programs

A youth version and a parent/caregiver version of the DCFS Residential and Psychiatric Inpatient Satisfaction Survey were administered. Two residential program areas were polled in Reno and six residential/inpatient program areas were polled in Las Vegas. Survey results indicated a statewide average 65% youth approval rating and an 80% parent/caregiver approval rating for the program areas targeted for review.

A detailed summary of the youth survey is found in DCFS Residential and Psychiatric Inpatient Youth Satisfaction Survey (Attachment D). A detailed summary of the adult survey is found in DCFS Residential and Psychiatric Inpatient Parent/Caregiver Satisfaction Survey (Attachment E).

Youth and Parent/Caregiver Satisfaction Surveys At Discharge

By reason of its Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification, the Desert Willow Treatment Center (DWTC) currently conducts patient and/or parent/caregiver consumer service evaluations at time of patient discharge from the facility. DCFS/PEU is implementing this practice statewide and is formatting discharge survey instruments and protocols for all its outpatient and residential treatment programs.

Service Delivery Compliance

DCFS policy requires that its children's mental health services promote clear, focused, timely and accurate documentation in all client records in order to ensure best practice service delivery and to monitor, track and analyze client outcomes and quality measures.

Client Clinical File Reviews

One of the DCFS/PEU performance and quality improvement plan objectives is to engage in ongoing quality assurance activities that monitor the mental health service delivery process documentation requirements stipulated in Nevada Medicaid Services Manual (MSM) Chapter 400.

In July of 2007 DCFS/PEU conducted a statewide client clinical file review using a statistical sample of the mental health clients active during SFY07. The DCFS File Review statewide sample size was 163 cases. 105 files were representative of the Southern region and 58 files represented the Northern and Rural Regions.

DCFS/PEU developed a file review tool consisting of 46 MSM service documentation indicators. Documentation areas covered by the tool include Client Rights and Client Privacy; Medical Necessity; Assessment; Treatment Plan; Discharge Plan; Progress Notes; 90 Day Reviews; Child and Family Involvement; Care Coordination and Discharge Summary.

Sample review results showed fairly consistent statewide program compliance in the areas of Client Rights, Client Privacy, Medical Necessity and Care Coordination. Assessments tended to be done well but not always within the stipulated five working day timeframe. Treatment Plans tended to be individualized and completed during the proper session. They included planned response to problems and used goals and objectives derived from assessment and diagnosis. Updating plans 30 days out from the initial session needed improved compliance as did the plans' stipulation of discharge criteria for

each treatment goal. Case Progress Notes tended to be within compliance in all areas save following a standardized format. Case 90 Day Reviews showed responsiveness to changing client circumstances, assessment needs and data documentation for medical necessity. Reviews did not always reflect required revisions in treatment plan elements. Clients and their families were most often involved in developing their treatment plans but were not as often a part of the 90 Day Review process. Discharge Summaries were compliant in some areas and needed improvement in other areas of case documentation.

A detailed summary of the file review is found in Division of Child and Family Services File Review FY07 (Attachment F).

Supervisor Checklists

It is a DCFS quality assurance objective that service providers be a part of any document review process. When it was determined that supervisors could profit from a tool designed to assist them when reviewing their active cases, mental health supervisors worked alongside DCFS/PEU staff in developing three separate supervisor review checklists for use respectively in outpatient and residential programs, early childhood programs, and the Wraparound in Nevada program areas. It seemed clear that such review tools could help guide immediate feedback to staff in directing and improving service provider adherence to documentation requirements.

The new checklists were first used by ten supervisors statewide for 75 cases reviewed from August through December 2007. Completed supervisor checklists were collected by DCFS/PEU for data entry and subsequent analysis.

It was found that the supervisor checklist can be used productively in different ways. Some supervisors assigned the file review task to other responsible staff. These supervisors then reviewed the completed checklists and responded with their observations and comments. Then the checklists were sent back to the direct service delivery provider for correction and feedback.

Some supervisors utilized the tool for supervisee self training purposes by requesting that the direct service delivery provider review their own files and after completion of the self assessment, the supervisor signed and dated the document.

Other supervisors reviewed the files themselves and made the necessary recommendations and comments on the Supervisor Checklist tool.

In all instances, following their review, supervisors provided feedback to staff requesting completion of the missing indicators or to follow the recommended changes. The checklist appears to be fulfilling its purpose.

Item analysis of the three supervisor checklists have also prompted revisions in the discharge planning and the discharge summary indicators that helped discriminate better between these two separate processes. Other revisions have accommodated more recent

Medicaid regulation changes and targeted case management policy. In fact a new supervisor checklist is now being developed expressly for the Targeted Case Management area.

Program Quality Assurance Monitoring

The Desert Willow Treatment Center program represents the Division's most comprehensive approach to on-going quality assurance and program improvement. As the Division's sole Joint Commission on Accreditation of Healthcare Organization (JCAHO) credentialed treatment facility, the Desert Willow Treatment Center (DWTC) continues to conduct its programs in strict compliance with the Commission's operational mandates. As mentioned earlier, patients and/or their parents/caregivers are administered consumer service evaluations upon discharge with monthly reports being forwarded to JCAHO. Several DWTC internal committees review monthly such patient-related care areas as Restraint and Seclusion data, treatment outcome measures and incident and accident data. Monthly Health and Safety Checklists are completed as is a Joint Commission Readiness walkthrough facility/programs inspection. Patient charts are audited daily and typical medical facility infection control activities/reports and medication audits/reports are conducted as well. Consumer complaints and Denial of Rights are reviewed, addressed and reported. Staff medical and clinical peer reviews and program utilization reviews occur monthly. Facility nutritional services undergo quarterly review. The entire facility undergoes an annual performance review that drives facility performance improvement projects. DWTC received an outstanding rating on its most recent JCAHO accreditation recertification review.

Client Case Record Data

Client case record documentation begins with timely data entry by appropriate staff. The management information system that houses the data must then be maintained and regularly monitored for client data accuracy and completeness. DCFS employs two primary processes in seeking to maximize the adequacy and integrity of its client data.

Data Clean-up Committee

This group engages in on-going efforts to identify, isolate, remediate and monitor specific data deficiencies in both the Avatar and the UNITY management information systems. The committee continues to issue regular and on-going data clean up reports that indicate specific data field errors or omissions and include timelines for corrections to be made. The process this past year has spurred a significant decline in statewide data error rates with often dramatic error downturns being realized within just a few weeks. In the course of doing its work, the committee also had to address such non-data specific issues as regional differences in business processes, differences that by themselves may occasion their own variations in data integrity.

Mutual Advocacy for Data Workgroup (MAD)

This workgroup is composed of key DCFS Information Management System (IMS) and DCFS/PEU personnel and is based upon a shared desire to have a close and informed relationship exist between mental health program service areas and the technical information system that captures, maintains and reports those services' clinical, demographic and financial client data.

MAD meets regularly to address any issues involving any data needs from anywhere in DCFS. The workgroup has addressed such areas as national provider identification on program billings; missing or inaccurate client assessment data fields; special fiscal audit needs in support of state mental health consortia projects; basic data system enhancement recommendations; special reports in support of ad hoc Administrative requests/needs; and supporting the development of educational and juvenile justice outcomes and reinitiating monthly performance indicators for all program areas. MAD is proving an important component of the DCFS commitment to its data quality, adequacy and integrity.

CONCLUSION

The DCFS quality assurance and quality improvement model encompasses efforts to understand and optimize all possible factors influencing service delivery and outcomes. PEU is tasked with developing a clear plan for measuring service delivery impact upon outcomes and for improving our understanding of the building blocks that lead to effective programs. Understanding the process of service delivery and evaluating and appreciating consumer satisfaction are all based upon the development of quality assurance and quality improvement standards. PEU partners with DCFS program managers in developing these standards within the different service areas and in measuring their effectiveness. Information generated by on-going outcome measurement allows characterization of program effectiveness and at times may indicate the need to refine or revise a standard for greater effectiveness. Quality assurance and quality improvement address system of care operations at the child and family level, at the supervisory level and at the managerial and community stakeholder level.

Approved by:

_____	_____
Susan L. Mears, Ph.D. Planning and Evaluation Unit, DCFS	Date
_____	_____
Patricia L. Merrifield, Deputy Administrator Children's Mental Health, DCFS	Date
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Nabil Jouni, M.D. Medical Director, Southern Nevada Child and Adolescent Services, DCFS	Date
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Larry Nussbaum, M.D. Medical Director, Northern Nevada Child and Adolescent Services, DCFS	Date
_____	_____
Fernando Serrano, Administrator Division of Child and Family Services	Date

ATTACHMENT A

DCFS Mental Health Services
Descriptive Study SFY 07

DIVISION OF CHILD AND FAMILY SERVICES
DESCRIPTIVE SUMMARY OF MENTAL HEALTH SERVICES FY 07

Nevada children's mental health services in concept and philosophy are based upon System of Care values and principles. System of Care incorporates a comprehensive spectrum of mental health and other necessary services for children with emotional and behavioral disorders. These services are organized into a coordinated network to meet the multiple and changing needs of children and their families. Services offered under System of Care need be responsive to the cultural context and characteristics of the populations they serve. It is imperative that DCFS know the children and families for whom it cares.

The following is the descriptive summary of the children who were admitted to the Division of Child and Family Services (DCFS) Children's Mental Health Services in Fiscal Year 2007 from July 1, 2006 through June 30, 2007.

This descriptive report summarizes the demographic and clinical characteristics of the 1608 children admitted for mental health services across the state of Nevada in DCFS Children's Mental Health programs statewide.

Of the 1608 children admitted to DCFS programs, 1121 (69.7%) were served in the southern region (Clark County), 419 (26.1%) were served in the northern region (Washoe County), and 68 (4.2 %) were served in the rural counties.

CHILDREN'S MENTAL HEALTH ADMISSIONS

Community-Based Outpatient Services

Southern Region: Of the total number of mental health admissions statewide, Children's Clinical Services accounted for 22.6% (n=363); Early Childhood Mental Health Services (ECMHS) accounted for 22.6 % (n= 364) and Wraparound in Nevada for Children and Their Families (WIN) accounted for 12.2% (n= 196).

Northern Region: Of the total number of mental health admissions statewide, Outpatient Services accounted for 10.1% (n=163); Early Childhood Services accounted for 8.9% (n= 143) and the WIN program admissions accounted for 3.7% (n=59).

Rural Region: The WIN program accounted for 4.2% (n=68) of total statewide admissions.

Residential and Psychiatric Inpatient Services

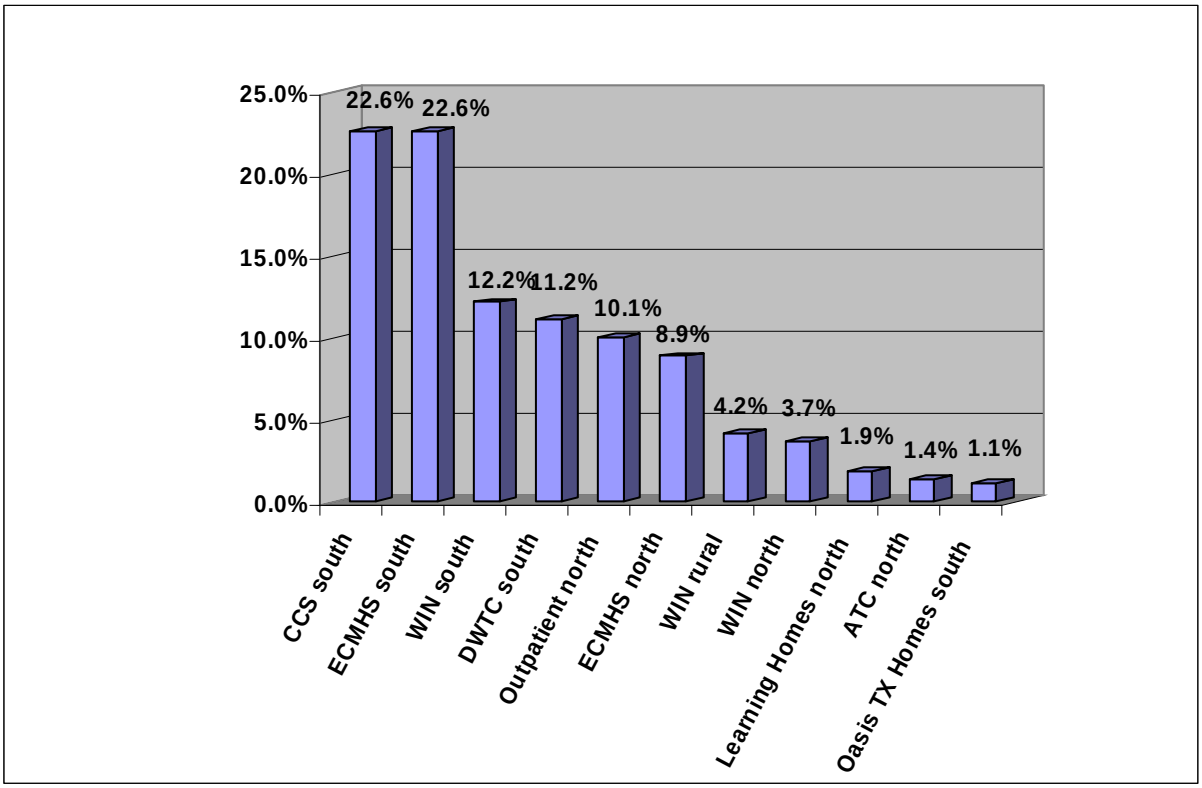
Southern Region: Desert Willow Treatment Center (DWTC) inpatient services accounted for 11.2% (n=180) and OASIS treatment homes accounted for 1.1% (n=18) of the statewide admissions.

Northern Region: Family Learning Homes accounted for 1.9% (n=31) and the Adolescent Treatment Center (ATC) accounted for 1.4% (n=23) of the statewide admissions.

Relative to admissions in FY06, WIN in the Southern Region, showed a 4% increase in 2007 admissions and Children's Clinical Services in the Southern Region showed an increase of 3.5%.

Graph 1 reflects the FY07 statewide admissions by program.

Mental Health Service Admissions by Program



CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

The 1608 children admitted statewide for mental health services in FY 07 reflected the following demographic characteristics

Age

At admission, the age of children ranged from 2 months through 20 years of age. Seven were older than 18 years of age at the time of admission. The mean age of all the children admitted in FY07 was 10.47 and the median age was 10.81 years old. The following is the percent of admissions by age group.

- 0-5 year old: 27.2% of total admissions
- 6-12 year old: 32.6% of total admissions
- 13-20 year old: 40.1% of total admissions

The distribution of age groups reflect that although the majority of children admitted in FY 07 are 13 years or older, the 12 year and younger group represents 59.8% of the total admissions. There was a slight increase in the number of children admitted in the age group 6-12 from FY06 to FY07.

The following is the regional breakdown of the ages of children admitted to DCFS mental health services in FY07:

Southern Region: Of the 1121 children admitted to mental health services, the percent of admissions by age group are:

- 0-5 year old: 30.9 %
- 6-12year old: 32.0%
- 13- 18 year old: 37.1%

Northern Region: Of the 419 children admitted to mental health services, the percent of admissions by age group are:

- 0-5 year old: 21.6%
- 6-12 year old: 34.4%
- 13-18 year old: 44%

Rural Region: Of the 68 children admitted to Wraparound In Nevada services, the percent of admissions by age group are:

- 0-5 year old: 1.5%
- 6-12 year old: 35.8%
- 13-18 year old: 62.7%

Gender

Males accounted for 59.5% of the statewide admissions and females the remaining 40.5%. The number of females admitted increased slightly relative to males from FY06 to FY07.
Regional breakdown of the gender of children and youth admitted to DCFS mental health services is as follows:

- Southern Region: 38.9% females and 61% males (n=1121)
- Northern Region: 44% females and 56.0% males (n=419)
- Rural Region: 45.6% females and 54.4% males (n=68)

Race

- Caucasians made up the majority of statewide admissions accounting for 70.1% (n=1067) of children whose race was known.
- African-Americans accounted for 21.0% (n=320)
- Mixed Races accounted for 5.7% (n=87)
- American Indian/Alaskan Natives accounted for 1.7% (n=26)
- Native Hawaiian/ Pacific Islanders accounted for 0.8% (n=12)
- Asians accounted for 0.4% (n=6)
- Other races accounted for 0.3% (n=5)

Not included in the race break down were 85 children. 67 had no entry for race, 14 had no one to identify race, 3 had race unknown and 1 declined to answer.

The relative proportion of Caucasian admissions increased nearly 10% from last fiscal year and the proportion of other races decreased 9%. This reflects a systematic change made in mental health data entry protocol so as to be consistent with child welfare reporting of Hispanics. In FY06, mental health data system reports classified certain Hispanics as Other race while the child welfare data system classified them as Caucasian. For FY07, the classification of race and ethnicity for these children was consistent in both data systems.

The regional breakdown of the children served by race is as follows:

Southern Region: 59.8% of the children admitted were Caucasian; 25.6% were African American; 4.4% were Mixed Race; 1.4% were American Indian/Alaskan Native; .8% were Native Hawaiian/Pacific Islander and .4% were Asian.

Northern Region: 81.6% of the children admitted were Caucasian; 7.1% were African American; 9.1% were Mixed Race; 1.2% were American Indian/Alaskan Native and .7% were Native Hawaiian/Pacific Islander.

Rural Region: 83.3% of the children admitted were Caucasian; 1.5% were African American; 7.4% were Native American; and 1.5% were Asian.

Ethnic Origin

Children of Hispanic origin accounted for 20% (n=321) of those admitted to DCFS mental health services statewide. There has not been a significant change statewide from FY06 to FY07 in the number of children admitted to mental health services among this group.

A regional breakdown of ethnicity of children reveals that in the Southern Region 20.8% of children admitted to services were Hispanic, the Northern Region had 19.1% and the Rural Region had 11.1%.

Custody Status

Two-thirds (66.3%) of the children admitted to mental health services statewide in FY07 were in the custody of their parent or family, 28.9% were in Child Welfare custody, 1.8% were in Youth Parole custody and 3.0% were in "Other" custody status**.** Children and their families involved with Child Protective Services or County Juvenile Probation were counted as being in the custody of their parents or family.

A breakdown of the custody status of the children and youth admitted by region is as follows:

Custody Type	Southern Region (n=572)	Northern Region (n=335)
Parent/Family	58.2%	87.0%
Child Welfare	37.1%	8.1%
Youth Parole	2.0%	1.0%
Other	2.7%	3.9%

Rural Region custody status was not included in this report. However, the WIN program is designed to serve children in child welfare custody and is the only DCFS program in the Rural Region that provides targeted case management.

CHILDREN'S CLINICAL CHARACTERISTICS

Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their child has encountered. Of the 45 problems listed, the five problems identified below accounted for one-third (33.7%) of all problems reported.

- Adjustment Problems (8.4%)
- Depression (7.4%)
- Physical Aggression (6.6%)
- Child Neglect Victim (6.3%)
- Suicide Attempt/Threat (5.1%)

Due to the increase in the number of presenting problems between FY06 (n=38) and FY07 (n=45), admitting problems identified were much more varied in FY07. In FY06 four identified problems accounted for nearly half of all admitting problems. In FY07 five identified problems account for only one-third of admitting problems. In FY07 adjustment problems accounted for 8.4% as the highest problem area identified, in contrast to FY06 where it held the highest ranking at 17.2%.

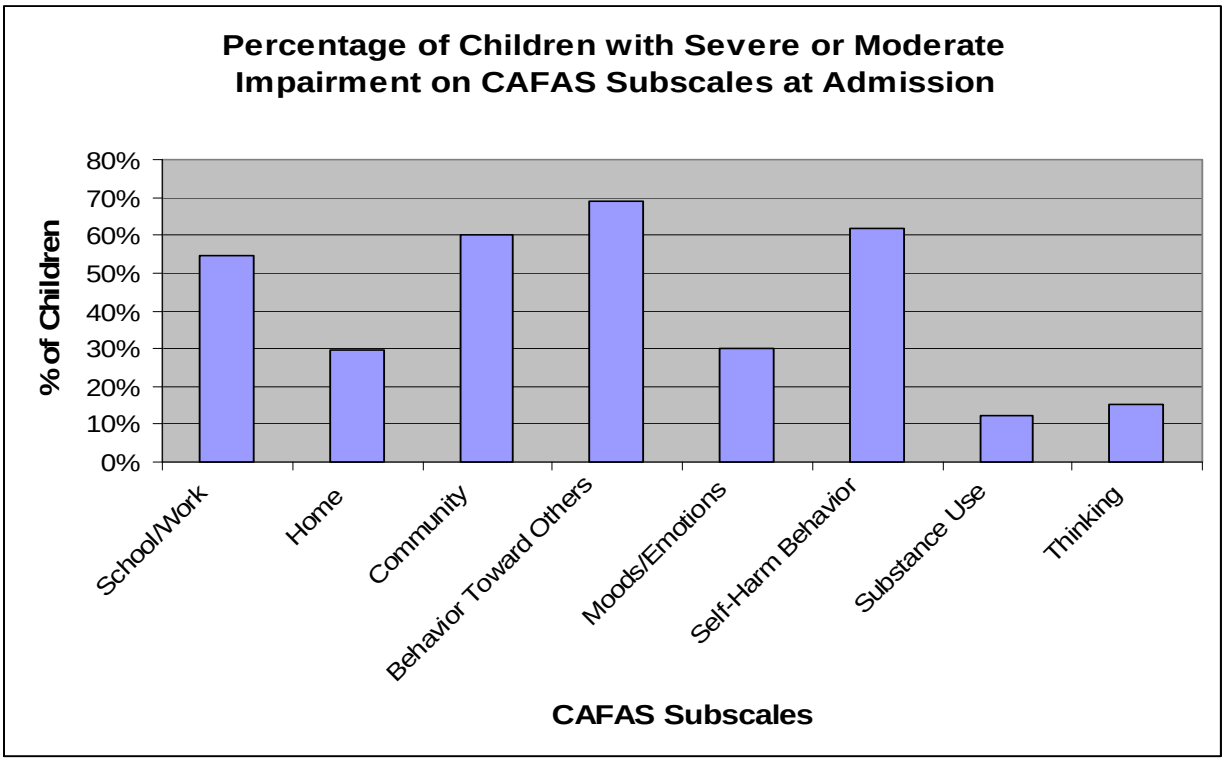
When analyzed by region, the two most frequent admitting problems were Adjustment Problems and Depression in each. Physical Aggression is the third most frequently reported problem in the Southern Region while Parent-Child Problems was the most frequently reported problem in the Northern Region.

Child and Adolescent Functional Assessment

The Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1999) was designed to assess in children ages 6 to 18 the degree of functional impairment regarding emotional, behavioral, psychiatric, psychological and substance-use problems. CAFAS scores can range from 0 to 240 with higher scores reflecting increased impairment in functioning.

Children ages 6 through 18 (n=571) that entered DCFS Children's Mental Health programs in FY 07 had a mean total CAFAS score of 106.25 at admission. The FY06 mean CAFAS total score at admission was 109. There was no significant difference in the mean 1st evaluation CAFAS scores from FY06 to FY07, indicating that children admitted to mental health services at intake are impaired in their overall functioning.

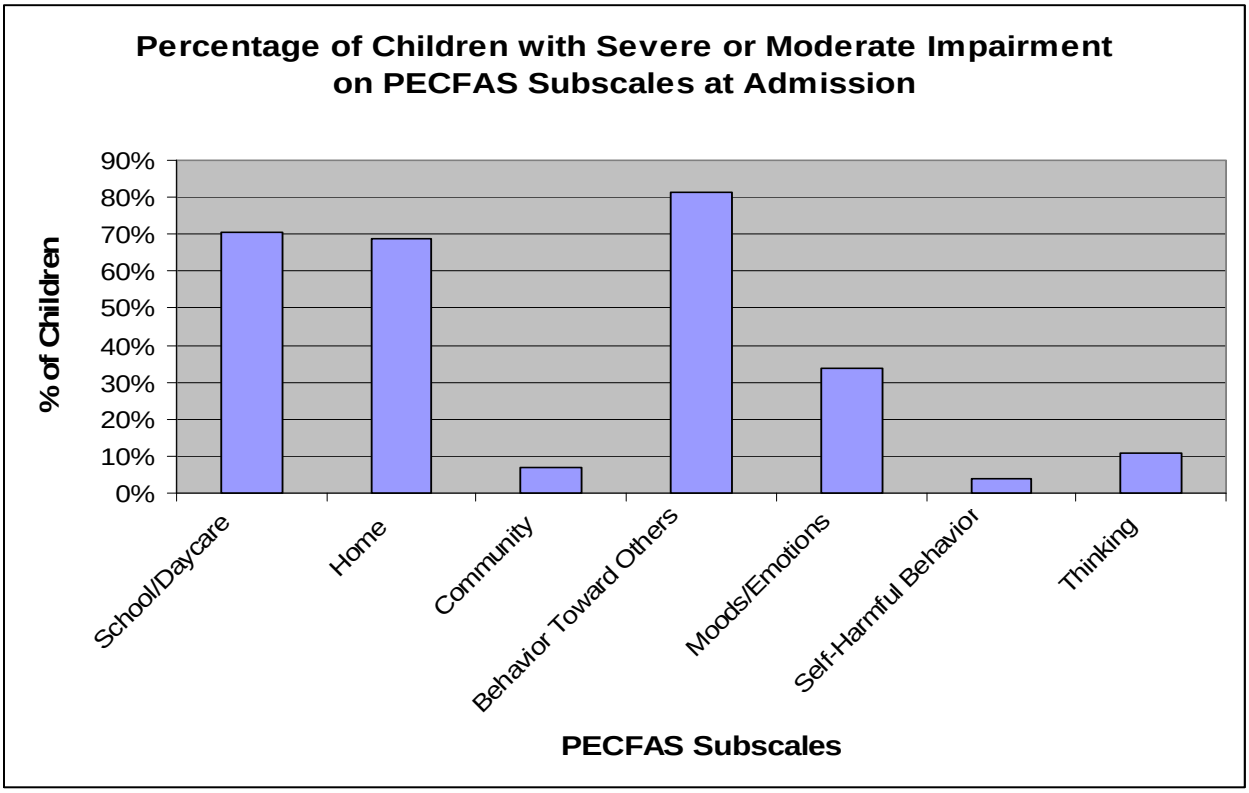
The graph below reflects the percentage of children who received a score of 20 (moderate impairment) or 30 (severe impairment) on the CAFAS at admission. The subscales can be used to determine the community partners that may be enlisted in the child's care coordination.



Preschool and Early Childhood Functional Assessment

Preschool and Early Childhood Functional Assessment Scale (PECFAS) (Hodges, 2000), was also designed to assess degree of impairment of functioning of children ages 3-7 with behavioral, emotional, psychological or psychiatric problems. PECFAS scores range from 0 to 210 with a higher score indicating greater impairment. In FY07, mean total PECFAS score of 247 children admitted to mental health services statewide was 68.29.

The graph below reflects the percentage of children who received a score of 20 (moderate impairment) or 30 (severe impairment) on the PECFAS at admission. As with the CAFAS, PECFAS subscales might suggest community partners when formulating the child's treatment plan.



Diagnosis at Admission

Nearly 40% of the FY 07 children had more than one diagnosis at admission. The most prevalent Axis I diagnoses of children at admission are reflected in the following age group categories.

Age Group 0-5

- Disruptive Behavior Disorder
- Deprivation/Maltreatment Disorder
- Adjustment Disorders

The most prevalent diagnosis for age group 0-5 in FY06 was Reactive Attachment Disorder.

Age Group 6-12

- Adjustment Disorder
- Attention Deficit Hyperactivity Disorder
- Posttraumatic Stress Disorder

These were also the most prevalent diagnoses in FY06 for age group 6-12.

Age Group 13-18

- Bipolar I Disorder
- Major Depressive Disorder
- Attention Deficit Hyperactivity Disorder

As was the case in FY 06, Major Depressive Disorder remains the most prevalent FY 07 admission diagnosis among the 13-18 age group.

Posttraumatic Stress Disorder

It is estimated that in the United States each year over 5 million children experience some form of extreme trauma. Nearly half of these children go on to develop neuropsychiatric problems sufficiently severe as to impair emotional, behavioral, academic and social functioning. Most of these problems result in anxiety disorder diagnoses, the most prominent being Posttraumatic Stress Disorder.

Posttraumatic Stress Disorder (PTSD) is characterized by impaired functioning following exposure to severe traumatic events. For all DCFS statewide mental health admissions in FY 07, PTSD accounts for 11.9% (101 males and 90 females). The breakdown of this diagnosis according to age group and gender is as follows:

Age Group	Total Number	Percent Within Age Group	Percent Within Total
0-5	22		11.5
	15 males	68.2	
	7 females	31.8	
6-12	88		46.1
	49 males	55.7	
	39 females	44.3	
13-18	81		42.4
	37 males	45.7	
	44 females	54.3	

It is of interest to note that statewide, PTSD diagnosis among the age groups and gender of the children admitted to DCFS mental health services in FY07 shows that there are twice as many males for age group 0 -5 and slightly higher number of males for age group 6 -12 with a slight increase in females in age group 13 - 18 year olds.

A regional breakdown of children diagnosed with PTSD according to their age group and gender is as follows:

Northern Region:

In the northern region 61 children received a diagnosis of PTSD at admission.

Age Group	Total Number	Percent Within Age Group	Percent Within Region
0-5	6	27.3	9.8
6-12	25	28.4	41.0
13-18	30	37.0	49.2

Age group 13-18 received the most frequent PTSD diagnosis at admission in the northern region.

Southern Region:

In the southern region 112 children received a diagnosis of PTSD at admission.

Age Group	Total Number	Percent Within Age Group	Percent Within Region
0-5	16	72.7	14.3
6-12	56	63.6	50.0
13-18	40	49.4	35.7

Age group 6-12 received the most frequent PTSD diagnosis at admission in the southern region.

Rural Region:

In the rural region 18 children received the diagnosis of PTSD at admission.

Age Group	Total Number	Percent Within Age Group	Percent Within Region
0-5	-	-	-
6-12	7	8.0	38.9
13-18	11	13.6	61.1

Age group 13-18 received the most frequent PTSD diagnosis at admission in rural region.

Posttraumatic Stress Disorder by Program and Age Group

	Total Number	Number in Age Group 0-5	Number in Age Group 6-12	Number in Age Group 13-18
SOUTHERN REGION				
DWTC	15	-	4	11
OASIS	4	-	1	3
WIN	38	2	27	9
CCS	37	-	20	17
ECS	13	9	4	-
TOTAL	**117**	**11**	**56**	**40**

WIN and CCS in the Southern Region 6-12 year olds have the most frequent PTSD.

	Total Number	Number in Age Group 0-5	Number in Age Group 6-12	Number in Age Group 13-18
NORTHERN REGION				
Learning Homes	5	-	3	2
ATC	3	-	-	3
ECMHS	18	11	7	-
WIN	19	-	3	16
Outpatient Services	20	-	11	9
TOTAL	**65**	**11**	**24**	**30**

	Total Number	Number in Age Group 0-5	Number in Age Group 6-12	Number in Age Group 13-18
RURAL REGION				
WIN	19	-	8	11

WIN (both Northern and Rural Regions) shows most frequent PTSD diagnosis for age group 13-18. ECMHS has the most frequent PTSD for age group 0-5 and Outpatient Services in the Northern region has the most frequent Posttraumatic Stress diagnosis for age group 6-12.

Diagnoses by Race and Ethnicity

Together, Caucasian and African-American youth make up over 90% of children's mental health admissions statewide. Children of Hispanic origin make up 20% of the children's mental health admissions statewide. What clinical characteristics did these three predominate groups manifest when initiating their treatment services?

Of 1608 children statewide, **African-American** (200 males and 120 females) children represent 21.0% of the statewide admissions to DCFS mental health services in FY07. The following table illustrates the most prevalent admission diagnosis of African American children by gender and age group.

	Male = 200			**Female = 120**		
Age Group	**0-5 = 68**	**6-12 = 69**	**13-18+ = 63**	**0-5 = 38**	**6-12 = 33**	**13-18+ = 49**
Diagnosis	Disruptive Behavior Disorder NOS (16)	Attention-Deficit/ Hyperactivity Disorder (16)	Bipolar Disorders (14)	Disruptive Behavior Disorder NOS (8)	Adjustment Disorder (10)	Major Depression (10)
	Deprivation/ Maltreatment Disorder (11)	Posttraumatic Stress Disorder (12)	Attention-Deficit/ Hyperactivity Disorder (13)	Deprivation/ Maltreatment Disorder (6)	Posttraumatic Stress Disorder (7)	Depressive Disorder NOS (8)
	Sensory Stimulation-Seeking/Impulsive (11)	Impulse-Control Disorder NOS (11)	Posttraumatic Stress Disorder (9)	Adjustment Disorder (5)	Attention-Deficit/ Hyperactivity Disorder (5)	Bipolar Disorders (7)
		Disruptive Behavior Disorder NOS (11)			Attention-Deficit/ Hyperactivity Disorder NOS (5)	

Although the number of African American males among the 6-12 age group is double the number of females in the same age group, the diagnoses signified by externalizing behavioral problems are reflected by both genders. In the 6-12 age group 23% account for ADHD diagnosis among males and 30% account for ADHD diagnosis among females. However, among the 13-18 age group there is a difference between genders. Females are diagnosed with a depressive disorder while male children are diagnosed with ADHD, PTSD and Bipolar Disorder.

Although the number of African American males among the Age Group 0-5 is nearly double the number of females in the same age group, both genders are represented equally with Disruptive Behavior Disorder and Deprivation/Maltreatment Disorder diagnoses. For the third most prevalent diagnosis, 16% of the African American males in the 0-5 age range are diagnosed with Sensory Stimulation Seeking/Impulsive diagnosis while 13% of the females exhibit Adjustment Disorders.

Of 1608 children statewide, **Caucasian children** (635 males and 432 females) represent 70.1% of the total statewide mental health admissions in FY07. The following table illustrates the most prevalent admission diagnoses of Caucasian children by gender and age group.

	Male = 635			**Female = 432**		
Age Group	**0-5 = 177**	**6-12 = 216**	**13-18+ = 242**	**0-5 = 107**	**6-12 = 123**	**13-18+ = 202**
Diagnosis	Adjustment Disorder (51)	Attention-Deficit/ Hyperactivity Disorder (75)	Bipolar Disorders (64)	Adjustment Disorder (29)	Adjustment Disorder (50)	Major Depression (75)
	Disruptive Behavior Disorder NOS (51)	Adjustment Disorder (63)	Attention-Deficit/ Hyperactivity Disorder (63)	Deprivation/ Maltreatment Disorder (28)	Posttraumatic Stress Disorder (38)	Bipolar Disorders (48)
	Deprivation/ Maltreatment Disorder (34)	Posttraumatic Stress Disorder (49)	Major Depression (40)	Disruptive Behavior Disorder NOS (26)	Attention-Deficit/ Hyperactivity Disorder (18)	Posttraumatic Stress Disorder (43)
	Sensory Stimulation-Seeking/Impulsive (25)					Depressive Disorder NOS (43)

In the 0-5 age group, the most prevalent diagnosis of both genders is Adjustment Disorders. Disruptive Behavior Disorder diagnosis among males accounts for 29% while 24% of the females of the same age group share the same diagnosis. 19% of the males in this age group are diagnosed with Deprivation/Maltreatment Disorder while 26% of the females in the same age group share the same diagnosis. On the other hand, Sensory Stimulation-Seeking/Impulsive diagnosis among males in 0-5 age group account for 14%. Absence of this diagnosis among same age group Caucasian females is consistent with the African American female children of the same age group.
In the 13-18 age group, depressive disorder spectrum (major depression and depressive disorder NOS) accounts for 58.4% of the females as compared to 16.5% of the males. Bipolar Disorders diagnosis for males accounts for 26.4% and females account for 23.7% of the children in the 13-18 age group. Males in 6-12 age group are diagnosed with ADHD (n=75) four times more frequently that females (n=18) in the same age group.

Twelve percent of Caucasian children (n=130) are diagnosed with PTSD. Among the 6-12 Age Group, PTSD diagnosis accounts for 25% (n=87) of all the Caucasian children of that age group. Statewide, 16% of all the children in 6-12 Age group are diagnosed with PTSD. Among the 13-18 age group, female Caucasians with PTSD accounted for 19% (n=43) of all the Caucasian children in that age range. This is 12% of all the admission diagnosis statewide within the same age range.

Of 1608 children statewide, **Hispanic children** (187 males and 134 females) represent 20% of the total statewide admissions to DCFS mental health services in FY 07. The

following table illustrates the most prevalent admission diagnoses of Hispanic children by gender and age group.

	Male = 187			**Female = 134**		
Age Group	**0-5 = 67**	**6-12 = 67**	**13-18+ = 53**	**0-5 = 47**	**6-12 = 25**	**13-18+ = 62**
Diagnosis	Disruptive Behavior Disorder NOS (14)	Attention-Deficit/ Hyperactivity Disorder (18)	Major Depression (11)	Adjustment Disorder (10)	Posttraumatic Stress Disorder (8)	Major Depression (27)
	Sensory Stimulation-Seeking/Impulsive (7)	Adjustment Disorder (13)	Bipolar Disorders (8)	Deprivation/ Maltreatment Disorder (7)	Adjustment Disorder (7)	Posttraumatic Stress Disorder (11)
	Sleep-Onset Disorder (6)	Impulse-Control Disorder NOS (8)	Depressive Disorder NOS (7)	Reactive Attachment Disorder (5)	Reactive Attachment Disorder (3)	Oppositional Defiant Disorder (7)
			Attention-Deficit/ Hyperactivity Disorder (7)		Depressive Disorder NOS (3)	Depressive Disorder NOS (7)

21% of the males in the 0-5 age group are diagnosed with Disruptive Behavior Disorder while 21% of the females of the same age group are diagnosed with Adjustment Disorders. Absence of Disruptive Behavior Disorders diagnosis only among Hispanic females of the same age group is of interest as Reactive Attachment Disorder diagnosis represents 11% of the Hispanic females of the same age group.

Twice as many Hispanic males as compared to females among the 6-12 age group have been admitted to mental health services statewide in FY 07. The diagnoses of the males in this age group reflect clusters of externalizing behaviors while females of the same age group show diagnostic clusters of internalizing behaviors. However, among the 13-18 age groups, 50% of both males and females are diagnosed with depressive disorders.

ATTACHMENT B

DCFS Outpatient
Youth Satisfaction Survey

DCFS OUTPATIENT MENTAL HEALTH YOUTH SATISFACTION SURVEY: SFY 07

***** SUMMARY OF RESULTS *****

NUMBER OF SURVEYS RECEIVED BY REGION & SITE

REGION & SITE	SURVEYS
Las Vegas	
East Neighborhood Family Services Center	1
West Neighborhood Family Services Center	7
Central Neighborhood Family Services Center	10
North Neighborhood Family Services Center	18
South Neighborhood Family Services Center	7
Las Vegas Total	43
Reno	
Enterprise Road	14
Mill Street	36
WIN – South Center Street	17
Unidentified sites	2
Reno Total	69
Statewide Total	112

PERCENTAGE OF POSITIVE RESPONSES BY REGION & STATEWIDE
SURVEY ITEMS

	General Service Questions	LV (LasVegas) %	RNO (Reno) %	SW (Statewide) %
1.	How long have you been receiving services indicated above?			
	Less than 1 month	13	8	9
	1-5 months	20	26	24
	6 months – 1 year	23	30	27
	More than 1 year	44	36	40
2.	Are you still receiving services?			
	Yes	98	68	99
	No	2	0	1

3.	Are you currently living with one or both of your parents?			
	Yes	29	43	38
	No	71	57	62
4 a	Your			
	Age 11 – 12	8	8	8
	13 – 17	80	87	84
	18 +	12	5	8
	Gender Male	45	46	45
	Female	55	54	55
4 b	Your Race			
	American Indian/Alaskan Native	5	4	5
	Asian	0	0	0
	White (Caucasian)	48	77	66
	African American	33	7	17
	Native Hawaiian/Other Pacific Islander	2	3	2
	Mixed Race	12	9	10
	Other	0	0	0
4 c	Your Ethnicity: Hispanic			
	Yes	32	24	27
	No	68	76	73
5.	Do you have Medicaid insurance			
	Yes	82	63	70
	Uncertain	10	15	12
	No	8	22	18
6.	Have you lived in any of the following places in the last 6 months (mark all that apply)			
	With one or more parents	14	31	25
	With another family member	10	16	13
	Foster home	55	33	42
	Therapeutic foster home	33	17	24
	Crisis shelter	5	1	3
	Homeless shelter	0	0	0
	Group Home	20	31	26
	Residential treatment center	10	14	12
	Hospital	7	5	6
	Local jail or detention facility	5	11	8
	State correctional facility	0	0	0
	Runaway/homeless/on the streets	5	0	2
	Other	7	11	9

Note:	**Items 7 thru 36: Endorsement = item was scored As "agree" or "strongly agree"**			
7.	Overall, I am pleased with the services I received.	84	82	83
8.	I helped to choose my services.	69	49	57
9.	I helped to choose my treatment goals.	84	81	82
10.	The people helping me stuck with me no matter what.	78	86	83
11.	I felt I had someone to talk to when I was troubled	87	82	84
12.	I participated in my own treatment planning.	69	76	74
13.	The services I received were right for me.	87	70	76
14.	Staff explained my diagnosis, medication and treatment options.	86	82	85
15.	Staff explained my rights and confidentiality issues.	94	85	88
16.	The location of services was convenient for me and my family	84	80	82
17.	Services were scheduled at a time that was right for me and my family.	89	81	84
18.	I got the help I wanted.	82	85	83
19.	I got as much help I needed.	84	79	81
20.	Staff treated me with respect.	92	91	91
21.	Staff respected my family's religious/spiritual beliefs	90	81	85
22.	Staff spoke with me in a way that I understood	97	92	94
23.	Staff was sensitive to my cultural and ethnic background.	89	89	89
24.	I received support and advocacy from my NV PEP Family Specialist.	70	59	63
25.	My NV PEP Family Specialist made sure my voice was heard during the treatment planning meetings.	67	64	65

	As a result of services:			
26.	I am better at handling daily life.	93	81	85
27.	I get along better with family members.	75	75	75
28.	I get along better with friends and other people.	85	82	83
29.	I am better able to do the things I want to do.	75	79	78
30.	I am doing better in school and/or work.	79	80	80
31.	I am better able to cope when things go wrong.	78	79	79
32.	I am satisfied with my family life right now.	74	59	64
33.	I am aware of people and services in the community that support me.	85	82	83
34.	I am better able to handle our family issues.	73	76	75
35.	I learned helpful skills while in services.	85	82	83
36.	I have information about my developmental expectations and needs.	68	69	69
37.	In the last year did you see a medical doctor (or nurse) for a health checkup or because you were sick?	69	54	60
	Yes, in a clinic or office	8	8	8
	Yes, but only in a hospital emergency room	8	23	17
	No	15	15	15
	Do not remember			
38.	Are you on medication for emotional/behavioral problems?			
	Yes	46	63	57
	No	54	37	43
38 a	If yes, did the doctor/nurse tell you what side effects to watch for?			
	Yes	61	74	69
	No	39	26	31

39.	Most helpful thing about services received	
	Las Vegas	**Reno**
	• I don't need the services • (name) and my mom helped me for anything • That I could control my acts before I do them • Coping skills • People talking with me • I can talk to people I don't know easier • Mrs.(name) has helped me a lot • Teaching me how to cope with issues that are happening. • That they help me get an apartment • They helping me get back with my family in put me in a helpful home • Undecided • The help I asked for • Being nice • When they remove the tumor out of my head and it's gone • They helped with my job searching • My WIN worker helped me with school putting services at home and home visits take me on outing to discuss plan of care • had someone to talk to when I wasn't feeling right • All the wonderful people on my case I don't know. • When I was on the run they made sure I had somewhere to go • Not sure • It has helped my cope with my anger. Express myself better. • I don't really remember • Learning to deal with family issues • Therapy • Just having people to talk to. • You are nice to me, stick up for	• Meeting new people, learning how not to act bad • Not sure • Lots of things but the best is that(name) was a friend to me and was just there for me • I had someone to talk to and now I feel like I want to be heard • To be able to talk to someone when I need. And I know they will keep it between us • It was fun and helped out • To get me to think about things more clearly • They taught me how to deal with things. There was always someone there for me • To talk to someone about my feelings and the way I feel on a daily basis • My Therapist has been there for me no matter what and in a way she became my friend. • I learned how to deal with daily life better • Helping me get back to be closer with my family • I have learned new things about my responsibility in relationships of all areas. Everything I have learned has been very helpful. • I have only had 2 sessions that don't even count. • It has helped me through personal problems • All most everything • Don't know • I can express my feelings in different ways • Treatment plans, knowing exactly how you were going to get helped • How to deal with unwanted stress and now I have a new perspective and new outlooks on my decisions and dealing with my problems • My counselor (name) is really helpful • I love (name)! • Being able to get along with my

	interest, had help me have contact with family • I feel better that I don't have to pay for my doctor • Treatment • The WIN workers have really been there for me and helped through it • That they talk to me and help me lots, they gave me hope	grandparents and family members better • That I was finally able to get the help I needed • Having someone to talk to and bounce situations off of • Nothing because I already know all this stuff from West Hills • They never gave up on me and I can trust them • I am able to deal with things a whole lot better • Anger management, Life skills, and self control strategies • Ideas on how to cope with foster parents • That I have someone to talk to • Someone to talk to • I am able to talk to my mom more • keeping in touch with my family • The help I needed • Helping me cope with things in my life • They would listen to what I would say • Don't know • Helping me get through the fact my grandma's dead and I was raped • Tools to use when overwhelmed • Has helped me with things • Support and Loving • Good schooling • So I can see my family members • Being able to see my family members • Lending a hand and a pat on the back • Great support from (name) • Can't really tell, it's all ok • The way the plans are made • Don't know • All services received have been helpful • All services have been helpful • The help I received at school and homework • Help if I need it • Good • Being able to talk about things and the help I got • They helped me get a job • Everything • I don't know.

40.	What would improve the services you received	
	Las Vegas	**Reno**
	• no comment • family • I don't know • Everything has helped • Nothing • Extra money for money - money for just to have not just $22 • To let me have a little more freedom • A lot • Me and my own say so I speak of what I need and want to improve on. Schooling, tutoring. I need to improve more on anger • more money for things • Not having them • They right now are trying to get me back home, asap • Not sure • Shorten the time limit. Schedule an appointment every other week. Make sure student can have time to do what they want • More support • More contact with case workers • None • Nothing really • It's good. • None • Not to much, I'm content • Nothing because they talk to you and they help you lots	• How to cope to my problems • Not sure • I really don't know because I think they are pretty good right now • I have no idea • Finding a job or career that's 100% perfect for me, since I want to do everything, but not when they tell me to • If I could spend more time with my family • To have it twice a week instead of once a week • I think services are great the way it is. • Nothing • Nothing I am satisfied. • Nothing they are doing fine • No much, I'm pretty content with my services. • None. • Nothing, they're just fine • Talking to each person 1-on-1 • I don't know • I don't need any • I don't know • Amount of time each session has • what? • Nothing but a little help • Can't think of anything • Nothing • I want to start playing with objects that will get me focused on my object of talking to that specific person • Less of the get together meetings and blaming from certain people • no to be lenient • More understanding • Um well sometimes I feel as if I'm the victim Helping me with school (of classes and such) and help with my family issues and I get irritated • Don't know • more techniques • Be more specific

		• More help finding lost siblings • More involvement with my Dad • Working toward getting out of the system • Good • Closer to our house, not have to be seen so much. Not to have appointments during school

ADDITIONAL COMMENTS

Las Vegas	Reno
• (name) helped me out • No, they are perfect • No • great WIN department • No, thanks for your support • That's it. I want all the help I can get school. Anything I'm not settling for less. • I want to say thank you for all your help and support • I don't want a WIN worker • I just wish I could go home • No answer • I (heart) (name) and other workers of mine • None • It's great! • They were great people that talk to you and give you hope on moving on with your life and to become someone in your better life	• It just been fun in boys town • I love how (name) has dealt with me, I wouldn't want it any other way. • I love therapy and group. I look forward to it every week. • I want a career in silence/artistic/philosophical stuff, but all free range, I want to research/draw what I want and when I want, cause when I am in the mood is the best time. • This is bull s---. (name) sucks, you can't take away visits with my dad. • Thank you for everything you guys have done. • Thank you. • Other than what I wrote: Thank you. • (name) is a great person, aka Therapist • Thank you. • (name) is my favorite social worker • Good • Nope

ATTACHMENT C

DCFS Outpatient
Parent/Caregiver Satisfaction Survey

DCFS OUTPATIENT MENTAL HEALTH PARENT/CAREGIVER SATISFACTION SURVEY: SFY 07

***** SUMMARY OF RESULTS *****

NUMBER OF SURVEYS RECEIVED BY REGION & SITE

REGION & SITE	SURVEYS
Las Vegas	
East Neighborhood Family Services Center	9
West Neighborhood Family Services Center	13
Central Neighborhood Family Services Center	12
North Neighborhood Family Services Center	28
South Neighborhood Family Services Center	16
Las Vegas Total	78
Reno	
Enterprise Road	47
Mill Street	39
WIN – South Center Street	13
Reno Total	99
Statewide Total	177

PERCENTAGE OF POSITIVE RESPONSES BY REGION & STATEWIDE

SURVEY ITEMS

	General Service Questions	LV (LasVegas) %	RNO (Reno) %	SW (Statewide) %
1.	How long has your child been receiving services indicated above?			
	Less than 1 month	14	6	9
	1-5 months	32	28	30
	6 months – 1 year	27	27	27
	More than 1 year	27	39	34
2.	Is your child still receiving services?			
	Yes	97	99	98
	No	3	1	2
3.	Is your child currently living with you?			
	Yes	93	94	94

	General Service Questions	LV (LasVegas) %	RNO (Reno) %	SW (Statewide) %
	No	7	6	6
4 a	Child's			
	Age 0 – 6	30	23	27
	7 – 12	24	56	41
	13 – 17	43	16	29
	18 –	3	6	3
	Gender Male	66	56	61
	Female	34	44	39
4 b	Child's Race			
	American Indian/Alaskan Native	7	2	4
	Asian	1	0	1
	White (Caucasian)	49	68	59
	African American	21	9	14
	Native Hawaiian/Other Pacific Islander	3	1	3
	Mixed Race	16	19	17
	Other	3	0	2
4 c	Child's Ethnicity: Hispanic			
	Yes	37	29	33
	No	63	71	67
5.	Does your child have Medicaid insurance			
	Yes	71	78	75
	Uncertain	6	2	3
	No	23	20	22
6.	Has your child lived in any of the following places in the last 6 months (mark all that apply)			
	With one or more parents	36	42	39
	With another family member	11	10	10
	Foster home	39	35	37
	Therapeutic foster home	16	9	12
	Crisis shelter	7	3	4
	Homeless shelter	0	1	1
	Group Home	5	8	7
	Residential treatment center	7	2	4
	Hospital	5	0	1
	Local jail or detention facility	4	0	2
	State correctional facility	0	0	0
	Runaway/homeless/on the streets	4	1	2
	Other	11	9	10
Note	**Items 7 thru 38: Endorsement = item was scored as "agree" or "strongly agree"**			
7.	Overall, I am pleased with the services my child and/or family received.	93	88	90

	General Service Questions	LV (LasVegas) %	RNO (Reno) %	SW (Statewide) %
8.	I helped to choose my child and family's services.	84	82	83
9.	I helped to choose my child and/or family's treatment goals.	88	90	88
10.	The people helping my child and family stuck with us no matter what.	89	83	85
11.	I felt my child and family had someone to talk to when he/she was troubled	92	88	89
12.	I participated in my child's and family's treatment.	94	86	90
13.	The services my child and family received were right for us.	99	83	90
14.	Staff explained my child's diagnosis, medication and treatment options.	90	82	86
15.	Staff explained my child and my family's rights and confidentiality issues.	95	89	91
16.	The location of services was convenient for us	88	80	83
17.	Services were scheduled at times that were right for us.	91	94	92
18.	I received the help I wanted for my child.	85	80	82
19.	My family got as much help as we needed for my child.	81	72	76
20.	Staff treated our family with respect.	96	89	92
21.	Staff respected our family's religious/spiritual beliefs	94	87	90
22.	Staff spoke with me in a way that I understood	92	94	93
23.	Staff was sensitive to my family's cultural and ethnic background.	92	88	89
24.	I received support and advocacy from my NV PEP Family Specialist.	80	78	79
25.	My NV PEP Family Specialist supported me in leading my child's treatment planning or Child and Family Team meetings.	78	81	79
26.	My child is better at handling daily life.	74	69	71
27.	My child gets along better with family members.	68	75	72
28.	My child gets along better with friends and other people.	73	73	73
29.	My child is able to do the things he/she wants to do.	73	75	74
30.	My child is doing better in school and/or work.	62	67	65
31.	My child is better able to cope when things go wrg	60	63	62
32.	I am satisfied with our family life right now.	63	63	63
33.	Our family is aware of people and services in the community that support us.	77	73	75
34.	I am better able to handle our family issues.	79	81	80
35.	I learned helpful parenting skills while in services.	79	81	81

	General Service Questions	LV (LasVegas) %	RNO (Reno) %	SW (Statewide) %
36.	I have information about my child's developmental expectations and needs.	78	79	78
37.	In the last year did your child see a medical doctor (or nurse) for a health checkup or because he/she was sick?	70	76	73
	Yes, in a clinic or office	11	6	8
	Yes, but only in a hospital emergency room	18	16	17
	No	1	2	2
	Do not remember			
38.	Is your child on medication for emotional/behavioral problems?			
	Yes	50	48	49
	No	50	52	51
38 a	If yes, did the doctor/nurse tell you and/or your child what side effects to watch for?			
	Yes	79	84	82
	No	21	16	18

39.	Most helpful thing about services received	
	Las Vegas	**Reno**
	• (Name) has been given information, but not required to actively participate • She been more calmer at home when playing instead of hyper • He is learning to follow instructions and get along with others • My daughter and grandson can do things together without fighting. He expresses his feelings a lot more • Day treatment services • It gets him around other children and helps us because he has been through some tough times and he is learning to listen to people better • Behavioral issues and how to effectively deal with them • Involving me-the foster parent to listen in regards to the children's needs and what is best for them. Also, introducing ways to help the children not be as anxious and cope with what has happened to them • When he acts out in front of his therapist and I, she guides me thru getting him through it. Hands on help and that she comes to the home • Being there for me when I needed help the most, mostly with behavioral problems • My counselor is always there for me, I feel she does really care about my needs • Ideas to break the lying and the medicine from the Doctor • Being able to discuss problems and solutions with the therapist. The therapist makes home visits • As of yet the only helpful thing is the medication that he has been taking to improve his outlook on life in general • That he has someone that he can talk to who he can trust and it's the same person • My daughter is happier, she tries	• Learning to better communicate with her peers as in sharing, etc. Plus it went along with the parents learning new or better techniques for home • Being able to learn about his disabilities • Being able to talk and be understood helps her a lot • Everything that supports him • We just received our child 3 weeks ago. We are still getting to know the services • individual therapy • TT is teaching him to communicate, using his words. He is able to allow himself to show emotions and know that there will be no physically abusive consequences • The therapist • Only a call away • Everyone in Reno has been very kind and not judgmental that is so important because sometimes its overwhelming to deal with just the child issues much less everything else • Both children are behaving better overall • Better understanding of their emotional issues • understanding his problems a lot better • his ability to react properly to stressful situations more often than he used to • Counseling, have the same counselor at all times • Therapist's willingness to address parent concerns • Staff very easy to communicate with • Child moving to her forever family • Helping him take a look at his "part" in the problems as they arise • He is better able to cope • How she turned her life around in the past year • A person that was non-judgmental, understanding and willing to work with our unique situation • My child is more able to express her

	harder at school, she is better at making and keeping friends. She deals with her anxiety better • Having someone for her to talk to • She got the help she wanted and they talk to her • Advise on moods and behaviors • Giving my grandson someone who understands his problems. Having someone to talk to • Counseling services support for mom. Treatment center was very helpful to my service needs • Someone is finally there for our family • We are just starting. But I greatly appreciated the fact our worker was there when I phoned in and emergency after hours and was so patient and helpful • (Therapist)'s availability • We are able to talk to someone that understand her mental state. And get help and answers to her problems • That he learn a lot and he change the way he thinks • So far, he is trying. He likes being able to talk to someone other than me • The staff explained everything to me and my child so that we both understood • They actually care • My child is comfortable talking to his therapist • helping us with eye contact, we master that problem • Believe in us • Knowing that our worker cares and goes out of her way for us • That she's on a consistent routine, and she looks forward to seeing her therapist • Easy to talk to • financial support, therapy • (Therapist) has helping in every way possible • Support and effort dealing with teenage issues - school/work • Assistance with NV partners, scheduling CFT's, assistance with	feelings better about other people and family members • The encouragement and support from the therapist • He likes to talk and likes to be talked to, he likes (therapist) a lot and trust him. He also sees (private therapist). He is a much better boy knowing he can trust grandma and the people who are helping him be a better boy • Counseling and techniques • Listen, time out, eye level • That our counselor has been with us through thick and thin and has adapted treatment as needed. (Psychiatrist) manages to fit us into his tight schedule with little notice • The support • Learning ways to be obedient and respectful • We are still fairly new to this agency however it has been helpful in that I believe our therapist is well trained and knowledgeable in areas we really need to work on an the agency is helping financially. I cannot afford a private practice therapist • Support, knowing what to do for my daughter and how to deal with different situations. Teaching her how to handle and how to deal with her feelings • Getting the schooling right for him • (Therapist), he really helps us. Has always done right • Having a person out of the situation to talk to and put things in perspective. Help with lots of different parenting ideas • He has learned to better express his feelings and needs • talk therapy • Our counselor • Our counselor really understands us. She cares • He is getting better at coping with stressors and controlling his behaviors • Learning to deal with emotional issues in his life • Behavioral skills in learning home • Is that my daughter has someone to trust

	placement section, school truancy • Having CFT meetings and linking services in the community. WIN facilitator has always been helpful and willing to communicate • Transportation, the other services that were so-called provided weren't worth a Damn • The therapist and workers have all been very helpful to our foster child and family • An additional person for her to speak with and provide support • Continuity and consistency • Understanding more about his self • Seeing a therapist • Evaluating my daughter • Communication • Tutoring - supporting, great people • Being able to ask questions and get answers on how to deal most effectively with my child's behaviors to most benefit her and our family • My children are not acting out as much as they used to. They are getting along with each other better now. They also get along with other people better as well • We are trying to get her to talk to us • counseling with (therapist) • Seeing the therapist and boys and girls town family preservation • Dealing with his anger issues • Therapy and tutoring	who can help her sort out what is appropriate and what is not. Thank you! • The building of self esteem • Improving listening skills, improving behavioral skills • Behavioral advise, social skills training • The emotional support and calm approach to crisis • Our therapists understanding of our sons issues • Her ability to cope with her life's everyday challenges; that were more difficult to handle; a short time ago • Some good advice • Diagnosing and collaborating with me about my child's behavior • Patience and not giving up • The help received has been phenomenal. I always had my WIN worker or PEP worker to talk to and help me with information, food, presents and support • being there for support • Help with visits with family • Support with family and mental health services • Consistent services, improvement in clients plans, consistent improvements and plans • Learning about all resources available for the child • The child proofing kit • No one has been very helpful • Support from (therapist) has been so helpful the night terrors have been almost totally eliminated • Services help us by allowing us to understand and positively respond to our child's issues • Learning about rules, social skills, manners • learning how to handle emotional problems • Learning how to work with other • I think being in the child find has helped him a lot, going to school and his therapy also • Being able to talk things out

		• knowing that her counselor really cared about her and making our family stronger • Reinforcement • Getting them to talk about how they are feeling • My anger • The support and understanding for my child and for myself • As foster children they are learning how to cope better with their family situation an their behavior is improving • We just started • Constant re-evaluation of the children's needs • Having a place for my daughter and I to deal with our issues together in a safe place and with a mediator • Counselor is usually available by phone to help deal with pop up situations • (Therapist), she has a positive way of making people accountable • Child just needs someone to talk to that is not in our home • The information I received so I can help and deal with my children's issues at home and in school • The information I received so I can help and deal with my children's issues at home and in school.

40.	What would improve the services you received	
	• Nothing really I'm happy with the services • We're only in the first couple of sessions, so, so far, I don't see any need for improvement • I am very happy with the services that I have received	• None I know • More in depth one/one, study of other meds • Nothing
	• More availability on the Dr.'s end regarding being able to see him more quickly to help resolve medication issues. It took 2 months before my son was able to see Dr.(name) • If my son was to open his mind and	• Push the system to make sure that when reunifying children with family they keep the child feeling secure in their environment and not giving the parent (abuser) so much control. It's the child that was hurt

	trust that we are all trying to help him instead of feeling punished • More short-term specific treatment goals discussed between parent and therapist. More info to parent about the child's diagnosis/condition and ways to deal with it more effectively at home • I wouldn't recommend anything different • It's all good • I think that I'm getting it now with Dr. Schrader tutoring them and having them both attend NCC. I can see a great change in them for the better. It's taking time since I've had them for 3 months • That my child would express herself more instead of keeping things in • It's too early to determine • If she was able to see him more than once a week • Being able to see the doctor sooner • ore resources for family and son. Especially for school, groups. Groups for kids • Have no problems so far • Therapy and life skills to catch up child's development • Don't know yet, have not thought about it yet • Where and how we can get help financially • Counseling • More therapist because one of my children are receiving the proper services and one has been waiting over 4 months • I don't know • Monetary support for outings - travel, etc. • Everything about these programs and services • None that I can think of at this time • That the care about our life to be better • Re-unification • More communication! • Ways to insist on the discipline	• Later or evening appointments, leaving work has problems • Better understanding of discipline with bad behavior • I am happy with the way things are now • Services are fine the way they are right now • written report / updates • More sibling meetings together brother and younger sister • To keep coming to our counselor and receiving services to help with any emotional issues my child may have or will have • Day treatment for the 4 year old (waiting list) • I feel the services he has and we all have are great • Closer location to Fallon, NV • It's wonderful to have service to help my beautiful son, it helps him and all of our family • I am very satisfied with our services • Being able to talk and have fun with the person that treats me • I do not know what else you can do • More communication! • Being able to receive services in the Fallon area, traveling takes up a lot of financial means for us - so I can't do counseling as often • At this time I am still too new to the agency to answer this fairly • A home visit to see about suggestions on how to help more at home • Nothing • nothing that I can think of • Nothing. • I feel he needs occasional one on one with therapist to talk about the issues • Nothing at this moment, therapist is doing a wonderful job with my daughter • More parenting classes and parental counseling hard to be a good parent when you are emotionally all screwed up • Stop solely blaming parents for a bi-polar child's oppositional behavior • Communication

	required to do the things required to go forward into adulthood • Nothing • I think he needs more speech • More locations and other options for • coverage in different income ranges • Have a day care program that helps people like Rebecca and myself, to care for children that are not with their parents • Assistance with Medicaid application • I cannot think of anything right now • Nothing I can think of • More feedback from the therapist about what's going on in the sessions so I can continue to help her with her goals at home so I can know what to expect at home and how to handle it best • They have offered so many services to us so far we are doing fine with all the services right now • If I had more cooperation from certain individuals	• No suggestions • Available sensory integration testing • Nothing else as of now • When I relocate back to California, if they could find some resources for me • If maybe the parents were helped with setting goals to better their and their children's lives and maybe schedule • activities • Tutoring, active programs • She needs job services and plan for after care - concerns about how she can receive support after she leaves care • A bigger role in planning services. Less condescending social workers • Social workers need to listen to foster parents not just pretend • More help for the foster mother • Better communication and willingness to work with school system, more on the part of Washoe County than DCFS • More or some representation in court • not sure • keep doing what you doing it's a good job • more sessions • Undecided • I don't know • I am very happy - Thank you all so very much • Helping (child) with her fears and pain • The therapist reporting accurate information • Can't think of anything • Not to have them every week, twice a month would be better • I'm really not sure - everything has been very helpful • One location only and a "campus" pharmacy

ADDITIONAL COMMENTS

Las Vegas	Reno
• This has been the best thing for my daughter and myself. I don't know if I	• Questions were tough because we've only had 5-6 appts (3/girl) so it's still early to

could have handled any of this on my own

- We are thankful for the services that are provided for our son. We don't have mental health coverage and our sons life was at stake. Thank you for helping our family
- Outstanding people skills! Very kind and understanding therapist
- I just wish father was more involved
- Thank you for your services
- None
- A school for (child), a safe school, need more education for school systems/teachers
- None for now. So far, so happy with our worker and the fact that we have finally got the help organized we have needed and tried to set up for so long
- Well I thank them lots to staffs ? ? For helping
- Thank you, we are looking for help and any door was open just here. Thank you so much
- That there are more family and teenage therapists. More, more, more and be more flexible with the different Medicaid coverage, i.e. Nevada check up or HPNOR it's all Medicaid, don't really understand
- Our family truly appreciates all the hard work DCFS provides to use and our community. Thank you!
- This program is excellent for teenagers - great assistance with teenage problems
- This win has gone above and beyond the expectations. She was responsive to crisis occurring w/ teen placements and has a great relationship with kids and team members
- You would have to call me for all additional comments
- Keep up the good work.
- First year, everything is going fine.
- (Child) has not learned to be responsible. He is spoiled, empowered and feels entitled.
- I like (therapist) she is a good person.

judge

- use her for my own children if the need was there
- (Name) not only helped my granddaughter but she helped with all of her issues and help me with the issues (name) brought to my home. I cannot express how much (name) has helped us I wish she was open to the public, I would
- Thanking (therapist) and (therapist) for their time and efforts
- I am a foster parent of many children. The services at CBS has been below standard in all respects with the exception of (therapist) whom is always helpful. Other than (therapist)'s services, I have tried to steer my kids away from this facility due to constant poor performance
- (Therapist) has been a huge blessing in our lives. Our family is very grateful to be receiving help from her
- I like coming to our counselor and our treatment plans that we work out. I feel very comfortable with all staff members. My calls here were always prompt and friendly all staff members are friendly and understanding.
- I would really like it if my child could come her while being on NV Checkup. I had to drop my child from NV Checkup because she could not be treated by professionals at DCFS. So now she has no health insurance because it would be a conflict. Because of this I have to pay $250 out of my pocket for her medications to help control her behavior.
- think the services I'm receiving are exceptional.
- It would be best for both parent/guardian and child if counselor would involve parents more.
- Thank you
- (Therapist) is great!
- (Therapist) has been a HUGE help to our family. He is a wonderful counselor!
- Had great success with CBS
- Feel father should be in on session once in a month via phone.
- I am thankful to have CBS working with my daughter, I no longer have to challenge the behavior alone, therapist is

- Work with the courts and have definite guidelines so the program works to reunite children with their parents in a timely manner, after all its about being responsible when people have children. In my case, these children are a burden in my life. I love them, but will not raise them their entire life unless i have too.
- I am very grateful for the services we have received
- Thank you to (therapist) to help us with (child)
- The people that have assisted me - were wonderful. These services should always be available to help/assist all families in need.
- (Name, name & name) are wonderful awesome people, they know their job well.
- Communication, communication! I need to be aware of how I can best help and what is being worked on in therapy so there can be carry over in the home. It is my responsibility as parent and caregiver to give her the best. I need the tools to do this.
- I am thankful of all the worker that keeps in contact with me all the time still.
- Really think that the worker you sent us has really help my whole family. When she comes she includes my whole family in her visits. We are going to miss her when she stops coming to see us.
- Thank you

wonderful and connects great with my daughter.

- The process has taken too long. We have been given invalid information from Child Services
- Activities are very hard to find out about where children are concerned, that can include entire family and then how to reach those goals.
- The WIN team is very helpful and supportive
- The social worker needs to listen more to parent concerns about health care needs. Especially with very disabled children with rare disorders they have not heard of.
- I just would like to add that the interaction with PEP is great they were quite willing to do whatever we needed for our child. Thank you.
- Good, useful sessions
- would be nice to know what is developmentally expected at his age
- We are new to this service. I hope this helps my child.
- No, just Thank you again.
- Our therapist reports false information to S.S.
- The therapists are great with these kids
- We appreciate all that CBS has done for us so far and look forward to our continuing sessions.
- Thanks to the staff for all their help and support.
- Our therapist (name) is wonderful. She's our saving grace.

ATTACHMENT D

DCFS Residential and Psychiatric Inpatient Youth Satisfaction Survey

DCFS RESIDENTIAL AND PSYCHIATRIC INPATIENT
YOUTH SATISFACTION SURVEY: SFY 08

***** SUMMARY OF RESULTS *****

NUMBER OF SURVEYS RECEIVED BY REGION & SITE

REGION & SITE	SURVEYS
Reno	
Adolescent Treatment Center	14
Family Learning Home	11
Reno Total	25
Las Vegas	
OASIS Group Home	17
Desert Willow Treatment Center Acute Adolescent Program	9
Desert Willow Treatment Center Children's Acute Program	0
Desert Willow Treatment Center RTC 1	10
Desert Willow Treatment Center RTC 2	12
Specialized Adolescent Treatment Program (SATP)	10
Las Vegas Total	58
Statewide Total	83

PERCENTAGE OF POSITIVE RESPONSES BY REGION & STATEWIDE

SURVEY ITEMS

	General Service Questions	RNO (Reno) %	LV (LasVegas) %	SW (statewide) %
1.	How long have you been receiving services indicated above?			
	Less than 1 month	20	21	20
	1-5 months	68	65	66
	6 months – 1 year	8	12	11
	More than 1 year	4	2	3
2 a	Your			
	Age 11 – 12	8	10	10
	13 – 17	92	88	89
	18 +	0	2	1
	Gender Male	52	56	55
	Female	48	44	45
2 b	Your Race			
	American Indian/Alaskan Native	4	3	4
	Asian	4	0	1
	White (Caucasian)	45	52	51
	African American	0	16	11
	Native Hawaiian/Other Pacific Islander	0	3	2
	Mixed Race	40	24	29
	Other	4	2	2
2 c	Your Ethnicity: Hispanic			
	Yes	39	33	35
	No	61	67	65
Note:	**Items 3 thru 28: Endorsement = item was scored as "agree" or "strongly agree"**			
3.	Overall, I am pleased with the services I received.	56	53	54
4.	My educational needs were met while in acute-residential services	58	65	63
5.	I helped to choose my services.	48	37	41
6.	I helped to choose my treatment goals in the treatment team meeting.	64	59	60
7.	The people helping me stuck with me no matter what.	56	71	67

	General Service Questions	RNO (Reno) %	LV (LasVegas) %	SW (statewide) %
8.	I felt I had someone to talk to when I was troubled	60	55	57
9.	I participated in my own treatment planning.	72	60	64
10.	I received services that were right for me.	44	62	57
11.	Staff explained my diagnosis, medication and treatment options.	60	67	65
12.	Staff explained my rights and confidentiality issues.	80	81	81
13.	Services were scheduled at times that were right for me and my family.	63	68	67
14.	I got the help I wanted.	52	55	54
15.	I got as much help I needed.	56	61	60
16.	Staff treated me with respect.	43	71	63
17.	Staff respected my family's religious/spiritual beliefs	73	74	74
18.	Staff spoke with me in a way that I understood	68	81	77
19.	Staff were sensitive to my cultural and ethnic background.	50	63	59
20.	Services are provided in a safe, comfortable environment that is well cared for.	56	70	66
21.	Visitation rooms are comfortable and provide privacy with my family.	46	53	51

	As a result of services:	RNO (Reno) %	LV (LasVegas) %	SW (Statewide) %
22.	I am better at handling daily life.	84	77	79
23.	I get along better with family members.	88	77	80
24.	I get along better with friends and other people.	84	80	81
25.	I am doing better in school or work.	83	65	71
26.	I am better able to cope when things go wrong.	72	67	68
27.	I am satisfied with my family life right now.	67	70	69
28.	I am aware of people and services in the community that support me.	64	70	68

29.	Most helpful thing about services received	
	Reno	**Las Vegas**
	• Staff to help me calm down when I am in need • Making friends and being able to talk to those friends • That my therapist was able to tell me what I was doing wrong so I could fix it..	• (Name) is helping me with my anger (name) has cared about me ever since I got here. • Accepting feedback • It was just what I needed • Cooking, helping people out • I am learning how to read and write

	• Nothing - I was already helped • I can talk to staff and I can play video games • Staff named (name), the skills • I got help • Separation from my mom so we don't fite as much • That they help me when I need it • They help me • Therapy with (name) and being able to realize I take things for grantit • How to follow instructions, listen, and give feedback. • Having to use a point-card system • They try their hardest to calm me down when I am mad • Going to school and doing the work • That I am not so emotional cause I know this is right home for me. • It has helps me become closer with my family. • So far right now nothing • Being able to spend more time with my mom • Help with my anger issues, and responding to people, and communicating • The care of others and the love that everyone's given me.	• I like my services because (name) is respectful • The way staff are here to help when in doubt • Learning how to be respectful to staff and family. • Providing supplies/things • I got the help I needed • They help me with my homework. • When I'm getting angry they help me calm down • (Name) coming in here helping me with math. • Them helping me with my anger • I like to play and bike and skateboard • Going on outings • They help me to calm down • Therapy with (name) • Taking advice from my elders and really using it. • Making goals meaning: getting to choose what goal I would like to work on • Medication, therapy, parent session. • Getting time to think My medication • Dessert Willow • The medication is very helpful I am glad that I asked for it • Meds • The people • Teaching myself on passes • I can control depression • The family therapy • Nothing. I haven't got help. Staff are very rude and they talk about my info among other staff. • None. I was told that I don't fit the criteria so they're supposedly releasing me in a couple months. But regardless they still are keeping me longer than necessary. • Anger • Having People to talk to • My therapist listens to me • I am making levels • That the staff are there for you • That when I have a problem I am able to talk about it and are offered cooping skills. • Counseling • My case worker and therapist on the acute adolescent program • The groups • The staff here at DWtc. They are every thing to me especially (name)

		• Coping skills • Family sessions • They help me with my problems. • I'm trying to learn something instead of just Being here & learning with no knowledge • That when I am stressed and need to talk to some one. They helped me. • My treatment learning that what I did was wrong • The counseling • That I can know how to relate to my peers. • Finding my danger signals • It's helped me in realizing my inappropriate behaviors. • The day I got beted up I did not reoffend

30.	What would improve the services you received	
	Reno	**Las Vegas**
	• No more (support) staff. I don't think they are qualified to our needs, like other staff • More respect with the staff and staff not choosing favorites • Not just watching movies all the time and room time • Nothing • Less time in room • Better food, more time with family, Able to have your blanket, Able to have I-Pods and burned CDs. I need my music • More focused on patient, listen to their needs • Better food. Seriously its like cardboard most the time • I don't know • No! Because I don't need help that much • Staff don't belittle me • I don't know. • Having more work and in a different way with all of the skills to learn and remember them properly. • Burn the house down • That they wont fly off the handle so	• Nothing • More feedback • No • Make pt less time for lv:2 and 2 weeks longer for LV:3. • An award • More stuff to help me when I can't see my family • Coping more • If staff wouldn't say they understood if they don't • I really don't know • Care more, instead of hate • Would like to see this place a little more safe centered • Even more help with anger • They would make me toast, oatmeal and cereal. • Nothing • To not be sad about my family • Talk with me more • Staff put them in us kids shoe's and then they will know what we really been through. • To be able to do more coping skills instead of keeping everything inside

	fast • Being able to see my family more as in I can do loss there and more over nights. • Nothing really • Just be there for me and show me support	• The staff be more nice and caring • Dessert Willow • If they let me go home • I don't know • Nothing-it is top notch • Better teachers, staff members that help, not be jerks! • If staff would support reliqions. • Try training your staff! • Anything • Food and beds and more activities • Food,beds,and more activities (gym) • Try to help me a little bit more. My room has dust bunnies & bugs. They don't mop the floor that much • If they let me visit every day • Not sure • Some respect, and for staff to be familiar with my treatment plan, and my problems • If they were more fun • More social groups (interacting) • More therapy sessions • If we got to see our siblings at visits and got to put family friends on a calling list not sure • If they would take a chance to listen to me. • They need to actually care and help you • This facility is alright I am glad I am here. • I wouldn't They are good how they cure • Don't know • No privs • I can't think of anything

ADDITIONAL COMMENTS

	Reno	Las Vegas
	• I do not like younger staff! They are too much like the kids! And the younger children of 13 should not be with the older young adults of 17 • Yes, well I do think we need better food and some juice every now and then • Let me out and let me go to a group home • I hate this place Im Level Nego	• I love you all • May I please be moved up to LV:2?! • Life be peace • II west is the best (? #2 west) • They help people • I've been riding a scooter - that's the fun part • I want to do better with reading • I just want to go home to my grandma • Thanks for all the help!! (followed by a

	Reno	Las Vegas
	and they won't let me go home I miss my family. • Great job • Have a nice day • Staff is power hungry they play big me little you. Staff lectures my 44 year old mom about life. • I think we should be able to have longer passes to spend time with the family so we all can work together longer. • This program is awesome the staff works w/you all the time • Yes, I would like it more if I can do lots at home, and if I can get to overnights. • Thank for showing me care	drawn happy face) • I would love to go home! • I don't like this place it is horrible I want to go home • The teachers here don't teach, they only see their way! • You people should (be) ashamed in running such a poor program • Keeping me here when they tell me I don't fit their criteria is a violation of my rights • I'm disappointed in you people • I'd like more help in getting along better with my family • The staff are great. I learn from my mistakes Please do something about the food • Need better food • The staff here doesn't schedule time for visits, and often have a group scheduled during our only phone time. I haven't been allowed to call my mom for 3 days • I have a thinning of the eye (cannot have head hit) staff were not careful with that. • Yes. Please do something about the food here. • I am glad I can be able to know I can get help. • This place is extremely boring

ATTACHMENT E

DCFS Residential and Psychiatric Inpatient Parent/Caregiver Satisfaction Survey

DCFS RESIDENTIAL AND PSYCHIATRIC INPATIENT
PARENT/CAREGIVER SATISFACTION SURVEY: SFY 08

***** SUMMARY OF RESULTS *****

NUMBER OF SURVEYS RECEIVED BY REGION & SITE

REGION & SITE	SURVEYS
Reno	
Adolescent Treatment Center	4
Family Learning Home	3
Reno Total	7
Las Vegas	
OASIS Group Home	2
Desert Willow Treatment Center Acute Adolescent Program	2
Desert Willow Treatment Center Children's Acute Program	0
Desert Willow Treatment Center RTC 1	6
Desert Willow Treatment Center RTC 2	2
Specialized Adolescent Treatment Program (SATP)	0
Unidentified program	1
Las Vegas Total	13
Statewide Total	20

PERCENTAGE OF POSITIVE RESPONSES BY REGION & STATEWIDE

SURVEY ITEMS

	General Service Questions	RNO (Reno) %	LV (LasVegas) %	SW (Statewide) %
1.	How long has your child been receiving the services indicated above?			
	Less than 1 month	14	8	11
	1-5 months	72	58	63
	6 months – 1 year	0	34	21
	More than 1 year	14	0	5
2 a	Child's			
	Age 9 – 12	43	64	56
	13 – 17	57	36	44
	18 +	0	0	0
	Gender Male	57	42	47
	Female	43	58	53
2 b	Child's Race			
	American Indian/Alaskan Native	0	0	0
	Asian	0	0	0
	White (Caucasian)	86	67	74
	African American	0	17	10
	Native Hawaiian/Other Pacific Islander	0	0	0
	Mixed Race	14	16	16
	Other	0	0	0
2 c	Child's Ethnicity: Hispanic			
	Yes	20	20	20
	No	80	80	80

	General Service Questions	RNO (Reno) %	LV (LasVegas) %	SW (Statewide) %
Note:	**Items 3 thru 31: Endorsement = item was scored as "agree" or "strongly agree"**			
3.	Overall, I am pleased with the services my child and family received.	100	92	95
4.	My child's educational needs were met during his/her stay in acute-residential services	100	75	84
5.	I helped to choose my child's services.	100	73	83
6.	I helped to choose my child's treatment goals in the treatment team meeting.	100	73	83
7.	The people helping my child and family stuck with us no matter what.	71	91	83
8.	I felt my child and family had someone to talk to when			

	General Service Questions	RNO (Reno) %	LV (LasVegas) %	SW (Statewide) %
	he/she was troubled	86	91	89
9.	I participated in my child's treatment.	100	100	100
10.	The services my child and/or family received were right for us.	57	75	68
11.	Staff explained my child's diagnosis, medication and treatment options.	100	100	100
12.	Staff explained my child and family's rights and confidentiality issues.	100	92	95
13.	Services were scheduled at times that were right for us.	86	100	95
14.	My family got the help we wanted for my child.	43	75	63
15.	My family got as much help as we needed for my child.	57	75	68
16.	Staff treated me and my family with respect.	86	92	89
17.	Staff respected my family's religious/spiritual beliefs.	100	88	93
18.	Staff spoke with me in a way that I understood.	100	83	89
19.	Staff were sensitive to my cultural and ethnic background.	83	83	83
20.	Services are provided in a safe, comfortable environment that is well cared for.	86	92	89
21.	Visitation rooms are comfortable and provide privacy with my child.	86	67	74

	As a result of services:	RNO (Reno) %	LV (LasVegas) %	SW (Statewide) %
22.	My child is better at handling daily life.	71	58	63
23.	My child gets along better with family members.	71	58	63
24.	My child gets along better with friends and other people.	71	58	63
25.	My child is doing better in school and/or work.	86	58	68
26.	My child copes with difficult situations much better.	71	58	63
27.	I am satisfied with our family life right now.	71	67	68
28.	Our family is aware of people and services in the community that support us.	57	67	63
29.	I am better able to handle our family issues.	100	67	79
30.	I learned helpful parenting skills while in services.	86	58	68
31.	I have information about my child's developmental expectations and needs.	100	75	84

32.	Most helpful thing about services received

	Reno	Las Vegas
	• That my child has become calmer and less difficult when told to do something she has not wanted to do • Having someone else back me up with a plan of action for my child • The wonderful attitude of all the people • He is learning how to control anger better • My son received positive feed back and reassurance to gain positive affirmations. • Patience by staff	• (Client) has learned how to respect adults a lot better and he is a much better behaved child. • (Client) has learned anger management skills • She just began treatment at Desert Willow so I don't know yet • Learned that everyone has responsibilities and rules that have to be followed • Learning to cope with anger • Staff always available • All the staff were very well informed & they worked w/her not just putting her on more meds. • The understanding from the staff and concern. She phone calls w/info about my child no matter the time • Trust her, respect • Our child seems to be much more respectful.

33.	What would improve the services you received	
	Reno	**Las Vegas**
	• That is undecided at this time • I think some staff members should attend maybe more classes on how to better deal with some of the children. • Everything is fine • Just keep doing what you doing? • Parent training including child but not all the time. • More ability to deal with out-of-control son in public	• Nothing - You are all doing a great job with (client) • My continuous participation in his school • Explanation of meds better, and child's daily routine • I can't think of anything off the top of my head. • Better nutritional program

ADDITIONAL COMMENTS

Reno	**Las Vegas**
• I feel that the kids should be able to leave for holiday regardless of what level they are on. Holidays are for family to be together not apart. • Some staff members seem a little immature for their responsibilities here, sometimes you wonder which one is the child! However, every concern I have voiced has been addressed in a timely manner • Happy to have (client) home.	• The staff is great and are really good at letting me know what is going on in his home and school life. (Client) still has his moments but he has really come a long way. Thank You! • Thank You

ATTACHMENT F

Division of Child and Family Services
File Review FY 07

DCFS FILE REVIEW

The focus of this paper is the investigation of DCFS mental health services delivery process documentation compliance with standard of care set forth in Chapter 400 of the Nevada Medicaid Services Manual.

Since the implementation of the transformation of children's mental health services in January 2006, child serving agencies in Nevada and their service providers are required to comply with service delivery standards when documenting their client mental health services in the client files.

DCFS Planning and Evaluation Unit (PEU) performance and quality improvement plan objective is to provide ongoing quality assurance activities regarding service delivery process documentation requirements. The purpose of the client file review is to identify areas of strength as well as areas of improvement necessary in documentation in order to meet the standards set by the Medicaid Services Manual Chapter 400.

Method

File Selection:

Random sampling of records was accomplished according to a process recommended by the Council on Accreditation (COA). This process consisted of first establishing the number of children served in FY06. The children served were identified by their case record numbers to account for an unduplicated number of 2246 children served. COA quality assurance standards recommend annual file reviews of 30% of the children served which resulted in 674 files. Further breakdown of the number of files for each quarter was 168.

Based on this projection, a random sampling of 168 files of active clients in FY07 from all of the DCFS mental health programs statewide was identified by case number.

Review of these cases was conducted by PEU during the months of June and July 2007. 105 files were reviewed in the Southern region and 58 files were reviewed in the Northern and Rural Region. Table 1 illustrates the distribution of files reviewed from each DCFS mental health programs. Five files were not reviewed for such reasons as the child was in an out-of-state placement.

Table 1 DCFS Client Files by Program and Region

	Early Childhood Services	Outpatient/Children's Clinical Services	Wraparound In Nevada	Desert Willow Treatment Center	OASIS / Learning Homes	Adolescent Treatment Center	Total
SNCAS	35	30	30	8	2		105
NNCAS	18	17	10		4	4	53
Rural WIN			5				5
Total	53	47	45	8	6	4	163

File Review tool: This tool, developed in May 2007 according to specifications of Chapter 400 of the Nevada Medicaid Service Manual, went through a series of revisions following several file review trials as the PEU reviewers worked on developing rater reliability during the months of April and May 2007. DCFS File Review Tool (see Attachment A) consists of 46 indicators that capture the following areas of documentation: Client Rights and Client Privacy; Medical Necessity; Assessment; Treatment Plan; Discharge Plan; Progress Notes; 90 Day Reviews; Child and Family Involvement; Care Coordination and Discharge Summary.

Data Collection and Rating Process: PEU raters accessed all the closed files from medical records and all the active files from respective service providers at their specific sites and region. Hard copy file reviews were also supplemented by review of the documentation in Avatar and UNITY when available.

Each file was identified by program, provider, and episode number. File Review Tool indicators provided the guideline to determine the documentation of the information in the client's files. When the documentation indicators were present in the file, the rating

response was "YES." When the information was missing, the rating response was "NO." Certain documentation indicators were not applicable with all service processes and they were marked as "Not Applicable." The indicators are as follows:

Monitoring of Treatment- 90 Day Review:

- Some cases were terminated or transferred to other services prior to 90 day review.

Child and Family Involvement:

- Some children were too young or developmentally not ready to participate in developing their treatment plans
- Some families were not be available to participate in treatment planning or at 90 day reviews

Discharge Summary:

- Transfer to another program was not indicated at discharge on all cases.
- Recommendation for further treatment was not indicated on all cases.

File Review Results

Table 2 and Table 3 illustrate the file review results for SNCAS and NNCAS mental health programs (see attachment B) in three categories of:

a) Areas of Strength identified as indicators with 85% compliance and higher;
b) Satisfactory areas identified as indicators with compliance rate of 70-84%; and
c) Areas for improvement identified as indicators with compliance rate less than 70%.

These tables provide a quick overview of the DCFS program documentation performance at each region and reflect the satisfactory and high compliance rate with documentation indicators as well as areas for improvement.

The highlights of the documentation file review findings are summarized in Table 4 according to the number of indicators present in each category for each program. Each mental health program documentation performance measured by file review checklist tool specifies the number of indicators that assess compliance rate to documentation standards.

Table 4
Statewide Compliance with Documentation Indicators*

SNCAS			
Programs	**Adherence to Number of Documentation Indicators**		
	Strong Compliance	**Satisfactory Compliance**	**Areas for Improvement**
DWTC	**35**	**4**	**4** (3 Not Applicable)
OASIS	**32**	**--**	**12** (2 Not Applicable)
ECS	**19**	**11**	**16**
WIN	**26**	**8**	**12**

CCS	**7**	**9**	**30**
NNCAS			
Programs	**Adherence to Number of Documentation Indicators**		
	Strong Compliance	**Satisfactory Compliance**	**Areas for Improvement**
ATC	**31**	**5**	**9** (1 Not applicable)
Learning Homes	**10**	**12**	**23** (1 Not applicable)
ECS	**11**	**13**	**22**
WIN Reno	**31**	**4**	**11**
WIN RURAL	**13**	**9**	**24**
Outpatient	**8**	**12**	**26** (1 Not Applicable)

*There are a total of 46 documentation indicators.

DESERT WILLOW TREATMENT CENTER: 8 files were selected for this review, and 35 of the documentation indicators were in the area of strength with 4 indicators in the satisfactory area.
Desert Willow Treatment Center (DWTC) files had the highest compliance rate with the documentation indicators. This is the only DCFS program in the Southern Region that has discharge planning documentation.

Areas for improvement are reflective of implementation of service delivery policies. For example, CASII implementation was in October 2006, therefore some files did not have CASII assessments. Similarly, standardized documentation format in writing progress notes (DAP) has not yet been officially implemented yet.
Treatment goals and objectives in developing the treatment plan are not expressed in the words of the child/youth or family/caregiver or guardian. The language of the treatment goals and objectives documented is consistent across all programs in the southern region and reflect the challenges in adherence to system of care principals.

OASIS On Campus Treatment Homes: With only 2 files selected from OASIS, caution is recommended in analyzing the findings of the file review. Documentation compliance review showed that 32 indicators were in the area of strength.
Some areas of strength worth noting are in Medical Necessity of services and the development of Discharge Summaries. Six indicators that support Medical Necessity of Services all had 100% compliance with the documentation indicators. Also, eight out of nine documentation indicators for Discharge Summary all had 100% compliance.
Oasis and Desert Willow Treatment Center are the two programs in the Southern Region where discharge/transition criteria is documented by identifying the agencies or independent providers in the community for aftercare services.
Areas for improvement address the enhancement of treatment planning process. Participation of the child in developing individualized treatment plans with goals and objectives that are expressed in the language of the child and family are areas that need improvement. Treatment goals and

objectives need to address the discharge criteria in each treatment plan. Also, Child and Family Team meetings with their participants and decision makers for service delivery need to be documented at a minimum of 90 days.
Discharge Plans and implementation of a standardized documentation format to track services also needs to be addressed in order to increase adherence to documentation indicators.
Both Desert Willow Treatment Center and OASIS On Campus Group Homes did not use billing codes for services delivered. Both programs bill under a core rate.

EARLY CHILDHOOD SERVICES: 35 client files were selected for the documentation review with results of 19 indicators in the areas of strength and 11 indicators in the satisfactory area.

Early Childhood Services file review reflects strong compliance with the indicators regarding client rights and privacy, medical necessity of services, assessments completed in a timely manner, treatment plans with five out of seven indicators effectively documented. Progress notes for monitoring the treatment process and care coordination have 100% compliance in documenting billing codes that are consistent with types of services delivered. This is the highest rate of compliance among outpatient services. Also, this program has detailed discharge summaries that address the effectiveness of treatment, progress or lack of progress toward treatment goals as documented in treatment planning.

Areas for improvement in documentation are in Treatment Planning process to address the language of treatment goals/objectives that need to be in the language of the parent/caregiver or guardian. Discharge criteria for each treatment goal/objective also needs to be included in the treatment plans with the scope, amount and duration of specified services recommended and providers who will serve the child are identified.

Discharge Plan and Child and Family Team meeting documentation are also areas that need improvement. Discharge summaries, in order to meet Medicaid standards, require the last service contact date, diagnosis at intake and at discharge with implementation steps towards transition or discharge. Among the files reviewed, progress notes that track service delivery did not follow a standardized format (DAP) which is one of the documentation indicators.

WRAPAROUND IN NEVADA: 30 client files were selected from WIN in the southern region with results of 26 indicators in the area of strength and 8 indicators in the satisfactory area.
WIN program has implemented a standardized format for documentation (DAP) of progress notes with a compliance rate of 75%. Child and Family Involvement in developing Plans of Care and 90 Day Reviews for monitoring treatment are both areas of strength for WIN program documentation which is the highest rate of documentation compliance among outpatient programs in the southern region.

Areas for improvement are in treatment planning process to include discharge criteria for each treatment goal that is expressed in the words of the child/youth/caregiver or guardian are documented. Absence of Discharge Plan documentation in the files that address the anticipated duration of overall services based on anticipated time of goal or progress achievement is missing in documentation across all outpatient programs. It is recommended that Discharge Summaries include the child's diagnosis at time of intake as well as at discharge. Also, the implementation steps towards transition or discharge need to be addressed in the discharge report.

When compared to the most recent WIN file review findings of 16 charts selected by the program supervisors in October 2006, the WIN program has indeed made some good strides in documentation process. The last file audit identified both treatment planning process and the monitoring of the treatment documentation with 90-day reviews as areas that needed improvement. The current file review findings show an improvement in both of these processes. In fact, WIN 90 Day Review documents in monitoring treatment show the highest rate of compliance in the southern region. Also, WIN treatment plans include specific treatment and care

coordination that address the amount, scope, duration and provider of services more frequently than any other outpatient services in the southern region.

CHILDREN'S CLINICAL SERVICES: 30 client files were selected from CCS with results of 7 documentation indicators in the area of strength and 9 indicators in the satisfactory area.
CCS file review results showed high compliance documenting client rights and client privacy, medical necessity for services and care coordination. Compliance in documenting billing codes accurately and reflecting what was requested in the assessment, treatment plan and progress note consistent with type of services delivered had a compliance rate of 97%. This high compliance with accurate billing codes consistent with type of services delivered is an area of strength across all outpatient services in the southern region.

Areas for improvement in documentation are timely completion of evaluation of client's history and functioning that includes strengths and needs of the child and family and assessments (CASII and CAFAS) and updates of treatment plans within 30 days of services. 90 day reviews as well as
discharge summaries fail to summarize treatment effectiveness and progress (or lack of progress) towards treatment goals and objectives as documented in the treatment plan. Absence of Discharge Plan documentation and a standardized method for documentation of progress notes are also areas that need improvement for most of the outpatient programs in the Southern Region.

When these findings are compared to the most recent 14 CCS files reviewed in October 2006, areas that need improvement reported previously are consistent with the findings of the current file review.

Table 5 summarizes SNCAS file review results for areas that need improvement by each program. Shaded areas identify documentation indicators that need improvement.

Table 5
SNCAS File Review Results
Areas for Improvement by Program

	DCFS Southern Region Mental Health Programs	DWTC	OASIS	ECS	WIN	CCS
	Number of Files:	**8**	**2**	**35**	**30**	**30**
	Client Rights/Privacy					
	Release of Information completed, expiration of 1 year or less, signed.					
	Medical Necessity					
	Intensity of Service Need (CASII or instrument for early childhood) completed at intake, every 90 days, at discharge or upon substantial change in status.					
	Level of functioning (CAFAS/PECFAS) completed at intake, every 90 days, at discharge or upon substantial change in status					
	Assessment - Assessment documents present in file					
	Includes strengths & needs of recipient and/or family (strengths, needs, abilities, preferences and culture assessment) and completed within 5 working days of the second session					
	Full evaluation of client's history and functioning complete within 5 working days of the second session					
	Treatment Plan					
	Each child has a treatment plan/plan of care updated within 30 days of the initial session					
	Treatment plan indicates planned response(s) to presenting Problems at intake, every 90 days, at discharge or upon substantial change in status.					
	Treatment plan/plan of care is individualized to reflect the child's age, gender, ethnic background, life experience, culture, etc.					
	Goals/objectives clearly derived from assessment/diagnosis					
	Discharge Criteria for each treatment goal					
	Specific treatment, service or care coordination that includes the amount, scope, duration and provider of service					
	Discharge Plan					

	DCFS Southern Region Mental Health Programs	DWTC	OASIS	ECS	WIN	CCS
	The anticipated duration of the overall services based on anticipated time of goal achievement/progress.					
	Discharge/Transition criteria					
	Required aftercare/transition services					
	The identified agency(ies) or Independent Provider to provide the aftercare services					
	A plan for assisting the recipient in accessing these services					

	DCFS Southern Region Mental Health Programs	DWTC	OASIS	ECS	WIN	CCS
	Number of Files:	**8**	**2**	**35**	**30**	**30**
	Monitoring of Treatment – Progress Notes					
	Follows standardized format (DAP)					
	Progress notes are documented in Avatar within one week after services are provided.					
	Billing code is consistent with type of service delivered – billing code accurately reflects what was requested in the assessment, treatment plan and progress note	Not Applicable Core Rate Billing	Not Applicable Core Rate Billing			
	Monitoring of Treatment- 90 day review					
	90 day written review for each child that includes (as applicable) adjustment to treatment home, staff members, peer group/community; school curriculum and progress, health, parental/relative contact and progress made in counseling with family.					
	Report explains updated/revised treatment plan, goals, objectives, anticipated time of goal achievement/progress, and discharge/transition plan					
	Includes updated assessment and medical necessity data: CASII, CAFAS, Diagnostic changes, etc.					

	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc.*	**DWTC**	**OASIS**	**ECS**	**WIN**	**CCS**
	Documentation of Child and Family Team meeting at a minimum every 90 days – who attended and decisions made					
	Treatment goals that are expressed in the words of the child, family or guardian.					
	Involvement of child in developing the treatment plan					
	Involvement of the family in developing the treatment plan					
	Involvement of the family in 90 day reviews					
	Discharge Summary*: (Rate only if this is a discharged case)*					
	If child was transferred to another program, a written summary was provided within seven (7) calendar days of the transfer	Not Applicable	Not Applicable			
	Date of last service contact					
	Diagnosis at admission and discharge					
	Implementation steps toward transition/discharge					
	Current level of functioning description and measurement					
	Summary of effectiveness of treatment, progress or lack of toward treatment goals and objectives as documented in the mental health Treatment Plan/Plan of Care					
	Recommendations for further treatment and how child has been transitioned to further services.					

Shaded areas are documentation indicators that need improvement.

ADOLESCENT TREATMENT CENTER: 4 client files were selected from ATC for review with results of 31 of the documentation indicators in the area of strength and 5 indicators in the satisfactory area. This program has the highest compliance rate with documentation indicators among all programs of NNCAS.

Progress notes in order to track service monitoring was at 100% compliance by following a standardized format of documentation (DAP).

ATC treatment planning documents treatment goals in the words of the child, family or guardian also at 100% compliance.

Areas for improvement in ATC are the development of discharge plans; update of assessment tools (CASII and CAFAS) for 90 day reviews and participation of children and families in developing treatment plans and 90 day reviews. Documentation of Child and Family Team meetings is also another area where improvement is recommended for the Adolescent Treatment Center.

LEARNING HOMES: 4 client files were selected from Learning Homes for review with results of 10 of the documentation indicators in the area of strength and 12 indicators in the satisfactory area.

Client rights and privacy, medical necessity of services, documentation of Child and Family Team meetings, involvement of the family in developing treatment plans and updated assessment of 90 day reviews that address the revised treatment plan, goals objectives as well as anticipated time of goal achievement and progress are some of the areas of compliance with documentation

Areas for improvement are in timely assessments and timely development of treatment plans that include children/youth in the planning process and address discharge criteria for each treatment goal that is expressed in the words of the child/youth, family/caregiver or guardian.

Development of Discharge Plans and implementation of a standardized documentation format for progress notes and developing comprehensive discharge reports are also areas that need attention for improvement. Reviewers noted that the charts were exceedingly confusing and that it was not clear whether the therapist or the residential program was documenting intake assessments, progress notes on treatment goals and discharge summary. Progress notes were present for each shift but did not reflect specific progress toward treatment goals. Both ATC and Learning Homes did not use billing codes for services delivered. Both programs use a core rate for billing.

EARLY CHILDHOOD SERVICES: 18 client files were selected from ECS for review with results of 11 of the documentation indicators in the area of strength and 13 indicators in the satisfactory area.

Client rights and privacy, medical necessity of services, strength and needs assessment of the child, treatment plans with goals and objectives derived from assessment and diagnosis of the child are indicators that are some of the areas of compliance with documentation. Also, treatment plans that are individualized to reflect the child's age, gender, ethnic background, life experience, culture with 94% compliance. Progress notes track treatment and care coordination by documentation amount, scope, duration and provider of service. Discharge summaries are also comprehensive and meet seven out of nine documentation indicators.

Areas for improvement are in the areas of establishing discharge criteria for each treatment goal or objective and expressing the treatment goals in the language of the family/caregiver or guardian while addressing specific treatment, service coordination with the amount, scope duration of services and identifying the provider of services. Documentation of Child and Family Team meetings at a minimum every 90 days and involvement of family in developing treatment plans and 90 day reviews are also areas where improvement is recommended. Absence of Discharge Plan documentation and lack of standardized documentation format for progress notes for monitoring treatment with 90 day reviews are areas that need improvement as well. Billing codes consistent with

type of services delivered requires improvement in order to meet the documentation standards. It was noted by reviewers that lower than desired ratings could have been due to factors of staff turnover, not using the NECSET until recently and the lack of compliance of families not showing for appointments.

Seven (7) Early Childhood Services client files were reviewed for documentation compliance in October 2006. Recommendations made at that time on areas for improvement were in documentation of Child and Family Team meetings. This is consistent with the recommendations of the current file review results.

OUTPATIENT SERVICES-RENO: 17 client files were selected from Outpatient Program in Reno with results of 8 of the documentation indicators in the area of strength and 12 indicators in the satisfactory area.
This is the only outpatient program in the NNCAS that met the compliance rate of 71% for following a standardized documentation format (DAP) in writing progress notes. Another area of strength for this program is in meeting the documentation requirements for medical necessity for services in all the six indicators and in services and care coordination. Children are involved in development of the treatment plans and the discharge summaries, completed in a timely manner, state the reason and implementation steps taken for transition/discharge; current functioning of the child and summary of effectiveness of treatment, progress on treatment goals and objectives as documented in treatment plan and recommendations for further treatment when indicated are all documented.
Areas for improvement are in the area of client rights and privacy with Informed Consents that need to be signed at 1st session. The following areas that need improvement in documentation are: Assessment documents completed in five days after the second session;

individualized treatment plans updated and address planned response to presenting problems at intake, 90 days and at discharge; Goals/objectives of the treatment plan that need to be clearly derived from assessment and diagnosis; treatment goals each have discharge criteria with recommendations for specific treatment and service coordination that includes the amount, scope duration and the provider of services in the treatment plan; Child and family team meeting participants and the decision makers are documented and treatment goals are expressed in the words of child/family or guardian; families are involved in developing the treatment plan . Developing discharge plans; monitoring treatment for billing code consistent with type of service delivered and 90 day review documentation are also areas that need improvement. It is noted by reviewers that the random selection of charts included a number that were opened as of 2005 or earlier prior to the implementation of the new Chapter 400 regulations.
11client files were reviewed for documentation compliance from outpatient services at NNCAS in October 2006. Recommended areas for improvement were in the area of full assessment with strengths and needs of the child and family and Child and Family team meeting documentation at a minimum of every 90 days. These areas, as reflected in the above paragraph, are still a challenge and need improvement in the documentation process of service delivery.

Results of the previous file review conducted October 2006, also indicates that documentation of progress notes needed improvement. However, the current file review results show an improvement in this documentation indicator. In fact, the outpatient program in Reno is the only outpatient program at NNCAS that has implemented the standardized format for documentation of progress notes at a satisfactory level of compliance.

WRAPAROUND IN NEVADA-RENO: 10 client files were selected from WIN-Reno with results of 31 of the documentation indicators in the area of strength and 4 indicators in the satisfactory area.

WIN Reno has the highest compliance rate among NNCAS outpatient programs. Medical necessity for services, assessment and treatment plan development as well as monitoring treatment with progress notes and 90 day review summaries and child and family involvement are all areas of compliance that meet the documentation standard. Also, WIN treatment plans reflect discharge criteria for each treatment goal at 100% compliance in documentation. Child and Family Team meetings documentation in reflecting child/youth and caregiver participation in all aspects of service delivery documentation is among the most significant areas of strength. Care coordination and service transfer reports are documented that meet the standard at 100% compliance.

Areas for improvement are in HIPAA acknowledgments at first visit and recommendation of services by a physician or practitioner of the healing arts. As is reflected statewide, absence of discharge plan and standardized format for documentation of progress notes are areas that require attention for improvement. In discharge summaries, effectiveness of treatment, progress or lack of towards treatment goals and objectives as documented in plan of care need to be included as well as the current level of functioning of the child.

6 WIN- Reno client charts were reviewed for documentation compliance in October 2006. Recommended areas for improvement were on documentation of assessments; Child and Family Team meeting information and establishing discharge criteria related to treatment goals in treatment planning is needed. Findings based on the current file review results reflect that all of these areas of deficiencies in documentation have improved.

WRAPAROUND IN NEVADA -RURAL: 5 client files were selected from WIN-Rural with results of 13 of the documentation indicators in the area of strength and 9 indicators in the satisfactory area.

Similar to WIN Reno WIN-RURAL documentation compliance of billing code consistent with services delivered is at 100% with progress notes that document the treatment and service coordination that includes the amount, scope, duration and provider of services. Treatments are recommended by a physician or practitioner of the healing arts with compliance rate of 100% in WIN-Rural. Assessment tools such as CASII and CAFAS as well as SED determinations are all documented within 100% compliance. Families are involved in development of treatment plans as well as in 90 day reviews and participate in Child and Family Teams. Care coordination and service summary reports are documented at high rate of compliance.

Areas for improvement require that informed consents are signed and dated at 1st session. Assessments of client history and functioning and CASII level of care determination consistent with services need to meet the documentation standards. Treatment Plan development and discharge criteria for each treatment goal are service processes that need improvement in documentation. Absence of a Discharge Plan and lack of standardized format in writing progress notes do not address the treatment goals or service coordination. Discharge summaries also need to be more comprehensive and address effectiveness of treatment, progress or lack of progress towards treatment goals and objectives as documented in treatment planning.

4 WIN- Rural client files were reviewed for documentation compliance in October 2006. Although recommended area for improvement in documentation was Child and family involvement as team process, the current WIN Rural file review results show an increased compliance rate of 80% and above in child and family involvement.

Table 6 summarizes NNCAS file review results for areas of improvement by program. The shaded areas identify documentation indicators that need improvement.

Table 6
NNCAS File Review Results
Areas for Improvement

	DCFS Northern Region Mental Health Programs	ATC	Learning Homes	ECS	WIN		Outpatient
					Reno	Rural	
	Number of Files:	**4**	**4**	**18**	**10**	**5**	**17**
	Client Rights/Privacy						
	Informed Consent signed and dated at 1st session						
	HIPAA Acknowledgement signed and dated at 1st session						
	Medical Necessity						
	Treatment recommended by physician or practitioner of the healing arts						
	Intensity of Service Need (CASII or instrument for early childhood) completed at intake, every 90 days, at discharge or upon substantial change in status.						
	CASII level of care determination is consistent with services or an explanation of exception is provided						
	Level of functioning (CAFAS/PECFAS) completed at intake, every 90 days, at discharge or upon substantial change in status						
	Assessment - Assessment documents present in file						
	Includes strengths & needs of recipient and/or family (strengths, needs, abilities, preferences and culture assessment) and completed within 5 working days of the second session						
	Full evaluation of client's history and functioning complete within 5 working days of the second session						
	Treatment Plan						
	Each child has an initial treatment plan/plan of care completed during the assessment session (for TCM must include medical, social, educational and other unmet needs)						
	Each child has a treatment plan/plan of care updated within 30 days of the initial session						

	Treatment plan indicates planned response(s) to presenting Problems at intake, every 90 days, at discharge or upon substantial change in status.						
	Treatment plan/plan of care is individualized to reflect the child's age, gender, ethnic background, life experience, culture, etc.						

	DCFS Northern Region Mental Health Programs	**ATC**	**Learning Homes**	**ECS**	**WIN**		**Outpatient**
					Reno	**Rural**	
	Treatment Plan, Continued…						
	Goals/objectives clearly derived from assessment/diagnosis						
	Discharge Criteria for each treatment goal						
	Specific treatment, service or care coordination that includes the amount, scope, duration and provider of service						
	Discharge Plan						
	The anticipated duration of the overall services based on anticipated time of goal achievement/progress.						
	Discharge/Transition criteria						
	Required aftercare/transition services						
	The identified agency(ies) or Independent Provider to provide the aftercare services						
	A plan for assisting the recipient in accessing these services						
	Monitoring of Treatment – Progress Notes						
	Progress notes that document the treatment, service or care coordination that includes the amount, scope, duration and provider of service						
	Follows standardized format (DAP)						
	Billing code is consistent with type of service delivered – billing code accurately reflects what was requested in the assessment, treatment plan and progress note	Not Applicable Core Rate Billing	Not Applicable Core Rate Billing				
	Monitoring of Treatment- 90 day review						
	90 day written review for each child that includes (as						

	applicable) adjustment to treatment home, staff members, peer group/community; school curriculum and progress, health, parental/relative contact and progress made in counseling with family.						
	Report explains updated/revised treatment plan, goals, objectives, anticipated time of goal achievement/progress, and discharge/transition plan						
	Includes updated assessment and medical necessity data: CASII, CAFAS, Diagnostic changes, etc.						
	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc.*						
	Documentation of Child and Family Team meeting at a minimum every 90 days – who attended and decisions made						
	Treatment goals that are expressed in the words of the child, family or guardian.						

	DCFS Northern Region Mental Health Programs	**ATC**	**Learning Homes**	**ECS**	**WIN**		**Outpatient**
					Reno	**Rural**	
	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc., Continued….*						
	Involvement of child in developing the treatment plan			Not applicable			
	Involvement of the family in developing the treatment plan						
	Involvement of the family in 90 day reviews						
	Discharge Summary*: (Rate only if this is a discharged case)*						
	Discharge summary was completed within 30 calendar days following a planned discharge and/or 45 calendar days following an unplanned discharge						
	If child was transferred to another program, a written summary was provided within seven (7) calendar days of the transfer						Not applicable

	Date of last service contact						
	Diagnosis at admission and discharge						
	Reason for transition/discharge						
	Implementation steps toward transition/discharge						
	Current level of functioning description and measurement						
	Summary of effectiveness of treatment, progress or lack of toward treatment goals and objectives as documented in the mental health Treatment Plan/Plan of Care						
	Recommendations for further treatment and how child has been transitioned to further services.						

Shaded areas are documentation indicators that need improvement.

Summary

File review findings for SNCAS mental health programs show similar trends across some documentation indicators. Client rights and privacy; medical necessity of services; assessment and initial treatment plans; care coordination; progress notes for monitoring treatment and discharge summaries are documented consistently across all programs of the southern region.

There is also a cluster of indicators that require improvement in documentation. **Treatment Plans** need a) discharge criteria for each goal or objective. b) The treatment goals need to be expressed in the language of the child/family or guardian. **Discharge Plans** that address required aftercare services are missing across all programs in the southern region except Desert Willow Treatment Center. Progress notes documented in a standardized format **(DAP)** have been implemented only in WIN program. Documentation of **Child and Family Team** meetings every 90 days are missing across all programs in the southern region except WIN Program. **Discharge**

Summaries of the outpatient programs miss documenting the last date of service contact; diagnosis at admission as well as discharge; implementation steps towards transition or discharge.

File review findings for NNCAS mental health programs also show a similar trend where documentation for medical necessity of services; diagnosis and care coordination, progress notes to track services, assessment of intensity of service need are all documented consistently except in Early Childhood Services. Early Childhood Services in Reno does not utilize Child and Adolescent Service Intensity Instrument since this tool is not an appropriate tool for preschool age clients.

Areas in documentation that need improvement also reflect similar cluster among all NNCAS programs. It is important to note that NNCAS Outpatient and Early Childhood Services have not yet fully implemented a service delivery model consistent with system of care practices. This is reflected as documentation challenge for child and family team meetings except for WIN program since service delivery is modeled after system of care principals and values therefore child and family involvement in service planning evident both WIN-RENO and WIN-RURAL. Treatment plans require discharge criteria for each treatment goal. However, except for WIN-RENO the documentation for this indicator needs improvement in order to meet the standards. Absence of **Discharge Plans** with required aftercare/transition criteria is also a challenge in service delivery process for all NNCAS programs.

It is helpful to provide program specific feedback on documentation compliance so that each program is able to appraise their unique needs for improvement. Program specific findings may be useful in preparing informed action plans that are designed to enhance the service delivery and documentation process.

DCFS mental health programs service delivery process is supported by policy and procedures set forth by program managers and the service implementation methods determine the documentation requirements. Planning and Evaluation Unit staff, following the file review conducted in October 2006, presented the findings to the program managers and recommended a "comprehensive plan for improving documentation and adherence to regulatory standards." Supervisor's File review Checklist was developed to assist supervisors in their efforts to improve compliance with documentation indicators.

Although it is necessary to provide program specific feedback on documentation compliance as a result of the file review process, it would be interesting to also look at the aggregate results of the documentation indicators of all DCFS mental health programs that participated in this investigation. Table 7 outlines statewide satisfactory compliance in documentation with areas of strength (70% and above compliance rate with each indicator). Table 8 outlines the areas for statewide documentation improvement (compliance rate lower than 70% with each indicator).

It is important to note that program specific feedback is not a measure of program compliance due to the small numbers reviewed for each program. All programs must carefully examine the Statewide Documentation Indicators for Improvement (Table 8) and address those Medicaid Chapter 400 requirements in their improvement plan.

Table 7
Statewide Satisfactory Compliance and Areas of Strength in Documentation

Client Rights and Privacy	Informed Consent HIPAA Acknowledgement Release of Information
Medical Necessity	Diagnosis SED determination Treatment recommendation by practitioner of the healing arts Intensity of Service Need Services consistent with level of care Level of functioning
Assessment	Strengths, needs and cultural assessment of child and family
Treatment Plan	Initial treatment plan completed during the assessment session Treatment plan addresses planned response to presenting problems in the course of treatment Treatment plan is individualized Goals and objectives of the treatment plan are derived from assessment and diagnosis
Progress Notes	Include the amount, scope, duration and provider of service Documented in Avatar within one week after services are provided Billing code is consistent with type of service delivered
90 Day Review	Includes adjustment to living environment, peer group/community and school and family and progress made Includes updated assessment and medical necessity data
Child and Family Involvement	Families are involved in developing the treatment plan
Care Coordination	Within a treatment program Among multiple treatment providers, parents, advocates, ect.
Discharge Summary	Completed within 30 days following a planned discharge or 45 days following an unplanned discharge Reason for transition/discharge specified Current level of functioning description and measurement included

	Summary of effectiveness of treatment, progress or lack of toward treatment goals as documented in plan of care

Table 8
Statewide Documentation Indicators for Improvement

Assessment	Full evaluation of the client's history and functioning complete within 5 working days of the second session
Treatment Plan	Each child has a treatment plan/plan of care updated within 30 days of the initial session Each treatment goal needs discharge criteria Specific treatment, service or care coordination includes the amount, scope, duration and provider of service
Discharge Plan	Anticipated duration of services based on anticipated time for goals achieved and progress made Discharge/transition criteria Required aftercare/transition services Identified agencies or Independent Provider for aftercare services A plan to assist the client in accessing the aftercare/transition services
Progress Notes	Follow standardized format (DAP)
90 Day Review	Includes revised treatment goals/objectives and anticipated time to achieve the goals and progress to be made as well as discharge/Transition plans
Child and Family Involvement	Documentation of Child and family Team meeting at a minimum every 90 days- who attended and the decisions made Involvement of the child in developing the treatment plan, when appropriate. Involvement of the family in 90 day reviews.
Discharge Summary	Date of last service contact Diagnosis at admission and discharge Implementation steps towards transition/discharge Recommendations for further treatment and how the child has been transitioned to further services If a child is transferred to another program, a written summary was provided within 7 days of the transfer

Attachment A

File Review Tool

(PEU file review for DCFS internal 05/16/2007)

Nevada Division of Child and Family Services File Review

Name of Service Provider: _____ Review Date: _____

Chart #: _____ Program:

_____

Episode Selected For Review Intake Date:_____

#	Standard	Met Yes/No	Comments
	Client Rights/Privacy		
1.	Informed Consent signed and dated at 1st session	**Y N**	
2.	HIPAA Acknowledgement signed and dated at 1st session	**Y N**	
3.	Release of Information completed, expiration of 1 year or less, signed.	**Y N**	
	Medical Necessity		
4.	5 Axis diagnoses at 1st session, upon substantial change, and annually	**Y N**	
5.	SED determination completed initially and annually thereafter	**Y N**	
6.	Treatment recommended by physician or practitioner of the healing arts	**Y N**	
7.	Intensity of Service Need (CASII or instrument for early childhood) completed at intake, every 90 days, at discharge or upon substantial change in status.	**Y N**	
8.	CASII level of care determination is consistent with services or an explanation of exception is provided	**Y N**	
9.	Level of functioning (CAFAS/PECFAS) completed at intake, every 90 days, at discharge or upon substantial change in status	**Y N**	
	Assessment - Assessment documents present in file		
10.	Includes strengths & needs of recipient and/or family (strengths, needs, abilities, preferences and culture assessment) and completed within 5 working days of the second session	**Y N**	
11.	Full evaluation of client's history and functioning complete within 5 working days of the second session	**Y N**	

	Treatment Plan		
12.	Each child has an initial treatment plan/plan of care completed during the assessment session (for TCM must include medical, social, educational and other unmet needs)	**Y N**	
13	Each child has a treatment plan/plan of care updated within 30 days of the initial session	**Y N**	

Nevada Division of Child and Family Services File Review

Name of Service Provider: _____ Review Date: _____

Chart #: _____ Program:

_____

Episode Selected For Review Intake Date:_____

14.	Treatment plan indicates planned response(s) to presenting Problems at intake, every 90 days, at discharge or upon substantial change in status.	**Y N**	
15.	Treatment plan/plan of care is individualized to reflect the child's age, gender, ethnic background, life experience, culture, etc.	**Y N**	
16.	Goals/objectives clearly derived from assessment/diagnosis	**Y N**	
17.	Discharge Criteria for each treatment goal	**Y N**	
18.	Specific treatment, service or care coordination that includes the amount, scope, duration and provider of service	**Y N**	
	Discharge Plan		
19.	The anticipated duration of the overall services based on anticipated time of goal achievement/progress.	**Y N**	
20.	Discharge/Transition criteria	**Y N**	
21.	Required aftercare/transition services	**Y N**	
22.	The identified agency(ies) or Independent Provider to provide the aftercare services	**Y N**	

23.	A plan for assisting the recipient in accessing these services	**Y N**	
	Monitoring of Treatment – Progress Notes		
24.	Progress notes that document the treatment, service or care coordination that includes the amount, scope, duration and provider of service	**Y N**	
25.	Follows standardized format (DAP)	**Y N**	
26.	Progress notes are documented in Avatar within one week after services are provided.	**Y N**	
27.	Billing code is consistent with type of service delivered – billing code accurately reflects what was requested in the assessment, treatment plan and progress note	**Y N**	

Nevada Division of Child and Family Services File Review

Name of Service Provider: _____ Review Date: _____

Chart #: _____ Program:

_____

Episode Selected For Review Intake Date:_____

	Monitoring of Treatment- 90 day review		
28.	90 day written review for each child that includes (as applicable) adjustment to treatment home, staff members, peer group/community; school curriculum and progress, health, parental/relative contact and progress made in counseling with family.	**Y N NA**	
29.	Report explains updated/revised treatment plan, goals, objectives, anticipated time of goal achievement/progress, and discharge/transition plan	**Y N**	
30.	Includes updated assessment and medical necessity data: CASII, CAFAS, Diagnostic changes, etc.	**Y N**	
	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc.*		
31.	Documentation of Child and Family Team meeting at a minimum every 90 days – who attended and decisions made	**Y N**	

32.	Treatment goals that are expressed in the words of the child, family or guardian.	**Y N**	
33.	Involvement of child in developing the treatment plan	**Y N NA**	
34.	Involvement of the family in developing the treatment plan	**Y N NA**	
35.	Involvement of the family in 90 day reviews	**Y N NA**	
	Care Coordination *Care coordination is documented based on the individualized needs of each child.*		
36.	Care coordination within a treatment program	**Y N**	
37.	Care coordination among multiple treatment providers, parents, advocates, etc.	**Y N**	
	Discharge Summary*: (Rate only if this is a discharged case)*		
38.	Discharge summary was completed within 30 calendar days following a planned discharge and/or 45 calendar days following an unplanned discharge	**Y N**	
39.	If child was transferred to another program, a written summary was provided within seven (7) calendar days of the transfer	**Y N NA**	

Nevada Division of Child and Family Services File Review

Name of Service Provider: _____ Review Date: _____

Chart #: _____ Program:

_____

Episode Selected For Review Intake Date:_____

40.	Date of last service contact	**Y N**	
41.	Diagnosis at admission and discharge	**Y N**	
42.	Reason for transition/discharge	**Y N**	
43.	Implementation steps toward transition/discharge	**Y N**	
44.	Current level of functioning description and measurement	**Y N**	
45.	Summary of effectiveness of treatment, progress or lack of toward treatment goals and objectives as documented in the mental health Treatment Plan/Plan of Care	**Y N**	
46.	Recommendations for further treatment and how child has been transitioned to further services.	**Y N NA**	

Notes:

Review Completed by: _____ Date: _____

Attachment B

Table 2 - SNCAS File Review Results

Table 3 - NNCAS File Review Results

Table 2
SNCAS File Review Results

		Percent Met Standard				
	DCFS Southern Region Mental Health Programs	**DWTC**	**OASIS**	**ECS**	**WIN**	**CCS**
	Number of Files:	**8**	**2**	**35**	**30**	**30**
	Client Rights/Privacy					
1.	Informed Consent signed and dated at 1st session	**100%**	**100%**	**100%**	**86.7%**	**86.7%**
2.	HIPAA Acknowledgement signed and dated at 1st session	**100%**	**100%**	**100%**	**83.3%**	**93.3%**
3.	Release of Information completed, expiration of 1 year or less, signed.	**100%**	50%	**88.6%**	**80.0%**	**82.8%**
	Medical Necessity					
4.	5 Axis diagnoses at 1st session, upon substantial change, and annually	**100%**	**100%**	**91.4%**	**93.3%**	**93.3%**
5.	SED determination completed initially and annually thereafter	**100%**	**100%**	**100%**	**96.7%**	**90.0%**
6.	Treatment recommended by physician or practitioner of the healing arts	**100%**	**100%**	**100%**	**100%**	**93.3%**
7.	Intensity of Service Need (CASII or instrument for early childhood) completed at intake, every 90 days, at discharge or upon substantial change in status.	66.7%	**100%**	**91.4%**	**93.1%**	63.3%
8.	CASII level of care determination is consistent with services or an explanation of exception is provided	**80%**	**100%**	**91.4%**	**100%**	**70.0%**
9.	Level of functioning (CAFAS/PECFAS) completed at intake, every 90 days, at discharge or upon substantial change in status	**75%**	**100%**	**71.4%**	**93.1%**	63.3%
	Assessment - Assessment documents present in file					
10.	Includes strengths & needs of recipient and/or family (strengths, needs, abilities, preferences and culture assessment) and completed within 5 working days of the second session	**100%**	**100%**	**80.0%**	**93.1%**	50.0%
11.	Full evaluation of client's history and functioning complete within 5 working days of the second session	**100%**	**100%**	**80.0%**	**72.4%**	46.7%
	Treatment Plan					
12.	Each child has an initial treatment plan/plan of care completed during the assessment session (for TCM must include medical, social, educational and other unmet needs)	**100%**	**100%**	**94.3%**	**93.1%**	**73.3%**
13	Each child has a treatment plan/plan of care updated within 30 days of the initial session	**100%**	**100%**	**77.1%**	**86.2%**	41.4%
14.	Treatment plan indicates planned response(s) to presenting	**100%**	50%	**80.0%**	**93.1%**	44.8%

	Problems at intake, every 90 days, at discharge or upon substantial change in status.					

		Percent Met Standard				
	DCFS Southern Region Mental Health Programs	**DWTC**	**OASIS**	**ECS**	**WIN**	**CCS**
	Treatment Plan, Continued					
15.	Treatment plan/plan of care is individualized to reflect the child's age, gender, ethnic background, life experience, culture, etc.	**87.5%**	50%	**82.9%**	**86.2%**	62.1%
16.	Goals/objectives clearly derived from assessment/diagnosis	**100%**	**100%**	**94.3%**	**75.9%**	67.9%
17.	Discharge Criteria for each treatment goal	**75%**	--	62.9%	62.1%	50%
18.	Specific treatment, service or care coordination that includes the amount, scope, duration and provider of service	**100%**	50%	57.1%	**93.1%**	46.4%
	Discharge Plan					
19.	The anticipated duration of the overall services based on anticipated time of goal achievement/progress.	**100%**	--	17.1%	24.1%	17.9%
20.	Discharge/Transition criteria	**100%**	**100%**	11.4%	20.7%	21.4%
21.	Required aftercare/transition services	**100%**	50%	17.1%	6.9%	3.7%
22.	The identified agency(ies) or Independent Provider to provide the aftercare services	**100%**	**100%**	17.1%	10.3%	14.8%
23.	A plan for assisting the recipient in accessing these services	**100%**	**100%**	20.0%	10.3%	11.1%
	Monitoring of Treatment – Progress Notes					
24.	Progress notes that document the treatment, service or care coordination that includes the amount, scope, duration and provider of service	**100%**	**100%**	**100.0%**	**100%**	**86.2%**
25.	Follows standardized format (DAP)	--	50%	48.6%	**75.9%**	37.9%
26.	Progress notes are documented in Avatar within one week after services are provided.	**100%**	50%	**88.6%**	**100%**	**72.4%**
27.	Billing code is consistent with type of service delivered – billing code accurately reflects what was requested in the assessment, treatment plan and progress note	Not Applicable Core Rate Billing	Not Applicable Core Rate Billing	**100%**	**96.6%**	**96.6%**
	Monitoring of Treatment- 90 day review					
28.	90 day written review for each child that includes (as applicable) adjustment to treatment home, staff members, peer group/community; school curriculum and progress, health, parental/relative contact and progress made in counseling with family.	**100%**	**100%**	**75.8%**	**93.1%**	60.0%

29.	Report explains updated/revised treatment plan, goals, objectives, anticipated time of goal achievement/progress, and discharge/transition plan	**100%**	**100%**	**78.1%**	**96.6%**	48.0%
30.	Includes updated assessment and medical necessity data: CASII, CAFAS, Diagnostic changes, etc.	**100%**	**100%**	**84.8%**	**93.1%**	56.0%
	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc.*					
31.	Documentation of Child and Family Team meeting at a minimum every 90 days – who attended and decisions made	**--**	50%	40.0%	**86.2%**	18.5%

		Percent Met Standard				
	DCFS Southern Region Mental Health Programs	**DWTC**	**OASIS**	**ECS**	**WIN**	**CCS**
	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc., Continued…*					
32.	Treatment goals that are expressed in the words of the child, family or guardian.	25%	--	42.9%	62.1%	31.0%
33.	Involvement of child in developing the treatment plan	**87.5%**	**--**	14.3%	**89.3%**	53.6%
34.	Involvement of the family in developing the treatment plan	**87.5%**	**100%**	**87.1%**	**93.1%**	**71.4%**
35.	Involvement of the family in 90 day reviews	N/A	**100%**	57.1%	65.5%	16.0%
	Care Coordination *Care coordination is documented based on the individualized needs of each child.*					
36.	Care coordination within a treatment program	**100%**	**100%**	**88.6%**	**93.1%**	**80.8%**
37.	Care coordination among multiple treatment providers, parents, advocates, etc.	**100%**	**100%**	**80.0%**	**89.7%**	**78.6%**
	Discharge Summary*: (Rate only if this is a discharged case)*					
38.	Discharge summary was completed within 30 calendar days following a planned discharge and/or 45 calendar days following an unplanned discharge	**71.4%**	**100%**	**88.9%**	**88.9%**	**76.5%**
39.	If child was transferred to another program, a written summary was provided within seven (7) calendar days of the transfer	Not Applicable	Not Applicable	50%	**100%**	50.0%

40.	Date of last service contact	**100%**	**100%**	41.2%	33.3%	23.5%
41.	Diagnosis at admission and discharge	**100%**	**100%**	58.8%	44.4%	41.2%
42.	Reason for transition/discharge	**100%**	**100%**	**100%**	**77.8%**	**82.4%**
43.	Implementation steps toward transition/discharge	**100%**	**100%**	52.9%	44.4%	12.5%
44.	Current level of functioning description and measurement	**100%**	**100%**	**94.1%**	**77.8%**	64.7%
45.	Summary of effectiveness of treatment, progress or lack of toward treatment goals and objectives as documented in the mental health Treatment Plan/Plan of Care	**100%**	**100%**	**88.2%**	66.7%	64.7%
46.	Recommendations for further treatment and how child has been transitioned to further services.	**100%**	**100%**	**76.9%**	**75.0%**	35.7%

The bold values are reflective of the areas of strength (85% compliance and higher) and satisfactory areas (70-84% compliance).

Table 3
NNCAS File Review Results

		Percent Met Standard					
	DCFS Northern Region Mental Health Programs	**ATC**	**Learning Homes**	**ECS**	**WIN**		**Outpatient**
					Reno	**Rural**	
	Number of Files:	**4**	**4**	**18**	**10**	**5**	**17**
	Client Rights/Privacy						
1.	Informed Consent signed and dated at 1st session	**100%**	**100%**	**88.9%**	**80%**	60%	62.4%
2.	HIPAA Acknowledgement signed and dated at 1st session	50%	**75%**	**82.4%**	50.0%	**80%**	**70.6%**
3.	Release of Information completed, expiration of 1 year or less, signed.	**100%**	**75%**	**77.8%**	**90.0%**	**100%**	**70.6%**
	Medical Necessity						
4.	5 Axis diagnoses at 1st session, upon substantial change, and annually	**100%**	**100%**	**94.4%**	**100%**	**80%**	**82.4%**
5.	SED determination completed initially and annually thereafter	**100%**	**100%**	**88.9%**	**100%**	**100%**	**88.2%**
6.	Treatment recommended by physician or practitioner of the healing arts	**100%**	**75%**	**100%**	20.0%	**100%**	**94.1%**
7.	Intensity of Service Need (CASII or instrument for early childhood) completed at intake, every 90 days, at discharge or upon substantial change in status.	**100%**	**75%**	33.3%	**90.0%**	**100%**	**94.1%**
8.	CASII level of care determination is consistent with services or an explanation of exception is provided	**100%**	**75%**	42.9%	**100%**	60%	**82.4%**
9.	Level of functioning (CAFAS/PECFAS) completed at intake, every 90 days, at discharge or upon substantial change in status	**100%**	**75%**	56.3%	**90.0%**	**100%**	**76.5%**

	Assessment - Assessment documents present in file						
10.	Includes strengths & needs of recipient and/or family (strengths, needs, abilities, preferences and culture assessment) and completed within 5 working days of the second session	**100%**	50%	**83.3%**	**90.0%**	**80.0%**	58.8%
11.	Full evaluation of client's history and functioning complete within 5 working days of the second session	**75%**	50%	50%	**90.0%**	60.0%	52.9%
	Treatment Plan						
12.	Each child has an initial treatment plan/plan of care completed during the assessment session (for TCM must include medical, social, educational and other unmet needs)	**100%**	66.7%	**75%**	**100%**	60.0%	**75.0%**
13	Each child has a treatment plan/plan of care updated within 30 days of the initial session	**100%**	**75%**	**71.4%**	**90%**	25.0%	41.7%

		Percent Met Standard					
	DCFS Northern Region Mental Health Programs	**ATC**	**Learning Homes**	**ECS**	**WIN**		**Outpatient**
					Reno	**Rural**	
	Treatment Plan, Continued….						
14.	Treatment plan indicates planned response(s) to presenting Problems at intake, every 90 days, at discharge or upon substantial change in status.	**100%**	50%	46.7%	**100%**	40.0%	64.7%
15.	Treatment plan/plan of care is individualized to reflect the child's age, gender, ethnic background, life experience, culture, etc.	**100%**	**75%**	**94.1%**	**100%**	40.0%	64.7%
16.	Goals/objectives clearly derived from assessment/diagnosis	**100%**	**75%**	**88.2%**	**100%**	40.0%	62.5%
17.	Discharge Criteria for each treatment goal	**75%**	25%	60.0%	**100%**	60.0%	52.9%
18.	Specific treatment, service or care coordination that includes the amount, scope, duration and provider of service	**75%**	50%	64.7%	**100%**	40.0%	52.9%
	Discharge Plan						
19.	The anticipated duration of the overall services based on anticipated time of goal achievement/progress.	50%	25%	46.7%	66.7%	60.0%	23.5%
20.	Discharge/Transition criteria	**75%**	50%	50.0%	60.0%	40.0%	41.2%
21.	Required aftercare/transition services	25%	25%	12.5%	44.4%	60.0%	20.0%

22.	The identified agency(ies) or Independent Provider to provide the aftercare services	25%	**100%**	12.5%	50.0%	40.0%	20.0%
23.	A plan for assisting the recipient in accessing these services	25%	**100%**	6.3%	50.0%	**80.0%**	20.0%
	Monitoring of Treatment – Progress Notes						
24.	Progress notes that document the treatment, service or care coordination that includes the amount, scope, duration and provider of service	**75%**	**75%**	**83.3%**	**100%**	40.0%	64.7%
25.	Follows standardized format (DAP)	**100%**	25%	66.7%	11.1%	---	**70.6%**
26.	Progress notes are documented in Avatar within one week after services are provided.	**100%**	**100%**	**77.8%**	**100%**	**100%**	**88.2%**
27.	Billing code is consistent with type of service delivered – billing code accurately reflects what was requested in the assessment, treatment plan and progress note	Not Applicable Core Rate Billing	Not Applicable Core Rate Billing	64.7%	**100%**	**100%**	43.8%
	Monitoring of Treatment- 90 day review						
28.	90 day written review for each child that includes (as applicable) adjustment to treatment home, staff members, peer group/community; school curriculum and progress, health, parental/relative contact and progress made in counseling with family.	**100%**	33.3%	38.5%	**80.0%**	**75.0%**	60.0%
29.	Report explains updated/revised treatment plan, goals, objectives, anticipated time of goal achievement/progress, and discharge/transition plan	**100%**	**100%**	42.9%	**90.0%**	50.0%	50.0%

		Percent Met Standard					
	DCFS Northern Region Mental Health Programs	**ATC**	**Learning Homes**	**ECS**	**WIN**		**Outpatient**
					Reno	**Rural**	
	Monitoring of Treatment- 90 day review, Continued….						
30.	Includes updated assessment and medical necessity data: CASII, CAFAS, Diagnostic changes, etc.	66.7%	**100%**	46.2%	**90.0%**	**75.0%**	50.0%
	Child and Family Involvement – *as documented through progress notes, CFT notes, signatures, etc.*						
31.	Documentation of Child and Family Team meeting at a minimum every 90 days – who attended and decisions made	50%	**100%**	26.7%	**100%**	**80.0%**	35.3%

		Percent Met Standard					
	DCFS Northern Region Mental Health Programs	**ATC**	**Learning**	**ECS**	**WIN**		**Outpatient**
					Reno	**Rural**	
32.	Treatment goals that are expressed in the words of the child, family or guardian.	**100%**	25%	40.0%	**100%**	**80.0%**	37.5%
33.	Involvement of child in developing the treatment plan	50%	33.3%	Not applicable	**100%**	**75.0%**	**75.0%**
34.	Involvement of the family in developing the treatment plan	**100%**	**100%**	66.7%	**100%**	**100%**	66.7%
35.	Involvement of the family in 90 day reviews	50%	66.7%	30.8%	**100%**	**100%**	64.3%
	Care Coordination *Care coordination is documented based on the individualized needs of each child.*						
36.	Care coordination within a treatment program	**100%**	**75%**	**87.5%**	**100%**	**100%**	**80.0%**
37.	Care coordination among multiple treatment providers, parents, advocates, etc.	**100%**	**75%**	**81.3%**	**100%**	**100%**	**88.2%**
	Discharge Summary*: (Rate only if this is a discharged case)*						
38.	Discharge summary was completed within 30 calendar days following a planned discharge and/or 45 calendar days following an unplanned discharge	**100%**	33.3%	**71.4%**	**100%**	25.0%	**71.4%**
39.	If child was transferred to another program, a written summary was provided within seven (7) calendar days of the transfer	**100%**	25%	**85.7%**	**100%**	**100%**	Not applicabl
40.	Date of last service contact	**100%**	25%	**71.4%**	**75.0%**	**100%**	42.9%
41.	Diagnosis at admission and discharge	**100%**	25%	**100%**	**100%**	25.0%	14.3%
42.	Reason for transition/discharge	**100%**	50%	**85.7%**	**100%**	50.0%	**71.4%**
43.	Implementation steps toward transition/discharge	**100%**	25%	40.0%	**75.0%**	50.0%	**83.3%**
44.	Current level of functioning description and measurement	**100%**	50%	**71.4%**	50.0%	50.0%	**85.7%**
45.	Summary of effectiveness of treatment, progress or lack of toward treatment goals and objectives as documented in the mental health Treatment Plan/Plan of Care	**100%**	25%	**85.7%**	50.0%	50.0%	**85.7%**
46.	Recommendations for further treatment and how child has been transitioned to further services.	**100%**	50%	60.0%	33.3%	25.0%	**100%**

The bold values are reflective of the areas of strength (85% compliance and higher) and satisfactory areas (70-84% compliance)