RISK MEASURES AND DEPARTURE CONDITIONS 2009 AGGREGATE REPORT

INTRODUCTION

In partnership with the Provider Support Team, the Planning and Evaluation Unit (PEU) of the Division of Child and Family Services (DCFS) collects identified risk measures and departure conditions from Specialized Foster Care providers for quality improvement purposes. By collecting and analyzing all risk measure data, providers can review where the risks are occurring and determine opportunities for improvement.

In early 2008, risk measure collection began. In this second year of collecting risk measures and departure conditions, most Specialized Foster Care providers have responded by turning in complete data sets. By September 2009, most providers had entered into contracts with DCFS, and/or Clark County Department of Family Services and Washoe County Department of Social Services. The contract specified that providers would participate in performance and quality improvement through DCFS' Planning and Evaluation Unit.

Specialized Foster Care providers who participated in providing risk measures and departure conditions data are to be commended for their willingness to share this very important information. Specialized Foster Care providers that collect and monitor risk data are more likely to support the structures and processes that ensure the safety, permanency and well-being of children and adolescents in their homes.

This report is an analysis of risk measures and departure conditions collected from January 2009 through December 2009. A few new Specialized Foster Care homes opened during the year, and when they began to serve children, they were added to the list of participating agencies and asked to participate in this initiative. A list of Specialized Foster Care agencies and their level of participation can be found in Attachment A.

There is limited certainty that the risk measures or departure conditions represent a true count of incidences. There is also missing information which impacts interpretation of the data. Although there are limitations to the study, the information is useful and can be used for program improvement.

RISK MEASURES AND DEPARTURE CONDTIONS

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Safety holds

Specialized Foster Care providers were also asked to track and report departure conditions for children and adolescents discharged from services during the 12-month reporting period. Collecting departure conditions data for analysis is one way to measure the effectiveness of Specialized Foster Care treatment and adherence to best-practice principles. Specialized Foster Care agencies are providing data on the following indicators of effective treatment and best practice:

- Treatment completion at discharge
- Restrictiveness level of next living environment
- Child and Family Team decision making

The following is the data and analysis of the four risk areas and departure conditions.

Forty-three Specialized Foster Care providers who held contracts with DCFS and/or Clark and Washoe Counties participated in the collection of risk measures and departure conditions. They were asked to submit a bed-capacity count each month. The average monthly bed capacity was 36.98 per agency, ranging from 1 to 225 beds. The average monthly number of children and adolescents served per provider was 30.37, ranging from 1 to 196.

Suicide

Specialized Foster Care providers were asked to track and report incidents of attempted and completed suicides. A total of 8 Specialized Foster Care providers reported incidents of attempted suicide. In 2008 there were 14 reported suicide attempts from 6 providers. Attempted suicide is defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself but was rescued or thwarted, or changed his or her mind after taking initial action. There were no reports of completed suicides. Agencies reporting a suicide attempt were:

Briarwood North	Mountain Circle
DCFS-SNCAS Oasis	SAFY
Eagle Quest	Saint Jude's
Kids First	Shaw Homes

There were a total of 16 reports of suicide attempt with the following descriptive information:
- 10 were male and 6 were female.
- Average age was 13.88, ranging from age 7 to 18 years.
- 7 were Caucasian, 6 were African American, 2 were of mixed race and 1 was unknown.
- 2 were of Hispanic origin.

Clinical and suicide attempt information:
- The 2 most frequent diagnoses were Adjustment Disorder and Depressive Disorder NOS.
- Average CASII score was 22.40, ranging from a score of 17 to 25; the mean CASII level was 4.27.
- Suicide means reported were 2 incidents of overdose, 1 incident of using a knife to harm oneself, 1 incident of wrist cutting, 5 incidents of attempted hanging, and 7 incidents using "other" means.
- 7 children and adolescents with incidents were reported as having previous suicide attempts.
- Following the suicide attempts, 7 were admitted to a psychiatric hospital, 2 resulted in emergency hospital medical procedures, and 7 were categorized as "other," to include youth placed on 15-minute checks.
- In all incidents, agencies implemented a suicide protocol.

Highlights:
- All 8 agencies that reported a suicide attempt have a suicide protocol in place.

- 8 (50%) of the children and adolescents who attempted suicide were either Black/African American or of mixed race.

Opportunities for improvement:
- Ensure that all provider agencies have a suicide protocol, and Specialized Foster Care parents and staff are trained to implement it.
- Ensure a complete suicide history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- In collaboration with Nevada Youth Care Providers, continue to provide Specialized Foster Care providers with information about available training opportunities.

Medication Errors

Specialized Foster Care providers were asked to track and report medication errors. To track medication errors, a definition was needed that clearly stated what constitutes an error. The following definition was used from the U.S. Pharmacopoeia:

"A medication error is any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use" (U.S. Pharmacopeia, 1997).

Using this definition, 19 Specialized Foster Care providers reported 192 medication errors over the 12-month reporting cycle. In 2008, 15 providers reported a total of 192 medication errors. Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopeia, 2000). Providers are encouraged to review the definitions of a medication error to ensure that if an error is made, it is being properly documented. If errors are documented, a review of errors can result in procedural improvements to minimize future errors.

Specialized Foster Care homes reporting medication errors were:

Agape
Briarwood North
Briarwood South
DCFS-NNCAS Adolescent Treatment Center
DCFS-NNCAS Family Learning Home
DCFS-SNCAS Oasis
Eagle Quest
Father Flanagan's Boys Town
Hand Up Homes
Kids First
Maple Star North
Maple Star South
Mountain Circle
Olive Crest
R House
SAFY
Saint Jude's Ranch
Sankofa
Ujima

The 192 incidents of medication errors reflect the following descriptive information:
- 168 (87.5%) were male and 24 (12.5%) were female.
- Average age was 15.05, ranging from age 5 to 19 years.

- 127 (66.1%) were Caucasian, 48 (25%) were African-American, 2 (1%) were American Indian/Alaskan Native, 1 (.5%) was Native Hawaiian/Other Pacific Islander, 12 (6.3%) were of mixed race and 2 (1%) were of unknown race or the report was missing information about the child or adolescent's race.
- 19 (9.9%) were of Hispanic origin.

Clinical and medication error information:
- The following 6 Axis I diagnoses account for nearly 59% of all diagnostic categories reported under medication errors.
  - Impulse Control Disorder NOS
  - Attention Deficit/Hyperactivity Disorder
  - Paraphilia NOS
  - Attention Deficit/Hyperactivity Disorder NOS
  - Bipolar Disorder NOS
  - Reactive Attachment Disorder of Infancy or Early Childhood
- Average CASII score was 22.65, ranging from a score of 14 to 28; the mean CASII level was 4.53.
- Type of medication error
  - 7 (3.6%) prescribing errors
  - 137 (71.4%) omission errors
  - 2 (1%) wrong time errors
  - 2 (1%) unauthorized drug administration errors
  - 5 (2.6%) improper dose errors
  - 6 (3.1%) wrong administration technique
  - 18 (9.4%) compliance errors
  - 15 (7.8%) other medication errors
- 144 (75%) of the medication errors were with psychotropic medication, 48 (25%) were non-psychotropic medication errors.
- The highest occurrence of medication errors were on Saturday - 35 (18.2 %) and Friday - 34 (17.7%). The lowest occurrence of medication errors were on Tuesday - 14 (7.3%).
- The most common time of day for errors was 8:00 pm, with 41 of the 192 errors occurring at this time (21.4%). Twenty-four (12.5%) medication errors occurred at 8:00 am.
- Medication error outcome
  - 27 (14.1%) were circumstances or events that had the capacity to cause error.
  - 121 (63%) were errors that did not reach the client.
  - 43 (22.4%) were errors that reached the client but did not cause the client harm.
  - 1 (.5%) error reached the client and required monitoring to confirm that it resulted in no harm to the client and/or required intervention to preclude harm.

Highlights:
- The most common type of medication error reported was omission errors (71.4%).
- 21.4% of medication errors occurred at 8:00 pm.

Opportunities for improvement:
- Medication errors can be improved by focusing on omission errors.
- Medication errors occurred most frequently on Friday (17.7%) and Saturday (18.2%). In 2008 more than 20% occurred on Saturday. Friday and Saturday are most likely transition times, with children and adolescents going on weekend visits or participating in weekend activities. Focusing on these high-activity times may help to reduce medication errors.

- By reviewing the circumstances surrounding an error, providers may be able to identify procedural changes needed to minimize further errors. A common contributing factor to medication errors is distractions (U.S. Pharmacopeia, 2000). The person responsible for the medication error can be informed of the error and receive education or training. A positive action is to ask the person responsible for the medication error to identify how he or she would correct the error in the future.
- Ensure the use of medication logs in each child's treatment home agency record and that each log is reviewed for quality assurance by someone other than the person who administered the medication.
- There are numerous types of medication errors which are tracked and reported in a Specialized Foster Care setting; these are identified in the table below ("Type of Medication Error Definitions"). These types of medication errors are also provided on the Medication Errors workbook in the Risk Measures and Departure Conditions spreadsheet which is submitted to DCFS by Specialized Foster Care providers on a monthly basis for analysis.

[3]**Type of Medication Error-Definitions** (Source: *American Society of Hospital Pharmacists. (1993). ASHP Guidelines on preventing medication errors in hospitals.* American Journal of Hospital Pharmacy, *50:305-14.)*	
1= Prescribing Error	Incorrect drug selection (based on indication, contraindications, known allergies, existing drug therapy and other factors), dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician (or other legitimate prescriber); illegible prescriptions or medication orders that lead to errors that reach the patient.
2= Omission Error	The failure to administer an ordered dose to the patient before the next scheduled dose, if any.
3= Wrong Time Error	Administration of medication outside a predefined time interval from its scheduled administration time (medication should be given within plus or minus one hour of time ordered).
4= Unauthorized Drug Administration Error	Administration to the patient of medication not authorized by a legitimate prescriber for the patient.
5= Improper Dose Error	Administration to the patient of a dose that is greater or less than the amount ordered by the prescriber or administration of duplicate doses to the patient, for example, one or more dosage units in addition to those that were ordered.
6= Wrong Dosage-Form Error	Administration to the patient of a drug product in a different dosage form than ordered by the prescriber.
7= Wrong Drug-Preparation Error	Drug product incorrectly formulated or manipulated before administration.
8= Wrong Administration Technique Error	Inappropriate procedure or improper technique in the administration of a drug.
9= Deteriorated Drug Error	Administration of a drug that has expired or for which the physical or chemical dosage-form integrity has been compromised.
10= Monitoring Error	Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy.
11= Compliance Error	Inappropriate patient behavior regarding adherence to a prescribed medication regimen.
*12= Other Medication Error	Any medication error that does not fall into one of the above predefined categories.

- Only 19 of the 43 Specialized Foster Care providers reported any medication errors.
- Only 192 total medication errors were reported.

A total of 192 medication errors is less than expected, and it was the same number reported in 2008. When one considers the potential number of both prescription and over-the-counter (OTC) medications each youth in a Specialized Foster Care placement may be taking, oftentimes multiplied by administration several times per day, multiplied again by the number of days in placement, one expects to see a higher number of errors over the course of a 12-month reporting period, given the definitions noted in the table above.

The administration and dispensing of all prescription and OTC medications are to be tracked and errors reported in the Medication Errors workbook. In multiple discussions with providers about the issue of tracking and reporting medication errors, it has been determined that some providers have a misunderstanding of what constitutes a medication for this reporting purpose. For example, several providers thought they were to report only psychotropic medication errors, while others thought they were to report only on prescription medication errors. Many providers did not understand the requirement to report all medication errors, whether they are prescription or OTC medications. This misunderstanding resulted in an identified under-reporting of medication errors overall for some providers.

Other common mistakes in tracking and reporting medication errors which the PEU has identified in discussions with providers include:

- the youth refusing to take the medication (code #11).
- dispensing a medication at the wrong time of day or failing to dispense a medication as prescribed or directed (code #3).
- sending medications with the youth on home passes and confirming on the youth's return to the Specialized Foster Care home that the medication was not dispensed by the family or other responsible adult (code #2).
- inability to fill the prescription and dispense the medication because the prior authorization has not yet been approved or consents had not been obtained or provided in a timely manner by the legal guardian/custodian (code #2).
- errors of omission do reach the client and should be categorized as an error that reached the patient but did not cause the patient harm.

PEU is available to provide technical assistance on any of these issues involving tracking and reporting medication errors, including providing clarification of medication error definitions. PEU encourages providers to seek out technical assistance whenever there is a need for clarity about medication administration and management and/or reporting data related to medication errors.

AWOLs – Child or adolescent absent for more than 24 hours

Specialized Foster Care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs). A total of 28 treatment home providers reported 166 incidents of child or adolescent runaway/absences of more than 24 hours. In 2008, 26 providers reported 183 AWOLs. Providers reporting child or adolescent absences of more than 24 hours are listed below:

Agape	Maple Star Rural
Briarwood North	Maple Star South
Briarwood South	Mountain Circle
DCFS-NNCAS Adolescent Treatment Center	My Home
DCFS-NNCAS Family Learning Homes	New Beginnings
DCFS-SNCAS Oasis	Olive Crest
Eagle Quest	Rite of Passage
Father Flanagan's Boy Town	SAFY
Foundation for the Stars	Saint Jude's Ranch
Golla Home	Sankofa
Hope Healthcare Services	Shaw Homes
Kids First	Ujima
London Family Services	Unity Village
Maple Star North	Visions

The 166 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 90 (54.2%) were female and 76 (45.8%) were male.
- Average age was 15.82, ranging from age 11 to 19 years.
- 87 (52.4%) were Caucasian, 44 (26.5%) were African-American, 8 (4.8%) were American Indian/Alaskan Native, 1 (.6%) was Asian, 1 (.6%) was Native Hawaiian/Other Pacific Islander, 19 (11.4%) were of mixed race, and 6 (3.6%) were unknown or missing information.
- 23 (13.9%) were of Hispanic origin.

Clinical and AWOL information:

- The most frequent diagnoses were Bipolar Disorder NOS, Major Depressive Disorder, and Posttraumatic Stress Disorder.
- Average CASII score was 23.51, ranging from a score of 18 to 30; the mean CASII level was 4.53.
- Average length of absence was 5.51 days, with a range of 1 to 42 days.
- 134 (80.7%) of children and adolescents absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL:
  - 38 (22.9%) left from school or work
  - 10 (6%) left from treatment home at night – staff asleep
  - 35 (21.1%) left from treatment home at night – staff awake
  - 63 (38%) left home during the day
  - 20 (12%) were other
- Behavior during AWOL
  - 15 (9%) substance abuse
  - 9 (5.4%) criminal activity
  - 6 (3.6%) sexual activity
  - 3 (1.8%) sexual misconduct
  - 2 (1.2%) assaultive to others
  - 1 (.6%) victim
  - 130 (78.3%) unknown

- Outcome
  - 30 (18.1%) returned to treatment home within 72 hours
  - 69 (41.6%) absent indefinitely – did not return to the home
  - 12 (7.2%) returned through juvenile detention
  - 19 (11.4%) found with family
  - 32 (19.3%) other
  - 4 (2.4%) missing information

Highlights:
- Although more males tend to be in treatment for behavioral and emotional disturbance, it appears that females run away more often than males.
- Over 80% of the children and adolescents who ran away had a history of AWOL.
- Nearly 42% of children and adolescents who ran away were absent indefinitely and did not return to the Specialized Foster Care home.

Opportunities for improvement:
- Develop a crisis plan at admission for children who have a known history of AWOL.
- Ensure that a complete AWOL history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Ensure that there is feedback to the home from which the child ran away when the child is found. This may provide some "closure" to children who remain in the home from which the child ran away.
- Focus on developing protocols regarding supervision between the school and the treatment home.
- Develop a protocol for children and adolescents who threaten to run away. The protocol would include the creation of a safety plan that provides appropriate alternatives to the runaway behavior.

Safety Holds

Specialized Foster Care providers were asked to track and report on safety holds used on children and adolescents. A safety hold is a method of restricting a child's freedom of movement for his/her safety or for the safety of others. The following 15 Specialized Foster Care providers reported a total of 168 incidents of safety holds:

DCFS-NNCAS Adolescent Treatment Center
DCFS-NNCAS Family Learning Homes
DCFS-SNCAS Oasis
Eagle Quest
Father Flanagan's Boys Town
Koinonia
Maple Star North
Maple Star South
New Beginnings
Reagan Home
Rite of Passage
SAFY
Saint Jude's Ranch
Sankofa
Trinity

In 2008, 16 providers reported a total of 154 safety holds.

Specialized Foster Care providers use a variety of safety hold models. Below is a list of the different models that were reported and the percent each model was used:
- 131 (78%) Conflict Prevention and Response Training (CPART or CPAR)

- 7 (4.2%) Jireh Escort/Jireh Standing/Jireh Seated
- 22 (13.1%) Crisis Prevention Institute **(**CPI**)**
- 4 (2.4%) David Mandt System
- 2 (1.2%) Therapeutic Crisis Intervention **(**TCI**)**

The 168 reports of the use of safety holds reflect the following descriptive information:
- 94 (56%) were male and 74 (44%) were female.
- Average age was 10.88, ranging in age from 6 to 17 years.
- 84 (50%) were Caucasian, 66 (39.3%) were Black/African-American, 6 (3.6%) were American Indian/Alaskan Native, 1 (.6%) was Native Hawaiian/Other Pacific Islander and 11 (6.5%) were of mixed race.
- 16 (9.5%) were of Hispanic origin.

Clinical and safety hold information:
- The 5 most frequent diagnoses were Bipolar Disorder NOS, Mood Disorder NOS, Bipolar Disorder I, Posttraumatic Stress Disorder, and Reactive Attachment Disorder of Infancy or Early Childhood
- 125 (74.4%) of children and adolescents had a safety hold used on them previously.
- Average length of safety holds was 10.65 minutes, ranging from 1 to 150 minutes.
- Type of supervision prior to use of safety hold
  - 50 (29.8%) group – 4 or more
  - 50 (29.8%) group of 2 or 3
  - 54 (32.1%) one-on-one
  - 5 (3%) line of sight
  - 8 (4.8%) other
  - 1 (.6%) missing information
- Injury report
  - 41 (24.4%) client injured
  - 6 (3.6%) staff injured
  - 2 (1.2%) peer injured
  - 118 (70.2%) no one injured
  - 1 (.6%) missing information

Highlights:
- Almost 75% of children and adolescents placed in safety holds had previous episodes of safety holds.
- Almost 24% of the children and adolescents who had safety holds had a diagnosis of Bipolar Disorder NOS.

Opportunities for improvement:
- Almost 25% of children and adolescents held in safety holds were injured as a result. This suggests the need to reduce the use of restraint as much as possible in Specialized Foster Care.
- Ensure that a complete safety hold history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- All Specialized Foster Care provider staff should receive training in a nationally recognized model of safety hold and de-escalation techniques.
- Specialized Foster Care providers should implement best practices in safety holds to include de-escalation techniques in order to reduce its use and to increase safety outcomes.

- Explore training in Aggression Replacement Training. Aggression Replacement Training (ART) is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART is to improve social skill competence, anger control, and moral reasoning (OJJDP Model Program's Guide).

Departure Conditions

Specialized Foster Care providers were asked to track and report departure conditions on children and adolescents discharged from services for calendar year 2009. A departure (or discharge) means either a child is discharged from a Specialized Foster Care agency or a child is discharged from one Specialized Foster Care home and admitted to another Specialized Foster Care home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period. The following list of 39 Specialized Foster Care providers reported a total of 907 departures, with an average of 22.35 per provider, ranging from 1 to 49. In 2008, 30 providers reported a total of 351 departures for the last 4 months of the year.

Agape
Briarwood North
Briarwood South
Casa De Vida
DCFS-NNCAS Adolescent Treatment Center
DCFS-NNCAS Family Learning Homes
DCFS-SNCAS Oasis
Eagle Quest
Father Flanagan's Boys Town
EEE
Foundation for the Stars
Golla Home
Hand Up Homes
Hope Healthcare Services
Impact Community Services
Kathy Hodge's House
Kids First
Koinonia
Las Vegas Home Health Our Kids Home
Lippert Home
London Family Services
Maple Star North
Maple Star Rural
Maple Star South
Mountain Circle
My Home
New Beginnings
Olive Crest
Reagan Home
Rite of Passage
SAFY
Saint Jude's
Sankofa
Shaw Homes
Trinity Youth Services
Ujima
Unity Village
Visions
White Pine Boys Ranch

The 907 departures reflect the following descriptive information.

- 565 (62.3%) were male and 342 (37.7%) were female.
- Average age at departure was 14.44, ranging from age 1 to 23 years.
- 473 (52.1%) were Caucasian, 263 (29%) were Black/African-American, 27 (3%) were American Indian/Alaskan Native, 4 (.4%) were Asian, 11 (1.2%) were Native Hawaiian/Other Pacific Islander, 95 (10.5%) were of mixed race, and 34 (3.7%) were unknown.
- 148 (16.3%) were of Hispanic origin.
- Custody Status
  - 469 (51.7%) were in child welfare custody

- 184 (20.3%) were in parental custody and on probation
- 153 (16.9%) were in custody of youth parole
- 14 (1.5%) were in Tribal custody
- 84 (9.3%) were in parental custody
- 3 (.3%) were missing custody information

- 856 (94.4%) were Medicaid or SCHIP recipients

Clinical and departure information:

- The most frequent diagnoses at admission were:
  - 108 (11.9%) Posttraumatic Stress Disorder
  - 90 (9.9%) Adjustment Disorder
  - 65 (7.2%) Bipolar Disorder NOS
  - 61 (6.7%) Mood Disorder NOS
  - 58 (6.4%) Attention Deficit/Hyperactivity Disorder
  - 56 (6.2%) Major Depressive Disorder
  - 55 (6.1%) Conduct Disorder
  - 53 (5.8%) Depressive Disorder NOS
  - 49 (5.4%) Bipolar I Disorder
- The average CASII composite score at admission was 22.82, with an average level of intensity of 4.46.
- The average CASII composite score at departure was 21.43, with an average level of intensity of 3.95.
- Reason for departure
  - 281 (31%) were reunified
  - 59 (6.5%) were adopted
  - 54 (6%) were placed with a relative
  - 24 (2.6%) were placed in independent living
  - 25 (2.8%) were emancipated
  - 56 (6.2%) were placed in a less restrictive setting
  - 166 (18.3%) were placed in a more restrictive environment
  - 105 (11.6%) were AWOL (runaway) from placement
  - 25 (2.8%) were placed in a private mental health facility
  - 47 (5.2%) were removed by placing agency
  - 25 (2.8%) were admitted to another home within the same agency
  - 36 (4%) were other responses
  - 4 (.4%) were missing information
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 9.74, which equals the restrictiveness score of a regular foster home.
  - 26 (2.9%) independent living by self
  - 25 (2.8%) independent living with friend
  - 70 (7.7%) home of natural parents for an 18-year-old
  - 226 (24.9%) home of natural parents for a child
  - 2 (.2%) school dormitory
  - 86 (9.5%) home of relative
  - 43 (4.7%) adoptive home
  - 3 (.3%) home of a family friend
  - 18 (2%) supervised independent living
  - 21 (2.3%) regular foster care

  - 49 (5.4%) special foster care
  - 3 (.3%) individual home emergency shelter
  - 35 (3.9%) family-based treatment home
  - 50 (5.5%) group treatment home
  - 1 (.1%) residential job corps center
  - 14 (1.5%) group emergency shelter
  - 50 (5.5%) residential treatment center
  - 16 (1.8%) wilderness camp (24-hour, year round)
  - 7 (.8%) medical hospital
  - 3 (.3%) drug-alcohol rehabilitation center
  - 14 (1.5%) intensive treatment center
  - 38 (4.2%) youth correction center
  - 33 (3.6%) county detention center
  - 22 (2.4%) state and private mental hospital
  - 13 (1.4%) jail
  - 39 (4.3%) missing information
- 381 (42%) completed treatment.
- Who recommended departure
  - 100 (11%) provider agency
  - 76 (8.4%) child welfare case manager
  - 73 (8%) parole/probation officer
  - 20 (2.2%) parent
  - 11 (1.2%) relative guardian
  - 3 (.3%) child's attorney
  - 36 (4%) judge or hearing master
  - 23 (2.5%) child's mental health practitioner
  - 439 (48.4%) child and family team
  - 89 (9.8%) child went AWOL
  - 27 (3%) other
  - 10 (1.1%) missing information

Highlights:

- 30% of children were in parental custody, while over half were in child welfare custody.
- 49% of children and adolescents achieved or returned to a permanent placement upon discharge (reunified, adopted, relative placement, independent living, and emancipation).
- The ROLES score of 9.74 for all discharged children and adolescents is equal to the restrictiveness of a regular foster home. The ROLES score for family-based treatment homes is 13 and for group homes is 14. This may indicate that, upon discharge from a family-based or group treatment home, children tended to be placed in a less restrictive environment.
- Upon departure, 57.3% of children and adolescents were going to a less restrictive setting to live.
- 48.4% of discharges from treatment homes were recommended by Child and Family Teams.
- Of the 375 children and adolescents who completed treatment, 290 (77.3%) of the discharges were recommended by the Child and Family Team. In 2008, only 138 (39.3%) of the discharges were recommended by the CFT.

Opportunities for improvement:

- Upon departure, 42% of children and adolescents had completed services in the treatment home. In 2008, 39.3% of children and adolescents had completed services. Children and adolescents are in Specialized Foster Care to receive treatment for their mental health needs. When treatment is not completed, one would assume that the client has not achieved the goals and objectives that would allow him/her to successfully function in a less structured, more normal environment. The reason(s) for the lack of treatment completion is not clear and warrants further exploration.

SUMMARY

This report outlines substantial opportunities for improvement for provider agencies to address. One of the primary opportunities for improvement will be to continue to report risk measures and departure conditions in an accurate and timely manner.

Based on aggregate data collected, areas of improvement can be addressed. Some of those recommended areas are:

- Provider agencies will have medication error policies that target positive actions steps when an error occurs and implement these policies.
- Provider agencies will maintain medication logs in children's Specialized Foster Care home agency records and implement medication log reviews by someone who does not administer the medication.
- Provider agencies will implement policies or protocols that address AWOL behaviors, including a section on the prevention of AWOLs when children and adolescents threaten to runaway and a section on crisis planning.
- Provider agencies will be trained in a nationally recognized model of restraint and manual guidance that emphasizes de-escalation techniques. Providers must be prepared in the event that an intervention becomes necessary.
- Provider agencies will address the reason(s) for the low percentage rate of successful treatment completion. Areas for exploration may include:
    - The need for Child and Family Team decision-making around client discharge
    - Comprehensive, individualized treatment plans that are reviewed every 90 days
    - Clarity on discharge criteria
    - Appropriate initial placement and admission criteria

In partnership with the Provider Support Team, the PEU will prioritize areas for program improvement and develop an action plan for implementation.

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ATTACHMENT A

PROVIDER NAME		# of Provider Reporting Periods	# of Provider Reports Submitted	% of Reports Completed
1.	Agape	12	12	100%
2.	Apple Grove	12	4	33%
3.	Briarwood - North	12	12	100%
4.	Briarwood - South	12	9	75%
5.	Casa De Vida	6*	6	100%
6.	DCFS Adolescent Treatment Center	12	12	100%
7.	DCFS Family Learning Homes	12	12	100%
8.	DCFS Oasis	12	12	100%
9.	Eagle Quest of Nevada	12	12	100%
10.	Evans Electrifying Enterprises	5**	5	100%
11.	Father Flanagan's Boys Town	12	12	100%
12.	Foundation for the Stars	3**	3	100%
13.	Fresh Start Services	12	2	17%
14.	Golla Home	12	12	100%
15.	Hand Up Homes	12	12	100%
16.	Hope Healthcare Services, Inc.	12	11	92%
17.	Impact Community Services	5*	5	100%
18.	Kathy's House	12	12	100%
19.	Kids First	12	12	100%
20.	Koinonia	12	12	100%
21.	Las Vegas Home Health –Our Kids Home	12	12	100%
22.	Lippert Home	7*	7	100%
23.	London Family & Children's Services	12	12	100%
24.	Maple Star Nevada - North	12	12	100%
25.	Maple Star Nevada – Rural	12	12	100%
26.	Maple Star Nevada – South	12	12	100%
27.	Mountain Circle Family Services	12	12	100%
28.	My Home	12	12	100%
29.	New Beginnings	12	12	100%
30.	Olive Crest Foster Family Agency	12	12	100%
31.	R House Community Treatment Center	12	12	100%
32.	Reagan Home	12	12	100%
33.	Rite of Passage	12	12	100%
34.	SAFY	12	12	100%
35.	Sankofa Group	12	12	100%
36.	Shaw Foster Homes, Inc.	12	12	100%
37.	St. Jude's Ranch for Children	12	12	100%
38.	Trinity Youth Services	12	12	100%
39.	Unity Village	12	12	100%
40.	Visions Treatment Home	12	12	100%
41.	Ujima Youth Services	12	12	100%
42.	Unity Family Services	12	2	17%
43.	White Pine Boys Ranch	7*	7	100%

* Agency was new in service or invited to report later in the data collection process.

** Agency closed.