MEDICAID REPORT 2010
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2009 SUMMARY

INTRODUCTION

Nevada children's mental health services in philosophy and practice 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, changing and challenging needs of children and their families. Mental health services offered under System of Care practice principals 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) appraises the children and families receiving mental health services and makes every effort to solicit feedback from the service recipients on 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) initiated and/or continued several key components of its expanding system for monitoring populations entering service, service recipient satisfaction and service delivery compliance.

Treatment Population

Descriptive Study of Mental Health Services

A detailed Descriptive Study was completed this past year that consisted of 3109 children served by the DCFS Children's Mental Health Services in Fiscal Year 2009 (July 1, 2008 through June 30, 2009). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 3109 children served by DCFS programs, 2196 (70.6%) received services in Clark County and 913 (29.4%) were served in Washoe County/Rural.

Community based outpatient programs served 87.5% of the clients statewide. The remaining 12.5% were served in residential and inpatient treatment settings.

Of all children served, 58% were 12 years of age or younger and 59% were male. Caucasian children accounted for 72% of all those served and African-American youngsters 24%. Children of Hispanic origin came to 24%.

In FY09, 58% of the children admitted to mental health services statewide were in the custody of their parent or family, 32% were in Child Welfare custody and 0.5% were in Youth Parole custody.

The complete report can be found in the appended DCFS Mental Health Services Descriptive Study SFY09. (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 provide feedback and information regarding those services in the course of their service delivery and later at the time of their discharge from treatment.

Service Surveys

DCFS/PEU conducted two youth and family service surveys during calendar year 2009.

DCFS Community-Based Mental Health Services

A parent/caregiver and a youth version of the DCFS community based mental health services survey was administered in April and May (Spring) of 2009. In the survey, five Neighborhood Family Service Center sites were polled in Las Vegas and three were polled in Reno. Responding to the survey were 287 parents/caregivers and 107 youth still in program services. Spring survey results indicated a statewide average 88% parent / caregiver positive rating and an 82% youth positive rating for the program areas targeted for review. Results of the Spring parent/caregiver and youth surveys were also reported to the federal Center for Mental Health Services as one requirement for Nevada's participation in the Community Mental Health Services Block Grant.

A summary of the Spring community-based survey results can be found in the appended DCFS Community Based Mental Health Services Survey. (Attachment B).

DCFS Residential and Psychiatric Inpatient Services

A parent/caregiver and a youth version of the DCFS Residential and Psychiatric Inpatient Services Survey was administered in mid-October through November (Fall) of 2009. The two Northern Nevada Child and Adolescent Services (NNCAS) residential program areas were polled as were the two Southern Nevada Child and Adolescent Services (SNCAS) residential / inpatient program areas. Responding to the survey were 22 parents/caregivers and 73 youth still in program. Results of the Fall survey indicated a statewide average 94% parent/caregiver positive rating and a 77% youth positive rating for the program areas targeted for review.

Following publication of the residential/inpatient services survey results, staff from the participating programs met to discuss issues raised in the survey and to propose solutions for increasing client satisfaction with their treatment experience. This process resulted in each program area formulating an Action Plan to be implemented by identified program staff during the next 12 months.

A summary of the Fall residential/psychiatric inpatient survey results can be found in the appended DCFS Residential and Psychiatric Inpatient Services Surveys. (Attachment C).

Youth and Parent/Caregiver Consumer Surveys At Discharge

By reason of its Joint Commission 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 has drafted and disseminated discharge survey instruments to additional residential programs and is now incorporating program feedback into rewrite versions of the documents. Protocol drafts are being readied for first review.

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 Risk Measurement

Risk measures are indicators based on the structure of a treatment home program and how it responds to and subsequently documents select critical incidents. Risk measures target safety issues that can arise with children and youth having behavioral challenges. Client demographic, clinical and other descriptive information is collected at the program level for such high risk areas as suicidal behavior, medication errors by type and outcome, client runaways (AWOL) with attendant information and incidents of safety holds including circumstances and outcomes. Risk measure data can serve to indicate treatment population trends and might suggest program areas in need of improvement.

In September 2008, client departure condition data were added to the risk measures data collection and analysis efforts. Departure condition data are captured for each client who leaves a treatment home. Information collected includes demographic and clinical variables, client Child and Adolescent Service Intensity Index scores upon admission and at departure, reason for departure and with what disposition, and was treatment considered completed.

In 2009, DCFS/PEU captured a full 12 months of DCFS community treatment home program risk measurement and departure condition data. For all of last year statewide there was one suicide attempt reported (no client harm); a total of 15 various medication errors (no client harm) and 130 safety hold episodes (no client harm). Of 138 client discharges statewide, 71% occurred with Child and Family Team recommendation.

Summaries of the high risk areas and departure conditions captured for DCFS community treatment home programs will be found in three appended Risk Measures and Departure Conditions Reports for SNCAS Oasis, NNCAS Adolescent Treatment Center, and NNCAS Family Learning Homes respectively (Attachments D, E and F).

Supervisor Checklists

For over a year mental health supervisors have been using two DCFS/PEU developed service-specific case review checklists to help guide their feedback to staff when directing and improving direct service provider and/or targeted case management service provider adherence to relevant policy and documentation requirements. In this past year, continued supervisor/PEU collaboration introduced additional revisions to these important tools.

Current versions of the Children's Mental Health Direct Service Delivery Clinical Supervisor Checklist and the Targeted Case Management Supervisor Checklist will be found appended respectively (Attachments G and H).

Program Quality Assurance Monitoring

As the Division's sole Joint Commission credentialed treatment facility, DWTC continues to conduct its programs in strict compliance with the Commission's operational mandates. As mentioned in earlier Medicaid reports, DWTC patients and/or their parents/caregivers are administered consumer service evaluations upon discharge with monthly reports being forwarded to the Joint Commission. 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.

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 several processes in seeking to maximize the adequacy and integrity of its client data.

Data Clean-up

DCFS/PEU engages in on-going efforts to identify, isolate, remediate and monitor specific data deficiencies in the Avatar management information systems. Recent efforts have focused on monitoring new Avatar data fields that capture the Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool Child Functioning Assessment Scale (PECFAS) scoring and a different data set for tracking client educational and juvenile justice outcome information.

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. In addition to its ongoing data monitoring efforts, last year MAD finalized the business processes and design for Avatar data input screens needed to capture juvenile justice and client educational outcome information. MAD has graduated to a "special issues" meeting schedule in continuing to be available as needed in support of the DCFS commitment to its data quality, adequacy and integrity.

Additional Program Evaluation Unit Activities

Community Mental Health Block Grant

The State of Nevada has been a long time participant in a Community Mental Health Block Grant (CMHBG) provided through the federal Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration. This grant assists participating states to establish or expand their capacity for providing organized and on-going mental health services for adults with severe mental illness (SMI) and children with severe emotional disturbance (SED). DCFS has represented children's mental health services in this grant since the Division was created by State legislative action in 1991.

CMHBG participation requires state accountability for funds expended and outcomes achieved. The CMHBG meets this goal by requiring that states use and report on a set of uniform National Outcome Measures. These measures identify five areas or "indicators" important for a state's mental health programming success and include such topics as increased access to services, client perception of care, reduced incidence of psychiatric program utilization, improved levels of functioning and social connection.

Grant implementation reporting also requires that states use a CMHS Uniform Reporting System (URS). The URS is made up of 21 separate tables of select client and program specific data that detail such information as the number and socio-demographic characteristics of children served by DCFS, outcomes achieved as a result of that service, client assessment of care received, client insurance status, program census characteristics, length of stay measures and so on.

The DCFS/PEU supports State of Nevada participation in the CMHS block grant by capturing, collating, analyzing and formatting and reporting all of the children's mental health program data noted above.

Wraparound Service Delivery Model Fidelity Evaluation

DCFS/PEU is partnering with Wraparound in Nevada for children and Families (WIN) program managers and supervisors by evaluating for model fidelity the services being provided to wraparound clients. This past year DCFS/PEU began conducting structured interviews with wraparound facilitators, parent/caregivers and age appropriate youth using the Wraparound Fidelity Index (WFI) instrument. These interviews are an important component of the project's evaluation design. WFI interviews began in December 2009 for the rural and north WIN programs.

Seclusion/Restraint of Clients

In support of a DCFS seclusion/restraint policy update begun last year, DCFS/PEU designed a data input form for capturing policy related incidents and built (and maintains) a database for housing reported incident related information. Regular reports required by the Nevada Commission on Mental Health and Developmental Services are generated from the database and it is available for other DCFS reporting or data needs as well.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Evaluation

TF-CBT is an evidenced-based mental health treatment approach designed to help clients overcome trauma-related syndromes secondary to child abuse and other traumatic events. The PEU collaborated with clinical program managers in designing an evaluative function for those program areas adopting TF-CBT as a treatment modality.

Clinical Training

The Child and Adolescent Functional Assessment Scale (CAFAS) is an evaluative tool used in children's mental health for assessing a youth's day-to-day functioning across critical life domains and for determining a youth's functional improvement over time. Select DCFS/PEU staff helped provide regional training to clinical staff on the CAFAS and how to use it when evaluating their clientele.

Ongoing Reports

Since last year's Medicaid report, a new case data integrity report has become fully operational. A client activity report identifies cases that have been open for more than 24 months or more. The report is used by managers and supervisors to ensure that clients' are receiving appropriate treatment and that treatment plans include a discharge plan. A second client activity report identifies all open cases inactive for 90 days or more and six months or more. The report identifies clients by name, program, therapist, and case supervisor. The report supports decision making for closing those cases that are no longer in need of treatment services.

CONCLUSION

The DCFS quality assurance and quality improvement model encompasses efforts to understand and optimize all possible factors influencing service delivery and outcomes. DCFS/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. DCFS/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. DCFS/PEU Quality assurance and quality improvement efforts continue to 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:

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ATTACHMENT A

DCFS Mental Health Services
Descriptive Study SFY 09

Division of Child and Family Services

DESCRIPTIVE SUMMARY OF CHILDREN'S MENTAL HEALTH SERVICES Fiscal Year 2009

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The following is the descriptive summary of the children who were served by the Division of Child and Family Services (DCFS) Children's Mental Health Services in Fiscal Year 2009 from July 1, 2008 through June 30, 2009. The FY 2009 Descriptive Study provides an expanded analysis of DCFS programs. This FY 2009 report examines served data statewide and by programs. Children served are those who received a service sometime during the fiscal year. This report provides descriptive information on each DCFS Children's Mental Health Services' program.

The Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) are used as clinical tools that assess individuals' progress and as pre-post outcome measures for program evaluation. The CAFAS and the PECFAS subscale scores were examined at admission and at 3-months for residential program areas and at admission and at 6-months for community-based program areas.

SURVEY COMMENT FROM A SATISFIED PARENT

I am just grateful that you and this service are here and available to us.

This descriptive report summarizes demographic and clinical information on the 3109 children served for mental health services across the State of Nevada in DCFS Children's Mental Health programs. DCFS Children's Mental Health programs are divided into Southern Nevada Child and Adolescent Services (SNCAS), with locations in southern Nevada, and Northern Nevada Child and Adolescent Services (NNCAS), with locations in northern Nevada, which includes the Wraparound in Nevada program serving the rural region. Programs are outlined in the following table.

Programs for Southern Nevada Child and Adolescent Services (SNCAS) and Northern Nevada Child and Adolescent Services (NNCAS)

SNCAS	NNCAS
Community-Based Services	
Children's Clinical Services	Outpatient Services
Early Childhood Mental Health Services	Early Childhood Treatment Services
Wraparound in Nevada	Wraparound in Nevada
Pharmacy Services	Pharmacy Services
Treatment Homes	
Oasis On-Campus Treatment Homes	Adolescent Treatment Center
	Family Learning Homes
Residential Facility and Psychiatric Hospital	
Desert Willow Treatment Center	

CHILDREN'S MENTAL HEALTH

Number of Children Served

Statewide	NNCAS	SNCAS
3109	913 (29.4%)	2196 (70.6%)

Admissions

Statewide	NNCAS	SNCAS
1722	491 (28.5%)	1231 (71.5%)

SURVEY COMMENT FROM A SATISFIED YOUTH

I think all the help they give me is the best help I have ever gotten.
It's really changed my life.

CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

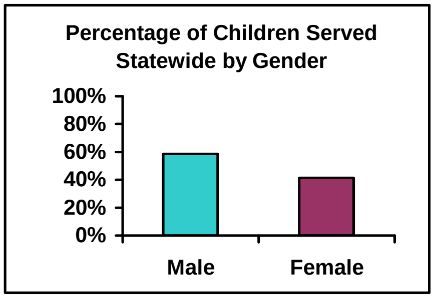
Statewide and by Region

Age

Age Group	Statewide	NNCAS	SNCAS
Average age	10.88	11.49	10.62
0–5 years old	24.3%	15.6%	27.9%
6–12 years old	33.9%	40.4%	31.2%
13–18 years old	40.4%	42.7%	39.4%
19+ years old	1.4%	1.3%	1.5%

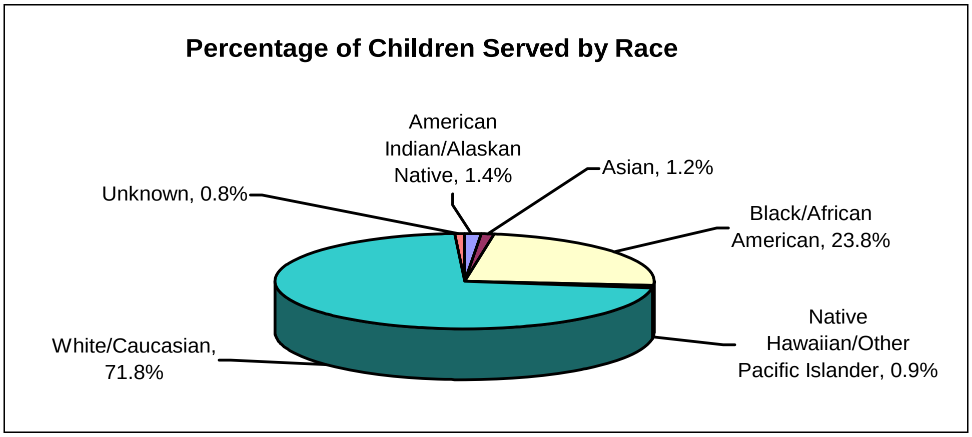
Gender

	Statewide	NNCAS	SNCAS
Male	1818 (58.5%)	520 (57%)	1298 (59.1%)
Female	1291 (41.5%)	393 (43%)	898 (40.9%)



Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	44 (1.4%)	23 (2.5%)	21 (1%)
Asian	38 (1.2%)	5 (.5%)	33 (1.5%)
Black/African American	741 (23.8%)	77 (8.4%)	664 (30.2%)
Native Hawaiian/Other Pacific Islander	29 (.9%)	11 (1.2%)	18 (.8%)
White/Caucasian	2232 (71.8%)	786 (86.1%)	1446 (65.8%)
Unknown	25 (.8%)	11 (1.2%)	14 (.6%)
Ethnicity	**Statewide**	**NNCAS**	**SNCAS**
Hispanic Origin	748 (24.1%)	198 (21.7%)	550 (25%)



Custody Status at Admission

	Statewide	NNCAS	SNCAS
Parent/Family	1810 (57.9%)	647 (70.9%)	1154 (52.6%)
Child Welfare	996 (32%)	126 (13.8%)	870 (39.6%)
DCFS Youth Parole	17 (.5%)	4 (.4%)	13 (.6%)
Other	76 (2.4%)	18 (2%)	58 (2.6%)
Missing	219 (7%)	118 (12.9%)	101 (4.6%)

Severe Emotional Disturbance Status at Admission

Statewide	NNCAS	SNCAS
2793 (89.8%)	841 (92.1%)	1952 (88.9%)

Demographics by Program

Community-Based Services

Outpatient Services (OPS) – NNCAS and Children's Clinical Services (CCS) – SNCAS

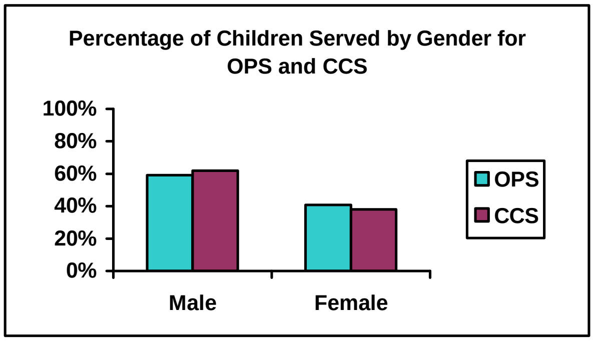
Number of Children Served

OPS	CCS
386	972

Age

The average age of children served for OPS was 13.8327 and CCS was 13.3429.

Age Group	OPS	CCS
0–5 years old	1 (.3%)	0 (0%)
6–12 years old	142 (36.8%)	426 (43.8%)
13–18 years old	240 (62.2%)	539 (55.5%)
19+ years old	3 (.8%)	7 (.7%)



Gender

	OPS	CCS
Male	228 (59.1%)	602 (61.9%)
Female	158 (40.9%)	370 (38.1%)

Race and Ethnicity

Race	OPS	CCS
American Indian/Alaskan Native	5 (1.3%)	10 (1.0%)
Asian	4 (1.0%)	12 (1.2%)
Black/African American	32 (8.3%)	266 (27.4%)
Native Hawaiian/Other Pacific Islander	7 (1.8%)	14 (1.4%)
White/Caucasian	338 (87.6%)	665 (68.4%)
Unknown	0 (0%)	5 (.5%)
Ethnicity	**OPS**	**CCS**
Hispanic Origin	96 (24.9%)	250 (25.7%)

Custody Status at Admission

	OPS	CCS
Parent/Family	338 (87.6%)	636 (65.4%)
Child Welfare	35 (9.1%)	292 (30.0%)
DCFS Youth Parole	3 (0.8%)	2 (0.2%)
Other	10 (2.6%)	35 (3.6%)
Missing	0 (0%)	7 (0.7%)

Early Childhood Treatment (ECT) – NNCAS and Early Childhood Mental Health Services (ECMHS) – SNCAS

Number of Children Served

ECT	ECMHS
290	692

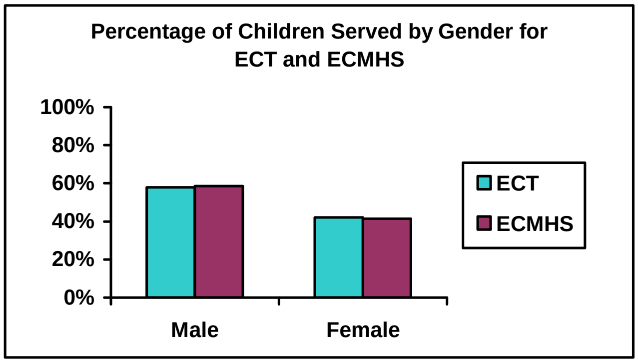
Age

The average age of children served for ECT was 6.2199 and ECMHS was 4.3094.

Age Group	ECT	ECMHS
0–5 years old	132 (45.5%)	573 (82.8%)
6–12 years old	158 (54.5%)	119 (17.2%)

Gender

	ECT	ECMHS
Male	168 (57.9%)	405 (58.5%)
Female	122 (42.1%)	287 (41.5%)



Race and Ethnicity

Race	ECT	ECMHS
American Indian/Alaskan Native	7 (2.4%)	3 (0.4%)
Asian	1 (0.3%)	13 (1.9%)
Black/African American	29 (10.0%)	267 (32.8%)
Native Hawaiian/Other Pacific Islander	3 (1.0%)	2 (0.3%)
White/Caucasian	250 (86.2%)	444 (64.2%)
Unknown	0 (0%)	3 (.4%)
Ethnicity	**ECT**	**ECMHS**
Hispanic Origin	67 (23.1%)	192 (27.7%)

Custody Status at Admission

	ECT	ECMHS
Parent/Family	266 (91.7%)	305 (44.1%)
Child Welfare	19 (6.6%)	379 (54.8%)
Other	5 (1.7%)	6 (0.9%)
Missing	0 (0%)	2 (0.3%)

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
807	162 (20.0%)	149 (18.5%)	496 (61.5%)

Age

The average age of children served was 13.71–Statewide; 14.33–North; 12.88–Rural; 13.75–South.

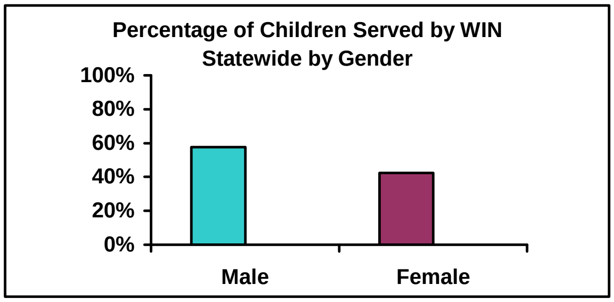
Age Group	Statewide	North	Rural	South
0–5 years old	18 (2.2%)	4 (2.5%)	13 (8.7%)	1 (.2%)
6–12 years old	303 (37.5%)	49 (30.2%)	56 (37.6%)	198 (39.9%)
13–18 years old	448 (55.5%)	103 (63.6%)	75 (50.3%)	270 (54.4%)
19+ years old	38 (4.7%)	6 (3.7%)	5 (3.4%)	27 (5.4%)

SURVEY COMMENT FROM A SATISFIED YOUTH

I have a better relationship with my mom.

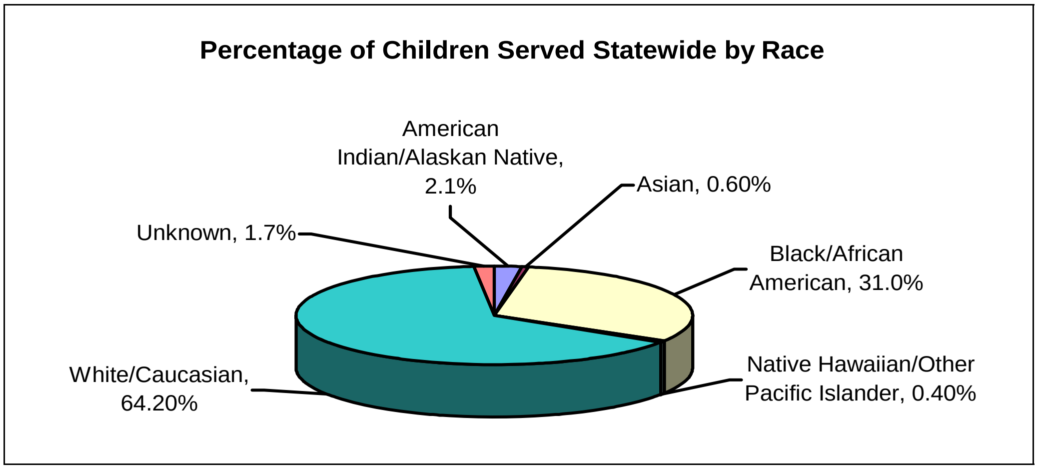
Gender

	Statewide	North	Rural	South
Male	466 (57.7%)	109 (67.3%)	69 (46.3%)	288 (58.1%)
Female	341 (42.3%)	53 (32.7%)	80 (53.7%)	208 (41.9%)



Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	17 (2.1%)	3 (1.9%)	9 (6.0%)	5 (1.0%)
Asian	5 (0.6%)	0 (0%)	0 (0%)	5 (1.0%)
Black/African American	250 (31.0%)	12 (7.4%)	11 (7.4%)	227 (45.8%)
Native Hawaiian/Other Pacific Islander	3 (0.4%)	1 (.6%)	1 (0.7%)	1 (0.2%)
White/Caucasian	518 (64.2%)	144 (88.8%)	119 (79.9%)	255 (51.4%)
Unknown	14 (0.4%)	2 (1.2%)	9 (6.0%)	3 (.6%)
Ethnicity	**Statewide**	**North**	**Rural**	**South**
Hispanic Origin	121 (15.0%)	30 (18.5%)	18 (12.1%)	73 (14.7%)



SURVEY COMMENT FROM A SATISFIED PARENT

> *The most helpful thing is that our child is safe and not hurting herself or others....*

Custody Status at Admission

	Statewide	North	Rural	South
Parent/Family	187 (23.2%)	78 (48.4%)	26 (78.8%)	83 (20.3%)
Child Welfare	386 (47.8%)	80 (49.7%)	5 (15.2%)	301 (73.8%)
DCFS Youth Parole	4 (0.5%)	2 (1.2%)	1 (3.0%)	1 (0.2%)
Other	25 (3.1%)	1 (.6%)	1 (3.0%)	23 (5.6%)

Treatment Homes

Adolescent Treatment Center (ATC) – NNCAS, Family Learning Homes (FLH) – NNCAS, On-Campus Treatment Homes (OCTH) – SNCAS

Number of Children Served

ATC	FLH	OCTH
44	51	77

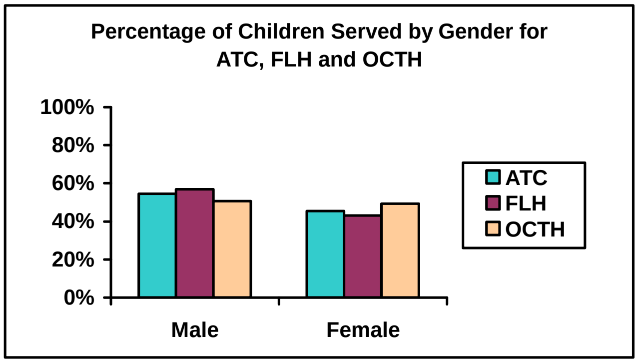
Age

The average age of children served was 15.89-ATC; 12.99-FLH, OCTH-13.75.

Age Group	ATC	FLH	OCTH
6–12 years old	2 (4.5%)	25 (49.0%)	30 (39.0%)
13–18 years old	42 (95.5%)	26 (51.0%)	47 (61.0%)

Gender

	ATC	FLH	OCTH
Male	24 (54.5%)	29 (56.9%)	39 (50.6%)
Female	20 (45.5%)	22 (43.1%)	38 (49.4%)



SURVEY COMMENT FROM A SATISFIED YOUTH
People are always there to help me.

Race and Ethnicity

Race	ATC	FLH	OCTH
American Indian/Alaskan Native	1 (2.3%)	1 (2.0%)	0 (0%)
Asian	0 (0%)	0 (0%)	0 (0%)
Black/African American	3 (6.8%)	3 (5.9%)	26 (33.8%)
Native Hawaiian/Other Pacific Islander	1 (2.3%)	0 (0%)	1 (1.3%)
White/Caucasian	39 (88.6%)	47 (92.2%)	49 (63.6%)
Unknown	0 (0%)	0 (0%)	1 (1.3%)
Ethnicity	**ATC**	**FLH**	**OCTH**
Hispanic Origin	9 (20.5%)	6 (11.8%)	8 (10.4%)

Custody Status at Admission

	ATC	FLH	OCTH
Parent/Family	36 (81.8%)	45 (88.2%)	36 (52.2%)
Child Welfare	7 (15.9%)	5 (9.8%)	23 (33.3%)
DCFS Youth Parole	0 (0%)	1 (2.0%)	2 (2.9%)
Other	1 (2.3%)	0 (0%)	8 (11.6%)

Residential Facility and Psychiatric Hospital

Desert Willow Treatment Center Acute Hospital (Acute) and Residential Treatment Center (RTC) – SNCAS

Number of Children Served

Acute	RTC
157	121

Age

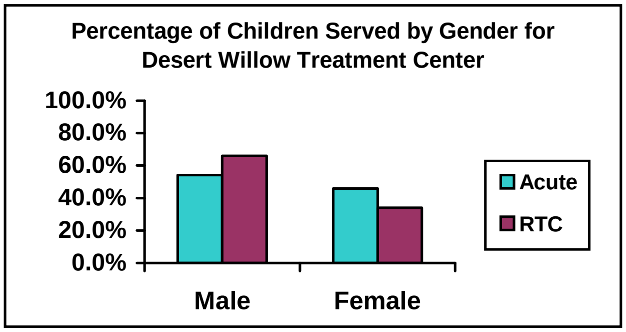
The average age of children served was 15.1933.

Age Group	Acute	RTC
0–5 years old	1 (0.6%)	0 (0%)
6–12 years old	45 (28.7)%	5 (4.1%)
13–18 years old	111 (70.7%)	115 (95.0%)
19+ years old	0 (0%)	1 (0.8%)

MEDICAID REPORT 2010
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2009 SUMMARY

Gender

	Acute	RTC
Male	85 (54.1%)	80 (66.1%)
Female	72 (45.9%)	41 (33.9%)

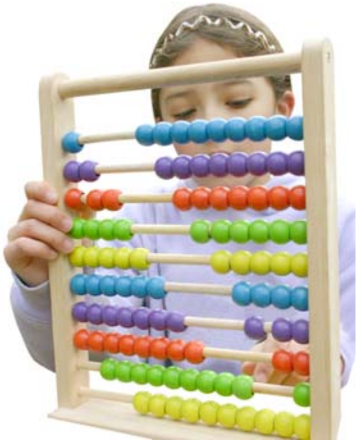


Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	2 (1.3%)	3 (2.5%)
Asian	5 (3.2%)	0 (0%)
Black/African American	31 (19.7%)	17 (14.0%)
Native Hawaiian/Other Pacific Islander	3 (1.9%)	0 (0%)
White/Caucasian	115 (73.2%)	100 (82.6%)
Unknown	1 (0.6%)	1 (0.8%)
Ethnicity	**Acute**	**RTC**
Hispanic Origin	61 (38.9%)	23 (19.0%)

Custody Status at Admission

	Acute	RTC
Parent/Family	143 (91.1%)	101 (83.5%)
Child Welfare	13 (8.3%)	7 (5.8%)
DCFS Youth Parole	0 (0%)	10 (8.3%)
Other	1 (0.6%)	2 (1.7%)
Missing	0 (0%)	1 (0.8%)



CHILDREN'S CLINICAL CHARACTERISTICS AND OUTCOMES

Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their child has encountered. Of the 51 problems listed, the six problems identified below accounted for forty-five percent (45%) of all problems reported.

- Adjustment Problems
- Depression
- Child Neglect Victim
- Parent-Child Problems
- Physical Aggression
- Suicide Attempt - Threat

Adjustment Problems and Depression are also the two most frequent admitting problems for NNCAS and SNCAS. Depression was not in the top five in FY 2008. Parent-Child Problems and Physical Aggression were tied for the fourth most frequent problem.

When analyzed by region, the most frequent admitting problem was Adjustment Problems. The second most frequent admitting problem was Depression. Parent-Child Problems was the third most frequently reported problem at NNCAS while Child Neglect Victim was the third most frequently reported problem at SNCAS.

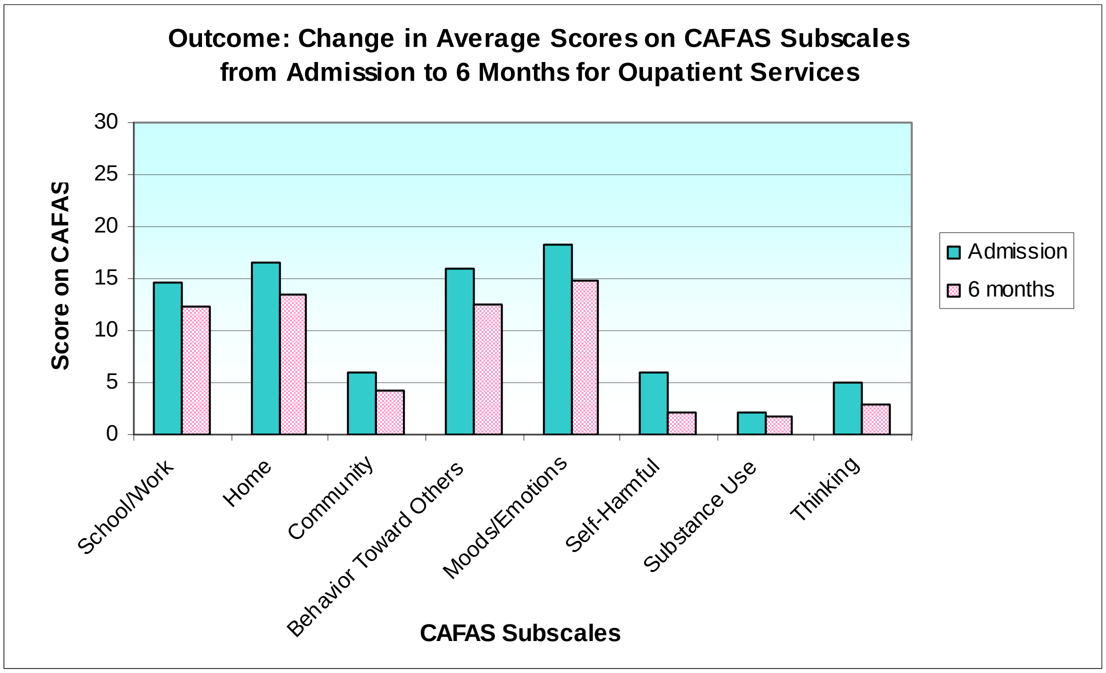
Child and Adolescent Functional Assessment and the Preschool and Early Childhood Functional Assessment

The Child and Adolescent Functional Assessment Scale (CAFAS) was designed to assess in children ages 6 to 18 years 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.

The Preschool and Early Childhood Functional Assessment Scale (PECFAS),[1] was also designed to assess degree of impairment in functioning of children ages 3-7 years with behavioral, emotional, psychological or psychiatric problems. PECFAS scores range from 0 to 210 with a higher score indicating greater impairment.

The CAFAS and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) are standardized instruments commonly used across child-serving agencies to guide treatment planning and as a clinical outcome measures for individual clients and program evaluation (Hodges, 2005). The CAFAS and the PECFAS are the primary outcome measures for DCFS Children's Mental Health.

Outpatient and Children's Clinical Services



Based on 138 pairs, the average CAFAS score was 84.35 at admission. At 6 months into services, the average CAFAS score decreased to 64.13, which indicates a statistically significant improvement in overall daily functioning.

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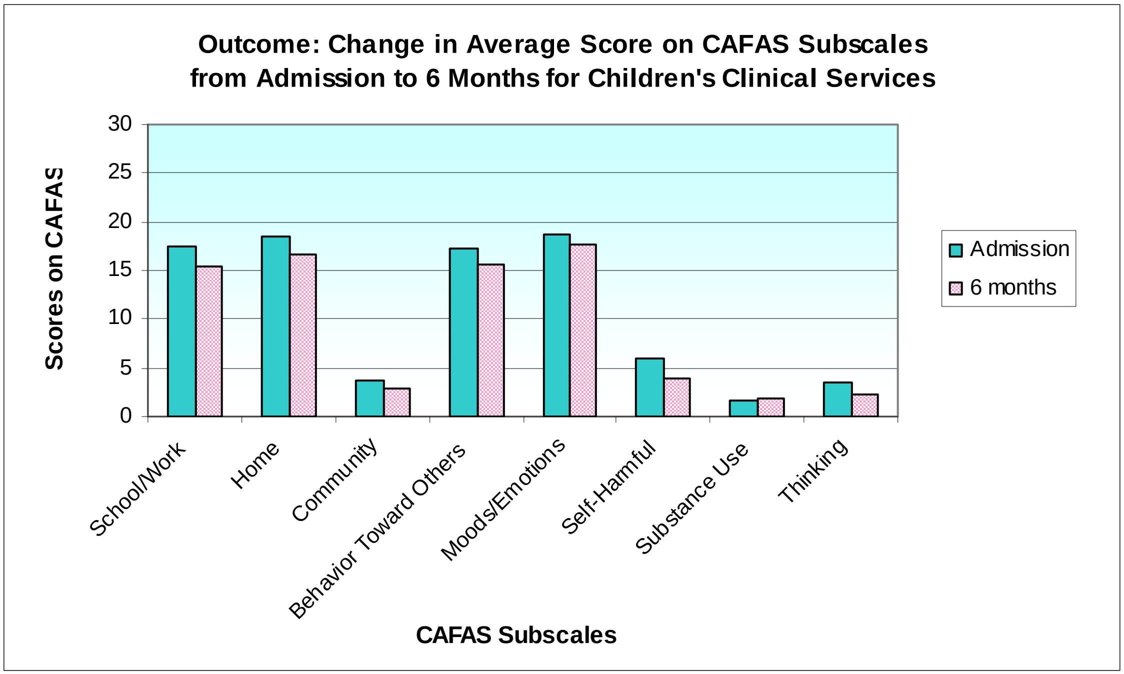
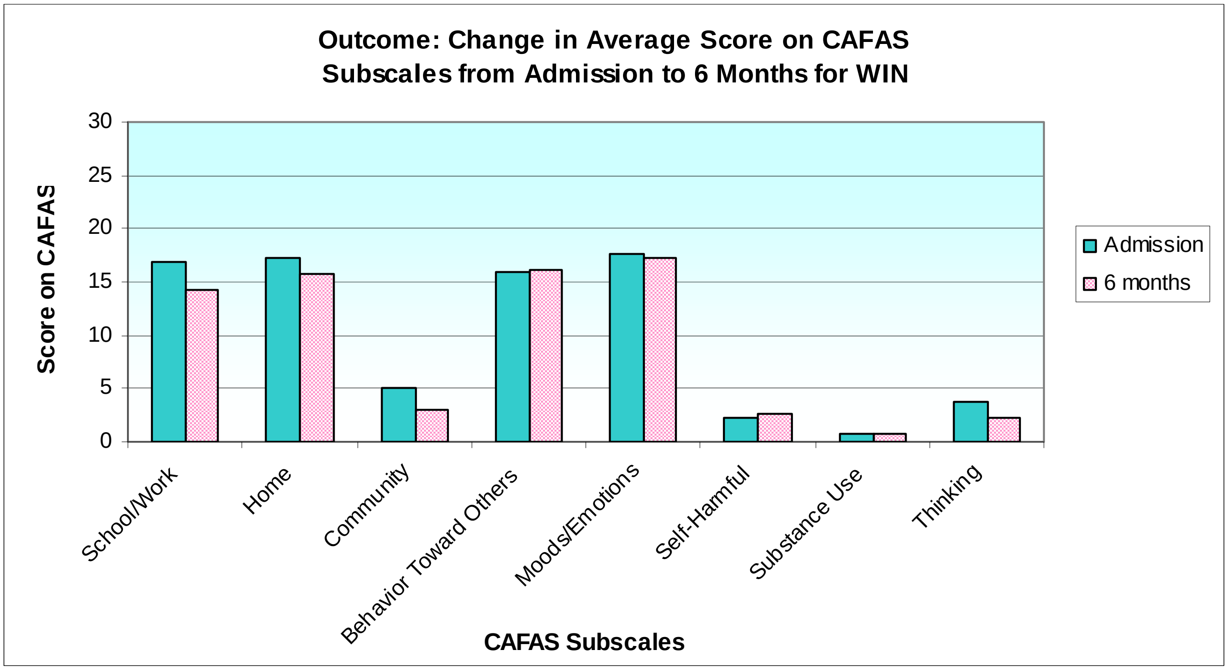
[1] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.



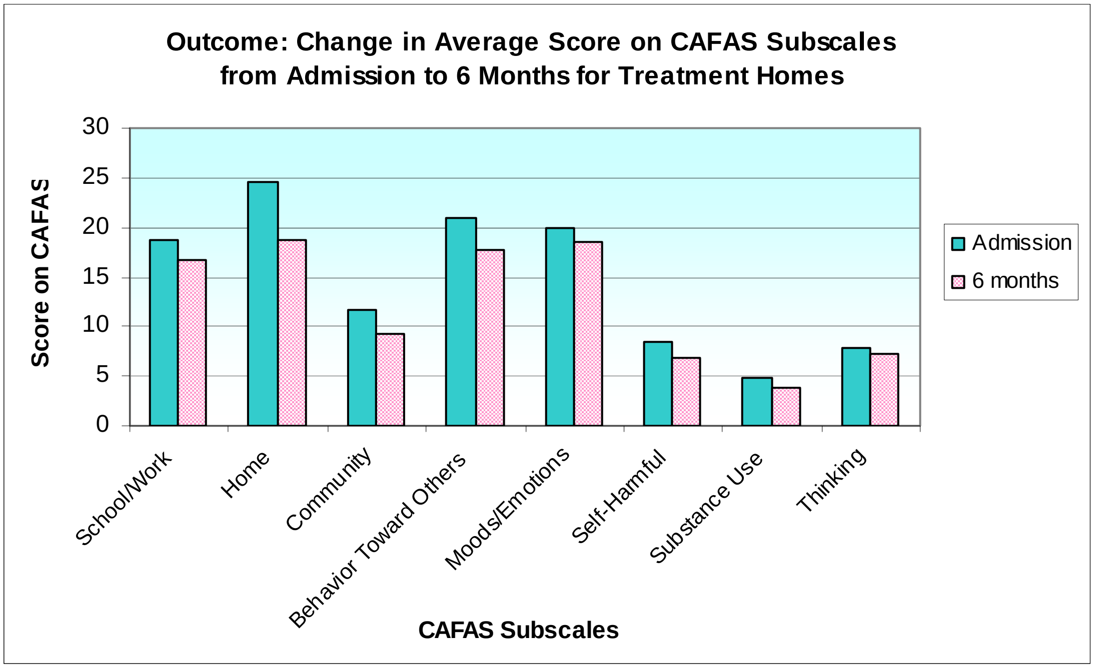
Based on 250 pairs, the average CAFAS score was 86.84 at admission. At 6 months into services, the average CAFAS score decreased to 76.44, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decease of 20 or more points.

WIN



Based on 74 pairs, the average CAFAS score was 79.46 at admission. At 6 months into services, the average CAFAS score decreased to 72.03, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decease of 20 or more points.

Treatment Homes

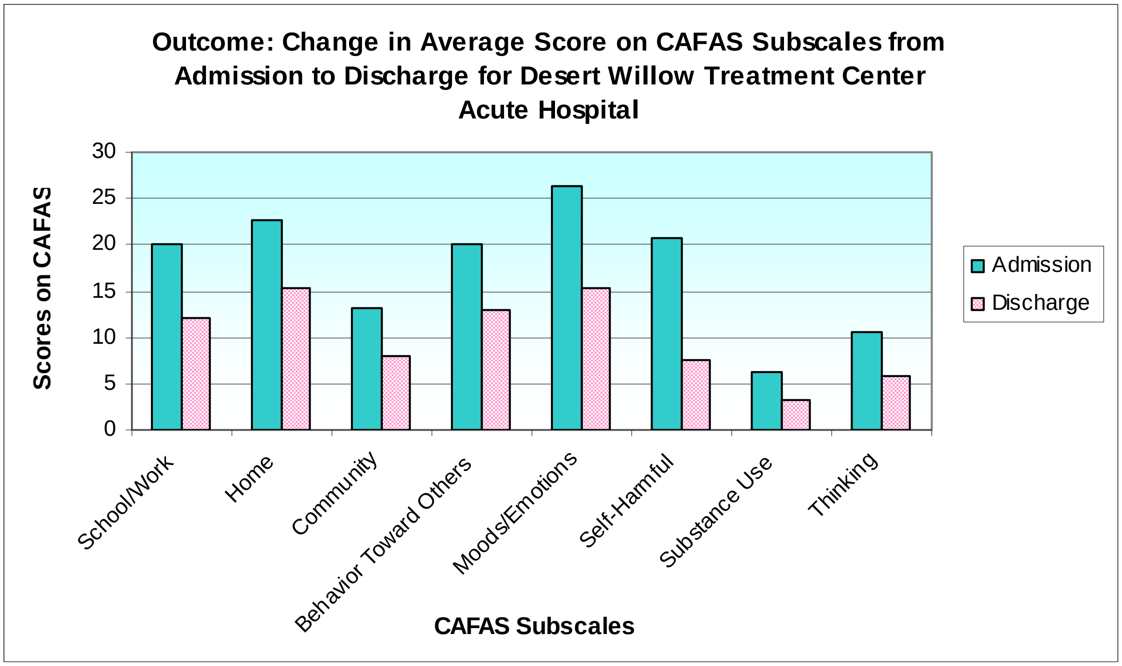


Based on 74 pairs, the average CAFAS score was 117.57 at admission. At 6 months into services or at discharge, the average CAFAS score decreased to 98.78, which indicates a statistically significant improvement in overall daily functioning which is nearly a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decease of 20 or more points.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

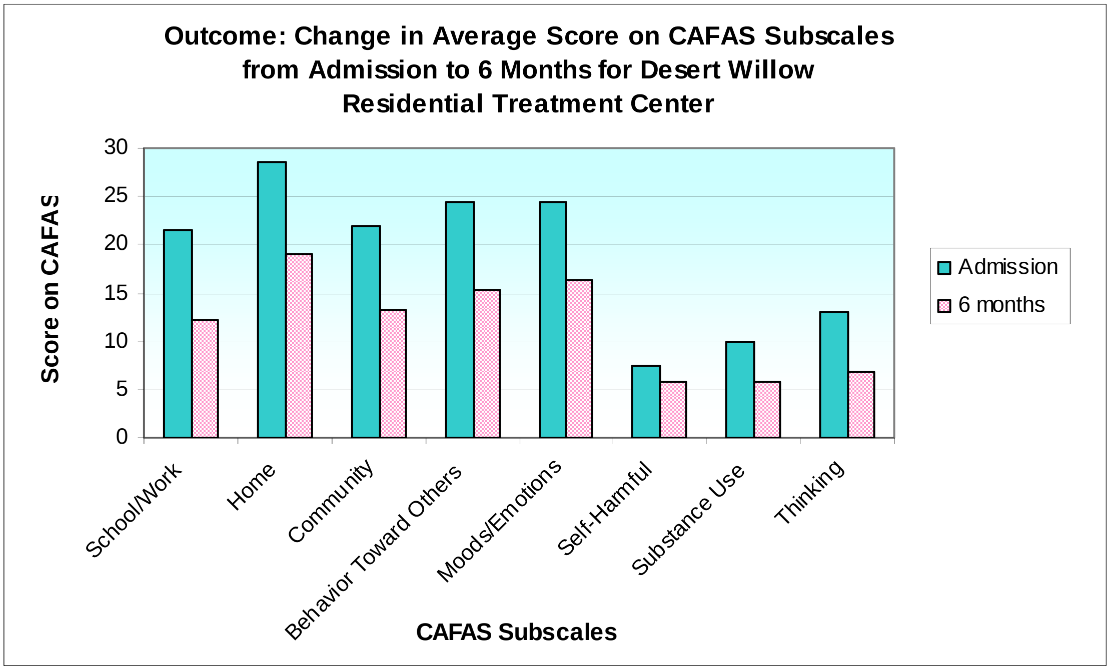
The crisis and danger were dealt with.
I feel like she is getting some serious help that she needs.

Desert Willow Treatment Center Acute Hospital



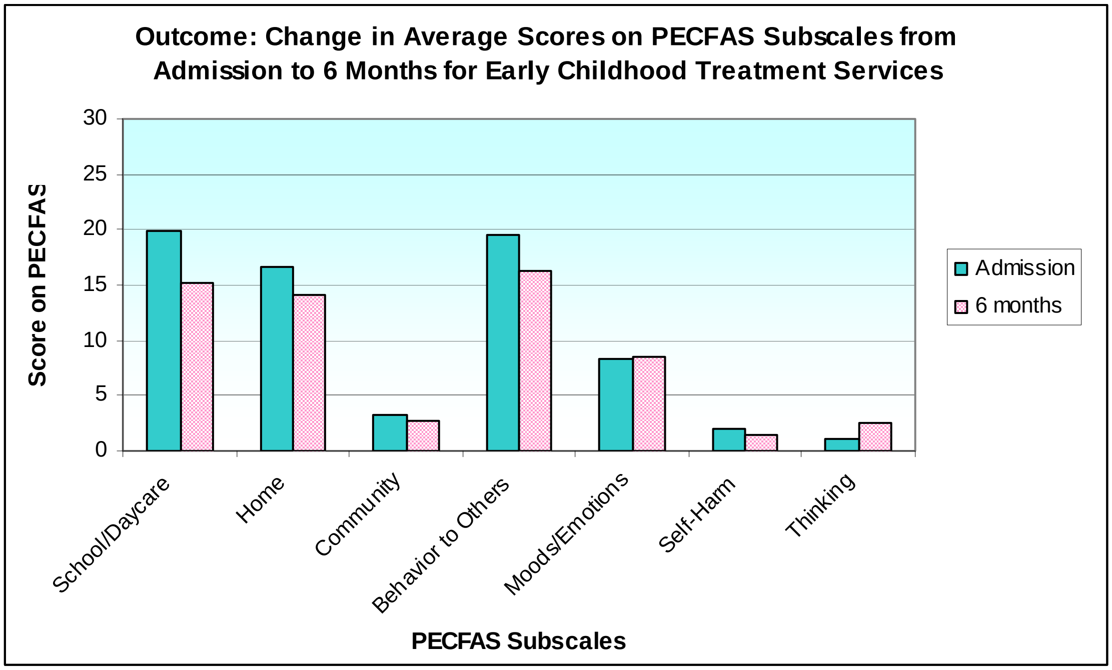
Based on 87 pairs, the average CAFAS score was 140 at admission. At 3 months into services or at discharge, the average CAFAS score decreased to 80.46, which indicates a statistically significant improvement in overall daily functioning.

Desert Willow Treatment Center RTC



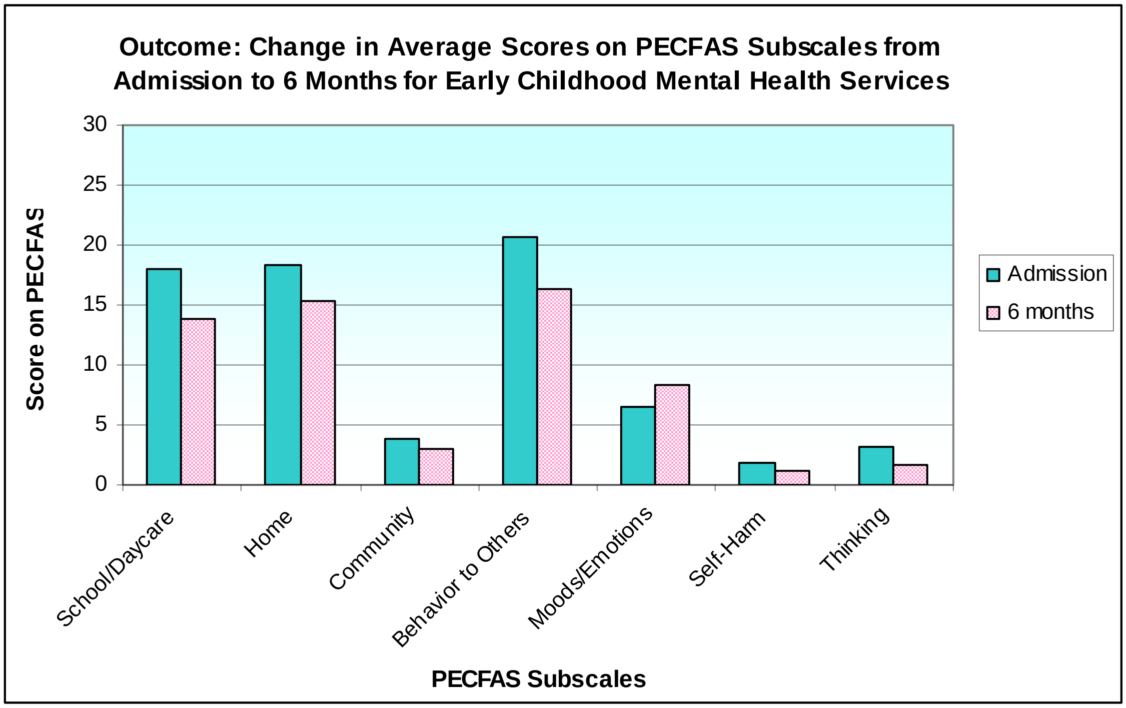
Based on 19 pairs, the average CAFAS score was 151.05 at admission. At 6 months into services or at discharge, the average CAFAS score decreased to 94.21, which indicates a statistically significant improvement in overall daily functioning.

Early Childhood Treatment Services (NNCAS)



Based on 41 pairs, the average PECFAS score was 72.93 at admission. At 6 months into services or at discharge, the average PECFAS score decreased to 60.73, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decease of 17.5 or more points.

Early Childhood Mental Health Services (SNCAS)



Based on 105 pairs, the average PECFAS score was 74.29 at admission. At 6 months into services or at discharge, the average PECFAS score decreased to 59.81, which indicates a statistically significant improvement in overall daily functioning.

Diagnosis

Over 32% of the FY 09 children met criteria for more than one diagnostic category at admission. The most prevalent Axis I diagnoses of children at admission by age category are listed below.

Age Group 0-5

- Disruptive Disorder NOS
- Adjustment Disorder
- Anxiety Disorder
- Deprivation/Maltreatment Disorder

Age Group 6-12

- Attention Deficit/Hyperactivity Disorder
- Posttraumatic Stress Disorder
- Oppositional Defiant Disorder

Age Group 13-18+

- Posttraumatic Stress Disorder
- Oppositional Defiant Disorder
- Depressive Disorder NOS
- Mood Disorder NOS

SURVEY RESULTS

Percent of Positive Response for Each Survey Domain

Community Based Services Survey – Spring 2009	Parent % positive	Youth % positive	National Benchmark for Parent Response[2]
Service are seen as accessible and convenient regarding location and scheduling	90	79	84
Services are seen as satisfactory and helpful	91	81	83
Clients get along better with family and friends and are functioning better in their daily life	73	76	64
Clients feel they have a role in directing the course of their treatment	89	80	87
Staff are respectful of client religion, culture and ethnicity	95	91	93
Clients feel supported in their program and in their community	91	86	NA
Clients are better able to cope and are doing better in work or school	75	78	NA
Important issues such as diagnosis, medication, treatment options, client rights and confidentiality were adequately explained by staff (community based domain)	88	82	NA

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[2] 2008 State Mental Health Measures: CMHS Uniform Reporting System Measures, available at http://download.ncadi.samhsa.gov/ken/excel/URS_Data08/AmericanSamoa.xls

Residential / Inpatient Services Survey – Fall 2008	**Parent % positive**	**Youth % positive**
Service are seen as accessible and conveniently scheduled	88	73
Services are seen as satisfactory and helpful	76	60
Clients feel they have a role in directing the course of their treatment	92	71
Important issues such as diagnosis, medication, treatment options, client rights and confidentiality were adequately explained by staff	84	71
Services are provided in a safe, comfortable and private environment	56	72
Staff are respectful of client religion, culture and ethnicity	78	69
Client educational needs are met while in treatment	63	83
Clients feel supported in their program and in their community	83	75
Clients feel they have a role in directing the course of their treatment	72	79

ATTACHMENT B

DCFS Community Based Mental Health Services Survey – Spring 2009

DCFS Community Based Services Parent / Caregiver – Youth Survey Results Statewide Spring 2009

From mid April to the end of May, 2009, DCFS conducted its spring survey of children's community based mental health service programs. Parent/caregivers with children in treatment and the children themselves (if age 11 or older) were solicited to voluntarily participate in completing the survey instrument. Participants were asked to disagree or agree with a series of statements relating to seven areas or "domains" that the Federal Mental Health Statistical Improvement Program (MHSIP) prescribes whenever evaluating mental health programming effectiveness. An eighth domain surveyed select items of interest to community-based service program managers.

The seven MHSIP domains include statements concerning the ease and convenience with which respondents received services (Access); whether they liked the service they received (General Satisfaction); the results of the services (Positive Outcomes); respondent ability to direct the course of their treatment (Participation in Treatment); whether staff were respectful of respondent religion, culture and ethnicity (Cultural Sensitivity); whether respondents felt they had community-based relationships and support (Social Connectedness); and how well respondents seem to be doing in their daily lives (Functioning). The eighth domain (Interest Items) includes statements regarding client treatment and confidentiality issues, family dynamics/relating skills and client awareness of available community support services.

Survey Results Format

For this report, community based services survey results are in table format and are presented by type of service: Children's Clinical Services, Wraparound in Nevada and Early Childhood Mental Health Services under the Southern Nevada Child & Adolescent Services (SNCAS) and Outpatient Services, Wraparound in Nevada, and Early Childhood Treatment under the Northern Nevada Child & Adolescent Services (NNCAS). Parent/caregiver and youth responses appear together under each domain. Statements listed under each domain are from the Parent/caregiver survey instrument. Youth responded to the same statements that had been reworded to apply to them. Early Childhood services have only parent/caregiver responses as the children served are too young (six years or less) to self-report on a survey instrument

The Parent/Caregiver and Youth Positive Response numbers appearing under each domain are percentages. A percentage number represents the degree to which a particular domain statement was endorsed or rated positively by respondents. Since not every survey respondent answers every

statement, each statement's percentage numbers are based upon the actual number of responses to that particular statement.
You will notice that any statement on the survey with less than a 60% Positive Response number is "courtesy highlighted". Courtesy highlights call attention to any survey item having a respondent endorsement rate that is approaching the lower end of the frequency scale. Children's Clinical Services/Outpatient, Wraparound in Nevada or Early Childhood programs having courtesy highlighted items may wish to monitor these particular items in subsequent surveys should similarly low endorsement rates re-occur. Programs might opt to give special attention to a highlighted statement's subject matter when considering if any programmatic or other corrective action might be taken. Programs may also want to compare results with previous survey findings.

Following each service area's domain results, you will find listed whatever remarks respondents offered regarding what was the most helpful thing about the services they received, what would improve upon the services they received and any additional comments they might have had.

A final section on survey participation concludes the report.

Survey Participants

Parents or caregivers with children receiving community based mental health treatment and the children themselves when age appropriate were participants in this spring survey. Responding to the survey were 287 parents/caregivers and 107 youth still in program. Survey participants were solicited by clerical/other office staff at the different locations providing the clients' mental health services. Survey questionnaires were self-administered and when completed put into closed collection boxes. Some caregivers and parents chose to complete the surveys at home and mailed them to Planning and Evaluation Unit offices. Survey participation was entirely voluntary and survey responses were both anonymous and confidential.

The following table presents the number of parent/caregiver and number of youth surveys received from each region and treatment site. The parent/caregiver section of the table also includes the percentage of clients served who were sampled by the respective area's survey. Youth percentages are not given since not all clients served were age eligible for survey participation so any percentage would be non representative.

REGION & SITE	SURVEYS				
	Parent/Caregiver			Youth	
	Number of Surveys	Number of Clients Served	Survey Sample Percent	Number of Surveys	Number of Clients Served
SNCAS					
Children's Clinical Services	52	434	12%	36	
WIN	43	358	12%	40	
Early Childhood Mental Health Services	106	304	35%	NA	NA
SNCAS Total	201	1096	18%	76	
NNCAS					
Outpatient Services	35	239	15%	9	
WIN –Reno/Rural	21	187	11%	22	
Early Childhood Treatment Services	30	186	16%	NA	NA
NNCAS Total	86	612	14%	31	
Statewide Total	287	1708	17%	107	

Note: SNCAS = Southern Nevada Child and Adolescent Services
WIN = Wraparound in Nevada
NNCAS = Northern Nevada Child and Adolescent Services

DCFS Community Based Services
Parent / Caregiver – Youth Survey Results
Statewide Spring 2009

SNCAS

Children's Clinical Services Results

Parent/Caregiver N=52; Youth N=36 **Total Served = 434 Sample = 12%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	90	67
Services were scheduled at times that were right for us.	94	80
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	94	89
The people helping my child and family stuck with us no matter what.	92	92
I felt my child and family had someone to talk to when he/she was troubled.	92	78
The services my child and family received were right for us.	92	72

I received the help I wanted for my child.	86	83
My family got as much help as we needed for my child.	82	86
POSITIVE OUTCOMES		
My child is better at handling daily life.	74	71
My child gets along better with family members.	66	57
My child gets along better with friends and other people.	76	68
My child is doing better in school and/or work.	80	81
My child is better able to cope when things go wrong	66	71
I am satisfied with our family life right now.	69	57
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	83	63
I helped to choose my child and/or family's treatment goals.	90	81
I participated in my child's and family's treatment.	92	79
CULTURAL SENSITIVITY		
Staff treated our family with respect.	94	91
Staff respected our family's religious/spiritual beliefs.	85	88
Staff spoke with me in a way that I understood.	96	91
Staff was sensitive to my family's cultural and ethnic background.	91	73
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	92	N/A
I have people that I am comfortable talking with about my child's problems.	92	N/A
In a crisis, I would have the support I need from family or friends.	86	86
I have people with whom I can do enjoyable things.	92	94
I am happy with the friendships I have.	N/A	71
I feel I belong in my community.	N/A	85
FUNCTIONING		
My child is better at handling daily life.	74	71
My child gets along better with family members.	66	57
My child gets along better with friends and other people.	76	68
My child is able to do the things he/she wants to do.	78	74
My child is doing better in school and/or work.	80	81
My child is better able to cope when things go wrong.	66	75

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	81	82
Staff explained my child and my family's rights and confidentiality issues.	90	92
I receive support and advocacy from my NV PEP Family Specialist.	87	65
My NV PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	86	74
Our family is aware of people and services in the community that support us.	88	80
I am better able to handle our family issues.	81	69
I am learning helpful parenting skills while in services	88	89
I have information about my child's developmental expectations and needs.	82	81

Parent / Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received?	1. What has been the most helpful thing about the services you received?

Parent / Caregiver comments	**Youth comments**
• being able to talk to someone other than me or his mom • access and information • Him able to talk to someone not me or his mom • To be able to see her more happy • Was able to get him off of ADHD medication • We have just started services • Don't know yet • The staff • The most helpful thing to me is that I have someone to talk to about issues at home who is not judgmental and is very knowledgeable and supportive of my family • Staff member name • The way services are implemented towards the whole family. • (Staff) has been wonderful in helping my boys and myself with discipline, controlling behaviors and being their when I need her. • The services adapt to my schedule as a single parent. • The ability to talk • Therapeutic sessions • That we aren't alone with these problems anymore. • Understand my child better, have more knowledge to handle it • The medication helps stabilize her. • Therapist honest, to the point. Uses easy to understand language. Genuinely cares, has our best interests @ forefront every time • I believe that knowing the people really care what happens to her and are willing (freely) to help. To some workers it becomes just a job, to these special workers it is more, maybe a calling or way of life • She has gotten better about a few things but needs to work hard at handling punishments and not throw temper tantrums when she doesn't get her way. • (Staff) is the best. He helps me understand my son. He gets things done. He really cares & it shows. You need more like him • Having someone to talk to about our problems and getting help for behavior issues • Services are very suited to the individual child. • A am very pleased that (son's) therapist takes my concerns regarding him seriously. • Change in behavior • Being a better person • The attention and support of the therapists, in the help with resources, when we need it. • Change in behavior • Being able to talk to someone regarding child's behavior & daily activities w/o judgment • Everything but I would say the counseling and the medication • Medication • Our therapist listened to our problems and had ideas to help resolve problems before they escalated • Someone else him being comfortable talking to about his issues not feeling like he only has me (mom) • Teaching (me) step mom how to deal with his behaviors neg. • WIN worker • Getting him on meds; getting school to help us • She likes her providers and looks forward to visiting them	• Having a home • Being able to talk about what's on my mind and being able to cry when I need to • Everything • Everything they do is helpful for me • The most helpful thing about the services I receive(d) is that I know who to do to when I need help • That they understand • I can talk to my mom and stuff, she can talk to me. • A friend that will always be there • Helping with anxiety • Nothing really. And that's more my fault I don't follow the direction of my therapist. • New placement • I don't know • Getting me an adoptive home I like • I feel like I am more confident and I'm not as angry • To walk away from someone who makes me mad • There are a lot of choices to make, but I liked the person to person talks • The fact that I cope better • Dealing with problems • Somebody to talk to • It's helped me see things differently • Medication • They help me with my problems • The most helpful things about the services I receive are how my therapist guides me step by step through the process. • I'm getting better • I know more about myself • I think all help they are giving me are the best help I have ever gotten it's really changed my life. • The coping skills. Having someone to talk to • (Staff) was most helpful for me she makes my family understand more about me and teaches me lesson • Don't really understand this question • The coping skills, family • The medication • They have helped me with most school problems
2. What would improve services your child and the family received? • In the past our family belief system was totally ignored. Our rights were never explained or adhered to. The physician has been excellent in respecting both. • Everything being done is great. Daughter is one who makes hard • OASIS • Everything is great • Better hours to see the doctor • (Client) receiving more intensive therapy w/Oasis group home and training for us to manage (client) in the same manner the group home would to improve family function. • Parenting classes for children with severe behavioral problems. • Well satisfied w/ services as they are • For the agency to have more money to help more people • She needs to be shown that not every-thing centers around her	2. What would improve services you received? • Nothing • Undecided at the moment • There's really nothing that needs improvement • I have no idea • New placement • He would take one out of class but he's great already • Help me get a cat, please • More games like the Ungame and interesting activities • Nothing would • Explain things better to me • Giving the therapist money to spend on kids for lunch, etc • It's already up to par • More one on one • Nothing everything is perfectly fine.

Parent/Caregiver comments	**Youth comments**
• After school activities • More organization at NV Partners. Just because my son looks ok it took me a long time to get anyone to realize he was not just a "normal teenager". I knew something was ***** • Nothing. The services thus far have been just great. • I am satisfied with the level of care my son is receiving. • More visits • To be more disciplined and obedient • Nothing. All good • More visits • No improvement needed at this time • Help w/ his school work, but they are working on that • Health service • Returned calls, actual help • More frequent maybe, he needs to be willing to open up • I would have liked an after hours/weekend person to talk to when problems occurred. • Do a meeting to diagnose or not of Aspergers and offer more suggestions or medication if feel necessary – PLEASE • The extra services we are waiting to start • Schools, Medicaid working w/ dcfs more cooperatively	• Nothing because they're very good • Having Medicaid services work faster getting meds and helping us out here.
3. Additional Comments • I feel that (staff), (staff) and staff are great. My family is always treated with great respect. Every staff member I have had contact with at this site has been very professional. • Many thanks, to (staff) for the help given, to my children and to me. Thanks to your organization for having these services in the community. God bless you and may you prosper with more money to continue with this service. • I am worried that we will be without the services that you offer to our children. • We thought (staff) was very helpful & patient, always returned phone calls immediately. We were very satisfied w/ him as (client's) counselor • I am just grateful that you and this service are here and available for us. Thank you and thank the lord. P.s. I don't know what we would have done if you had not been here. • I appreciate staff	3. Any additional comments? • I'm better than I was seven months ago • You're the best (staff) • (Staff) is funny • They should have more stuff like this • No, everything else is exceptional • For question 26 and 27 our specialist doesn't help us at all she never answers the phone and doesn't give us advise • I love it there best • I am grateful that I receive the services that you provide for my need. I congratulate you for your outstanding services.

SNCAS

WIN Results

Parent/Caregiver N=43; Youth N=40 **Total Served = 358 Sample = 12%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	95	97
Services were scheduled at times that were right for us.	88	89
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	86	88
The people helping my child and family stuck with us no matter what.	93	83
I felt my child and family had someone to talk to when he/she was troubled.	98	88
The services my child and family received were right for us.	86	79
I received the help I wanted for my child.	88	87
My family got as much help as we needed for my child.	76	95
POSITIVE OUTCOMES		
My child is better at handling daily life.	64	92
My child gets along better with family members.	80	74
My child gets along better with friends and other people.	65	84
My child is doing better in school and/or work.	75	87

SNCAS

WIN Results

Parent/Caregiver N=43; Youth N=40 **Total Served = 358 Sample = 12%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
My child is better able to cope when things go wrong	57	77
I am satisfied with our family life right now.	60	68
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	78	71
I helped to choose my child and/or family's treatment goals.	79	75
I participated in my child's and family's treatment.	95	73
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	95
Staff respected our family's religious/spiritual beliefs.	95	86
Staff spoke with me in a way that I understood.	95	95
Staff was sensitive to my family's cultural and ethnic background.	93	83
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	85	N/A
I have people that I am comfortable talking with about my child's problems.	93	N/A
In a crisis, I would have the support I need from family or friends.	93	89
I have people with whom I can do enjoyable things.	95	93
I am happy with the friendships I have.	N/A	85
I feel I belong in my community.	N/A	73
FUNCTIONING		
My child is better at handling daily life.	64	92
My child gets along better with family members.	80	74
My child gets along better with friends and other people.	65	84
My child is able to do the things he/she wants to do.	83	85
My child is doing better in school and/or work.	75	87
My child is better able to cope when things go wrong.	57	77

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	87	83
Staff explained my child and my family's rights and confidentiality issues.	90	88
I receive support and advocacy from my NV PEP Family Specialist.	73	68
My NV PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	68	77
Our family is aware of people/ services in the community that support us.	93	85
I am better able to handle our family issues.	90	75
I am learning helpful parenting skills while in services	87	89
I have information about my child's developmental expectations and needs.	86	84

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received?	1. What has been the most helpful thing about the services you received?
• Not a thing • therapy to help process the abuse she suffered • He has someone to talk • Calmed him down	• Food, shoes, clothes • Food and comes when a problem occurs • The food and the clothes • Coping skills

• Having (staff) as a WIN worker. She is professional, honest and caring • Willing to listen to possible things that could be or not be wrong • Assistance w/ transportation to therapy & visits by sw, win, psr • Team support • Someone to talk to other than a social worker • The team is great • We all agreed on the best situation and problem solving methods. We put all our ideas together • Sufficient medication • Our WIN worker • Staff & therapist @ safy • Able to talk to someone • Information we have received • The help he received from his team • They're always there if you need them • Having other adults who are willing to help, spend time with her etc. as she is in crisis w/ mental health issues • Knowing there is a team to assist him with issues • Have someone to talk to about his problems • Our family is working on issues of major concern. Direction for help which has been implemented and we continue to seek medical for other concerns • How caring staff is and continues to be during this process • Monthly cfts to assist w/ motivation, needs, etc to keep youth working on goals • To know my worker is always available • Appreciate the transportation help when needed. Communication is great • WIN worker very helpful • The services take into account family dynamics which affect all members and services are based on need • Services help all to cope more better with our issues • When she goes to therapy she seems more relaxed & confident about herself • Meds • Having a support team help me understand needs. Having a PSR • It helps him reach his goals • Cft mtg plus one on one w/ my WIN worker • Getting him the help he needs • Being able to call and talk freely w/ our therapist • Working on anger and getting community services all worked out in place	• I've learned how to cope with different problems • Dealing with life better • I don't know • I really don't know • They had given me the best foster home • WIN worker is always prepared for CFT • Having someone to talk to when I have to • They help me understand things and make me and my family happy! • Therapy because it helped me learn from my mistakes • Has been having a therapist because she has been talking to me about the things I need to do. • Therapist • That they understand • Who knows • My drug awareness class. It helped me get to where I need to be • Having people I can trust • Communication skills • Everyone so supportive of me and they help with whatever I need • Medication • Medicine helps control anger • They help me get to my appointment mtgs; they go to school meetings; all mtgs • I talk to more people and I'm happier • Trying to cope better • Talking about the situations I been through and letting go and moving on • Support the school • Manipulation • Having someone to talk to • Everything that they have taught me
2. What would improve services your child and the family received? • Basic skill worker • Workers are not on the same page and disagree & sabotage each other's recommendations • My child is receiving great services • Keep hiring great people • Easier accessibility • If someone can work one on one w/ her special need • More activities for kids NR • All the services are there for him. If we need more I call to ask for help • Time • Get an IEP right away, be given the test needed and medication needed • Everything was okay • That services continue so that the children are able to cope and recognize their condition • Stop switching staff. No new face • Additional community resources that could be made available to the service providers. Sometimes there aren't services available • Services don't need improvement • Having a DFS caseworker would be more helpful and stays longest on the case	2. What would improve services you received? • Nothing • The services I need I already got • To improve my services is to get me home with my mommy? • Nothing • I still don't know • Seeing my family • My home I have. I would like to move to a different house. • Having shorter therapy sessions • Nothing I can think of • I don't know. Everything's perfect. Thank • Scheduling • Nothing. Everything is fine the way it is • More insight
3. Additional Comments • (Staff) helped me a lot • Consistency of follow-up by workers has been great • They were very helpful to us in our time of need • Workers all have different opinions and lack understanding of foster parent role. They make decisions and then say "but don't tell the kids" we can't parent & be expected to be dishonest	3. Any additional comments? • Fun to talk to and laugh with • Not at all • (Staff) was the best person through this bad time in my life • I love everyone that is helping me • I hate you • I love my workers

- Everything is good
- (Staff) is very concerned about (client) & her needs. She is in constant contact
- I would like to get the test the kids need done right away. It's dragging along to me he has serious behavior problems.
- I am very grateful to have a team working with me and show genuine concern for my family and our needs
- Staff is inadequate and waiting lists are excessively long
- (Staff) is awesome. Very helpful and professional. I cannot say this about all win workers
- I appreciate what the WIN worker has done for us
- (Client) has shown improvement since joining New Vista
- (Staff) is very helpful and very understanding and patient and clearly concerned about the children

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=106; Youth = NA **Total Served = 304 Sample = 35%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	89	N/A
Services were scheduled at times that were right for us.	93	N/A
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	92	N/A
The people helping my child and family stuck with us no matter what.	90	N/A
I felt my child and family had someone to talk to when he/she was troubled.	93	N/A
The services my child and family received were right for us.	92	N/A
I received the help I wanted for my child.	90	N/A
My family got as much help as we needed for my child.	91	N/A
POSITIVE OUTCOMES		
My child is better at handling daily life.	75	N/A
My child gets along better with family members.	78	N/A
My child gets along better with friends and other people.	77	N/A
My child is doing better in school and/or work.	78	N/A
My child is better able to cope when things go wrong	63	N/A
I am satisfied with our family life right now.	76	N/A
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	82	N/A
I helped to choose my child and/or family's treatment goals.	92	N/A
I participated in my child's and family's treatment.	94	N/A
CULTURAL SENSITIVITY		
Staff treated our family with respect.	94	N/A
Staff respected our family's religious/spiritual beliefs.	94	N/A
Staff spoke with me in a way that I understood.	95	N/A
Staff was sensitive to my family's cultural and ethnic background.	93	N/A
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	90	N/A
I have people that I am comfortable talking with about my child's problems.	91	N/A
In a crisis, I would have the support I need from family or friends.	88	N/A
I have people with whom I can do enjoyable things.	89	N/A
I am happy with the friendships I have.	N/A	N/A

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=106; Youth = NA **Total Served = 304 Sample = 35%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I feel I belong in my community.	N/A	N/A
FUNCTIONING		
My child is better at handling daily life.	75	N/A
My child gets along better with family members.	78	N/A
My child gets along better with friends and other people.	77	N/A
My child is able to do the things he/she wants to do.	81	N/A
My child is better able to cope when things go wrong.	63	N/A

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	90	N/A
Staff explained my child and my family's rights and confidentiality issues.	91	N/A
I receive support and advocacy from my NV PEP Family Specialist.	85	N/A
My NV PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	87	N/A
Our family is aware of people/ services in the community that support us.	89	N/A
I am better able to handle our family issues.	89	N/A
I am learning helpful parenting skills while in services	94	N/A
I have information about my child's developmental expectations and needs.	90	N/A

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received?	1. What has been the most helpful thing about the services you received?
• They are understanding more of what they have to do • Therapy in the home setting - also the therapist allowing for bonding time - wasn't rushed • Showing her how to get along with other kids • He can play with other kids, do not hit me a lot, he can listen more • Teaching me better parenting to skills for all my children and showing me how to deal and help child with emotional behavioral problems. • Help with adjusting from an abusive foster home and settling into a new home • What I learned at the all day training at Safy working with our mental health specialist (staff) CPI training and county trainings are good also. • The support received for all our foster children • (Client) was put in the system early. (Client) is able to bond with me and love in a family environment • My child controls his anger • He has some else to talk too. Our M/H specialist was a great 'voice' and advocate for a young foster child. • Talking and intervention strategies dealing with issues that come up • The therapist and case worker have been the best they really care • They are understanding more of what they have to do • (Staff) did an outstanding job providing all the treatments needed for (client) and met all those goals we planned for him to accomplish. Day treatment was excellent service for any child who needs help with their behaviors and (client) turned 360% from where he started getting treatments • Able to attend school for two hours • He pays more attention when we are playing. He is changing his behavior	• NA

- The feeling I get that there is always someone to "watch my back" and direct me to needed resources
- Support on all his needs
- Everything
- They're always there whether or not they able
- Independent assessment of client needs
- My son is able to get along much better with others, especially in school
- Education and knowledge to help her
- Teaching us as a family. Some of his actions are normal for him. She has helped us a lot
- Therapy
- Always has answers to all my questions Helps us in anyway that she can can call her anytime we need her
- Now I can see what I was doing wrong by having a pro talk me through it
- When I have problems coming up on things I don't know what to do Services are the ready to help when I ask.
- He is beginning to open up and talk about painful feelings
- Close attention by trained specialist, early childhood, quest, child haven.
- (staff), (staff) dps and foster parents with his school and diagnosis and therapy treatment
- I have seen so much progress in him
- My child is getting along better w/ his sibling and expressing himself better
- She has someone who understands her traumas
- (Client) is becoming more stable and secure living with me her grandmother
- His behavior
- His behavior
- Better behavior
- Better behaved at home and with brother
- Answering my questions
- On site help, doctor’s appointments, etc
- I am happy that this service has really help me get my child back
- He’s communicating his feelings more positively and calmly
- The transportation, bus passes when available and having someone to talk to
- Understanding behaviors
- He is more high functioning
- Seeing my child become more receptive to services & learning skills that apply to everyday life that my family can use
- Speech therapy, behaviors
- Very patient with my two children, good service
- (Client) has great worker that works w/ him and siblings. She is just great w/ them
- She helped me get early intervention
- His speech and OT
- Everything they do to family is working real good
- I have learned how to deal w/ any problem w/ my child
- Medications
- By working on her developmental stage
- The support I receive from the case manager and the help she gives to our family
- The information that is given to us. They are very helpful to our family
- (Staff) is the only one that is genuinely concerned about child's welfare. Very professional and attentive. Not only knowledgeable in her field but willing to share the information
- Not sure yet. Only 2nd visit
- Learning how to help her separation anxiety
- The one on one sessions
- Being able to handle his anger. Also the support that we are not the only ones going through this
- Information on behavioral problems
- Knowing what his issues are and being able to recognize them and help him through them
- Helping her achieve some sort of a normal life. Having her be a happy little girl
- Having help and education for (client) to be a happy little boy
- Learning therapy techniques
- Understanding his emotional problems and now I am learning to deal with them and be more
- Community resources
- He is listening better
- My child is more able to discuss his feeling more and is learning more appropriate ways to handle anger and to interact with others more properly.
- Chill him out. Less anger

• Support from social worker and social services • Respect of others • He can deal w/ everyday situations and its getting better for him to express himself • He can communicate much better and ask for help • I'm dealing with it in different ways, trying new things • it has been helpful to have support through all of the family issues that have arisen during this hard time in our family • Listen to her • Lots of support • He is learning how to cope with this situation and his anxiety panics that he sometimes has • Therapist very good at helping child deal with emotions • Someone to talk to and help me feel empowered to reach the goals needed for my child • Starting therapy • One on one care • So far my son has started to listen better and be more patient • Getting them into Head Start • The medicine helps a lot • Helping her to feel more secure in her world • Learning • Counseling • Listening; put kids first; offering different services & options • Helping to deal with my child • Training for expectations that (client) can achieve • I have not had services long enough to give real input • I am learning many new things in order to better help my brother • Better behavior	
2. What would improve services your child and the family received? • Everything they're doing now is great • Services closer to Henderson • Good communication with my child. I learn to help him to get his goals and work with him. • Undecided. Everything great so far • The Day Treatment • Day program during (client's) track breaks • I would like to have information explaining some of the diagnosis the children have example 99552 Neglect of Child, focus on victim something we could read when needed. • Establishing rapport • Services are great right now, no complaints. • Day service or home worker to work on not hugging or talking to strangers. • I thought we received good services • So far I'm very satisfied with all the help and treatment that has been provided for my son and my family. Excellent job from your staff most especially (staff). She's outstanding. She showed she cared a lot for (client) and for his future. Thank you • I am very pleased with my son's progress • Finding continuation of services for children with Aspergers/Autism over 6 yrs old. • I do not know at this point • Keep learning. I am thankful for their time and effort • Early day care treatment • Everything seems to be working out fine. I would enjoy to have permission to work with him as far as bathroom issues • If Nevada pep would return calls • Having the service earlier than received • I think my child is doing very well • Everything is great • Everything is great • Enjoying the positive spirit we currently are receiving • Family counseling • Making bus passes more available and making sure case managers have more info available to them about the community and what is available to the clients • All our appointments fit our busy life style • Speech and behaviors • she's a good person, sometimes helpful when I tell her I have some problems w/ my kids behavior • Learn how to talk better, listen better. His behavioral • We already have a great worker that works w/ (client) and siblings. She is just great w/ them • He understands things better • If Medicaid didn't make it more difficult to obtain services	2. What would improve services you received? • NA

• Needing more work on her developmental stage since she's delayed • 1) getting a psychiatrist that will call us back when needed. 2) getting the child into therapy again. 3) getting the child into day treatment • Nothing. We like everything the way it is. • Initial assessment interviewer was hard pressed to form "his" answers and tried to force his opinions as our own. Assessment was written up with a high number of mistakes. • Just knowing he will continue to have services • If he could have longer day care • Talking more and listening more; willing to try new things and always looking for best way • Getting both girls into therapy • Nothing, everything that is being done is excellent • I think we are receiving everything we need. • A ride to the doctor's would be nice but everything is okay • Maybe just a first meeting to explain the whole process & why. Multiple fingerprinting, ect. Kinship foster program. Court. Other than that I am very pleased at this point. • Social exposure and corrections in behavior • There is nothing that would make them better since the services are excellent	
3. Additional Comments • I want to thank (3 staff) from Easter Day Treatment Center for the great job also (2 staff) for all the support for my son and myself. Thank You. • I would just like to thank you for your help and support. My child has learned a lot as well as myself. So, thank a lot. • I have met a lot of professionals but (staff) goes above and beyond with our family she is wonderful if she doesn't have an answer or solution she will help you find one She has always been very kind and respectful always including parents when making decisions. I would request her again. • I know this program has benefited both (client) and (client). (Staff) has worked with us to help these children stabilize. • (Staff) was very good with (client) • (Staff) is doing an excellent job for (client). • I am so thankful for (3 staff). • I hope you'll have more employees like (staff) in the future. She's awesome. I give her a standing ovation. She'll be missed • I am very satisfied with the help of the therapist because he is helping my son a lot and my son trusts him. Thanks for your program. • I can't imagine anyone better equipped o more accessible than (staff) in the way she greats us and advocates for our boy! • I am very pleased with our PEP family worker. She feels like part of our family She always has all the answers to my questions Thanks for all your help • Wonderful work - I don't want to lose progress by having to stop services now. (see #46) • It's making sense to me. I need to just relax and enjoy my child and its feeling so good. Its clicking. Thank you (staff) and company • Thank you for the support from the whole staff in therapy in helping me understand by learning of issues I didn't know about for a whole year on my son. Thank you all • (Staff) is the best. • We are working toward a goal. It is a slow process but we are grateful and patient it will continue • Thank you for having this wonderful program for very young children otherwise I had no where for her to receive these services • Some of the questions weren't answered because of the short time my son has been in therapy, but in the short time my son has been in therapy I have seen good changes. • Only that I give thanks to everyone who helped us. Many thanks… • (Staff) is very professional and well educated • (Staff) is an excellent ecs worker. She is very patient, kind, gentle. In that my child receives help and healing she needs • I'm very happy with the services I've received from (staff) and I very much wish to continue receiving services from her. • I would not have gotten a lot of my business taken care of if (staff) had not been there to help us or to be my sounding board when I'm having a bad day. • (Staff) has been awesome help for me and my son. • Very nice person • (Staff) is the best • Thanks for the services offered to my family • (Staff) has been so helpful at explaining to me what his issues are. She is also very easy to understand and is professional and pleasant to be around.	3. Any additional comments? • NA

- My service provider and social worker are the best. Thank you
- I really love the services my children are receiving the counselors are very nice and seem to go out of their way to help with family's needs and they also listen to the parents of children which is very important.
- (Staff) has done a good job with (client) and with helping me see where (client) needs help
- Over all, once the kids got placed, everyone has been so great. Putting the kids first, really listening and guiding us through this process. The staff in every department is worth their weight in gold. Thank you
- My brother is doing a lot better since he began seeing (staff)

NNCAS

Outpatient Services Results

Parent/Caregiver N=35; Youth N=9 **Total Served = 239 Sample = 15%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	91	71
Services were scheduled at times that were right for us.	91	57
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	97	88
The people helping my child and family stuck with us no matter what.	88	57
I felt my child and family had someone to talk to when he/she was troubled.	94	75
The services my child and family received were right for us.	88	50
I received the help I wanted for my child.	95	75
My family got as much help as we needed for my child.	82	63
POSITIVE OUTCOMES		
My child is better at handling daily life.	79	100
My child gets along better with family members.	74	75
My child gets along better with friends and other people.	74	75
My child is doing better in school and/or work.	74	75
My child is better able to cope when things go wrong	71	88
I am satisfied with our family life right now.	67	88
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	75	67
I helped to choose my child and/or family's treatment goals.	97	100
I participated in my child's and family's treatment.	97	100
CULTURAL SENSITIVITY		
Staff treated our family with respect.	97	100
Staff respected our family's religious/spiritual beliefs.	86	100
Staff spoke with me in a way that I understood.	97	100
Staff was sensitive to my family's cultural and ethnic background.	97	100
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	89	N/A
I have people that I am comfortable talking with about my child's problems.	89	N/A
In a crisis, I would have the support I need from family or friends.	88	86
I have people with whom I can do enjoyable things.	91	86
I am happy with the friendships I have.	N/A	100
I feel I belong in my community.	N/A	67

NNCAS

Outpatient Services Results

Parent/Caregiver N=35; Youth N=9 **Total Served = 239 Sample = 15%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
FUNCTIONING		
My child is better at handling daily life.	79	100
My child gets along better with family members.	79	75
My child gets along better with friends and other people.	74	75
My child is able to do the things he/she wants to do.	91	71
My child is doing better in school and/or work.	74	75
My child is better able to cope when things go wrong.	74	88

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	93	100
Staff explained my child and my family's rights and confidentiality issues.	91	100
I receive support and advocacy from my NV PEP Family Specialist.	75	50
My NV PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	67	80
Our family is aware of people/ services in the community that support us.	91	88
I am better able to handle our family issues.	85	100
I am learning helpful parenting skills while in services	94	88
I have information about my child's developmental expectations and needs.	85	88

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received?	1. What has been the most helpful thing about the services you received?
• Behavioral • Allows my kids to communicate better with us • Someone outside of our home to talk to • He talks openly in session • Before coming here my child did not know how to process his emotions. Now he does • CBS and meds • (Client) responds to (staff) very well and I have been able to deal better and so has (client) • Consistency of therapist • Methods to use when my son gets an anger fit • Self-assurance and telling us what she was going to do • My child has been able to transition into our home without a lot of problem • Stabilizing his mood swing • Knowing my child will look back at her adolescence and be grateful she was given the skills to succeed and cope • Support of our therapist • Cost = free Counselor willing to see us soon after we called • Everything • Communications • Our issues handled in timely manner • Weekly meetings keep me on track • Transitional process. Moved from east coast to west. Culture shock • My daughters ability to help herself through daily life • Good in-depth exploration of underlying issues affecting his mood and behavior • She's dealing with life better • Getting the help we needed to put our family back together • They have explained to us how to deal better with him • Since we've been here in NV (from Florida), he has received more	• I can get help for my problems • The support I get • I helped me get along with everyone a little better • The relief to be able to talk to someone about anything • I feel I don't need this • They help me understand things that are going on in my life better • Getting out of school

help from here than we ever did. He has certainly changed his personality & ability to make friends • Talking about his emotions • The support and empowerment that my daughter is receiving • Guidance, suggestions from therapist • My daughter is in treatment and is already much better • Since coming I can talk more with her and dialog about problems	
2. What would improve services your child and the family received? • Parenting skills • Services are just fine • Later hours on weekdays and weekend hours • Everything is great • Expanded hours - evenings & weekend • Seeing the doctor to receive a diagnosis • I am pleased with the services that I have received from (staff) • I would appreciate a bit more firm stand in dealing with my child's issues. i.e the therapist encouraging the child taking more responsibility for the child's actions • We are very happy with all the services • Maybe "family" counseling - sometimes my older children need help understanding her. They really get frustrated from her behaviors too. I would like classes to help me understand how to help her and myself more • Not yet, just beginning the process • Be more peaceful • I got everything needed • Comprehensive psych testing for bipolarity • Shorten survey form for parents w/ disability • Thank you • I really do like the services completely • Nothing. In reality everything is pretty good • Nothing beyond what you are doing well	2. What would improve services you received? • Nothing else • Everything's perfect • Get out of school more
3. Additional Comments • They were very helpful • TRANS Many thanks for your help • (Staff) has been an exceptional help to not only our child, but also to our family as a whole. He has always been extremely professional, caring and willing to help • I love my daughter's therapist. She is awesome • I have also been coming here with many of my past F.C. children and I have always received the help we and they needed. Thanks for all your hard work on our behalf • I am grateful for the help my daughter received • Thanks for helping the families be better parents • Thanks to doctor (staff) for her services and her attention to us	3. Any additional comments? • Nope • Thank you CBS for helping me

NNCAS

WIN Results

Parent/Caregiver N=21; Youth N=22 **Total Served = 187 Sample = 11%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	95	88
Services were scheduled at times that were right for us.	90	81
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	86
The people helping my child and family stuck with us no matter what.	95	81
I felt my child and family had someone to talk to when he/she was troubled.	100	90
The services my child and family received were right for us.	95	86

NNCAS

WIN Results

Parent/Caregiver N=21; Youth N=22 **Total Served = 187 Sample = 11%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I received the help I wanted for my child.	90	86
My family got as much help as we needed for my child.	95	90
POSITIVE OUTCOMES		
My child is better at handling daily life.	85	73
My child gets along better with family members.	81	67
My child gets along better with friends and other people.	71	77
My child is doing better in school and/or work.	71	71
My child is better able to cope when things go wrong	67	81
I am satisfied with our family life right now.	76	62
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	88	79
I helped to choose my child and/or family's treatment goals.	95	81
I participated in my child's and family's treatment.	95	85
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	90
Staff respected our family's religious/spiritual beliefs.	100	84
Staff spoke with me in a way that I understood.	100	90
Staff was sensitive to my family's cultural and ethnic background.	95	83
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	90	N/A
I have people that I am comfortable talking with about my child's problems.	100	N/A
In a crisis, I would have the support I need from family or friends.	95	95
I have people with whom I can do enjoyable things.	100	91
I am happy with the friendships I have.	N/A	91
I feel I belong in my community.	N/A	77
FUNCTIONING		
My child is better at handling daily life.	85	73
My child gets along better with family members.	81	67
My child gets along better with friends and other people.	71	77
My child is able to do the things he/she wants to do.	76	82
My child is doing better in school and/or work.	71	71
My child is better able to cope when things go wrong.	67	81

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	89	80
Staff explained my child and my family's rights and confidentiality issues.	100	90
I receive support and advocacy from my NV PEP Family Specialist.	82	82
My NV PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	83	80
Our family is aware of people/ services in the community that support us.	100	82
I am better able to handle our family issues.	100	67
I am learning helpful parenting skills while in services	95	82
I have information about my child's developmental expectations and needs.	90	68

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? • Very thankful to be hooked up w/ WIN prg • Haven't had child in my home long enough to use services • I love my WIN worker. I have learned so much from her. She is a great support for our family • They have helped me a lot. I'm really glad to be involved with win, especially (staff). She is so understanding. Great to talk to. Thank you	1. What has been the most helpful thing about the services you received? • Don't know • Help with my problems • Help with the problems I face in my daily life • The effectiveness of job searching • I like it and like the services' help because I feel safer in foster care • I got a lot of help from people when we had meeting • Knowing you not alone in the world • They teach me skills about life • Meetings, home visits to see I'm doing okay • All the support I have • It's dependable • My win worker is very helpful and extremely good at understanding me • I can better cope with my anger • Having someone to talk to • It helps me succeed with things I never could do or get over with • I can get out of the house • The people who help me when I need it • Talking to (staff); close to foster mom
2. What would improve services your child and the family received? • I have not been w/ WIN long to see any improvements. I like the services we receive and grateful for having case mg • More one on one time w/ child • Everything you have done has been so helpful. Thanks • Nothing • Working harder in getting us out of the system • If we could all be there together as a group so we all know what's going on • None that I can think of • Does not apply • Nothing. My worker goes above & beyond for my whole family • Services are fine. I'm happy with it • Everything has been working out great, thank you • I don't know of any right now that will help me and my family	2. What would improve services you received? • Nothing • I don't know • Things I did help like some things • They're already great • Stop changing workers • Nothing really. I'm very happy with what services are provided • To be back at (placement) home
3. Additional Comments • Haven't had child in my home long enough to use services • I love my WIN worker. I have learned so much from her. She is a great support for our family • They have helped me a lot. I'm really glad to be involved with win, especially (staff). She is so understanding ? Great to talk to. Thank you	3. Any additional comments? • None • No comments • Thank you

NNCAS

Early Childhood Treatment Results

Parent/Caregiver N=30; Youth N=NA **Total Served = 186 Sample = 16%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	77	NA
Services were scheduled at times that were right for us.	90	NA
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	97	NA
The people helping my child and family stuck with us no matter what.	87	NA

NNCAS

Early Childhood Treatment Results

Parent/Caregiver N=30; Youth N=NA **Total Served = 186 Sample = 16%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I felt my child and family had someone to talk to when he/she was troubled.	90	NA
The services my child and family received were right for us.	93	NA
I received the help I wanted for my child.	90	NA
My family got as much help as we needed for my child.	83	NA
POSITIVE OUTCOMES		
My child is better at handling daily life.	83	NA
My child gets along better with family members.	87	NA
My child gets along better with friends and other people.	73	NA
My child is doing better in school and/or work.	77	NA
My child is better able to cope when things go wrong	73	NA
I am satisfied with our family life right now.	79	NA
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	75	NA
I helped to choose my child and/or family's treatment goals.	93	NA
I participated in my child's and family's treatment.	100	NA
CULTURAL SENSITIVITY		
Staff treated our family with respect.	93	NA
Staff respected our family's religious/spiritual beliefs.	91	NA
Staff spoke with me in a way that I understood.	100	NA
Staff was sensitive to my family's cultural and ethnic background.	95	NA
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	93	NA
I have people that I am comfortable talking with about my child's problems.	97	NA
In a crisis, I would have the support I need from family or friends.	83	NA
I have people with whom I can do enjoyable things.	97	NA
I am happy with the friendships I have.	N/A	NA
I feel I belong in my community.	N/A	NA
FUNCTIONING		
My child is better at handling daily life.	83	NA
My child gets along better with family members.	87	NA
My child gets along better with friends and other people.	73	NA
My child is able to do the things he/she wants to do.	80	NA
My child is doing better in school and/or work.	77	NA
My child is better able to cope when things go wrong.	73	NA

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	96	NA
Staff explained my child and my family's rights and confidentiality issues.	93	NA
I receive support and advocacy from my NV PEP Family Specialist.	67	NA
My NV PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	75	NA
Our family is aware of people/ services in the community that support us.	87	NA
I am better able to handle our family issues.	83	NA
I am learning helpful parenting skills while in services	100	NA
I have information about my child's developmental expectations and	87	NA

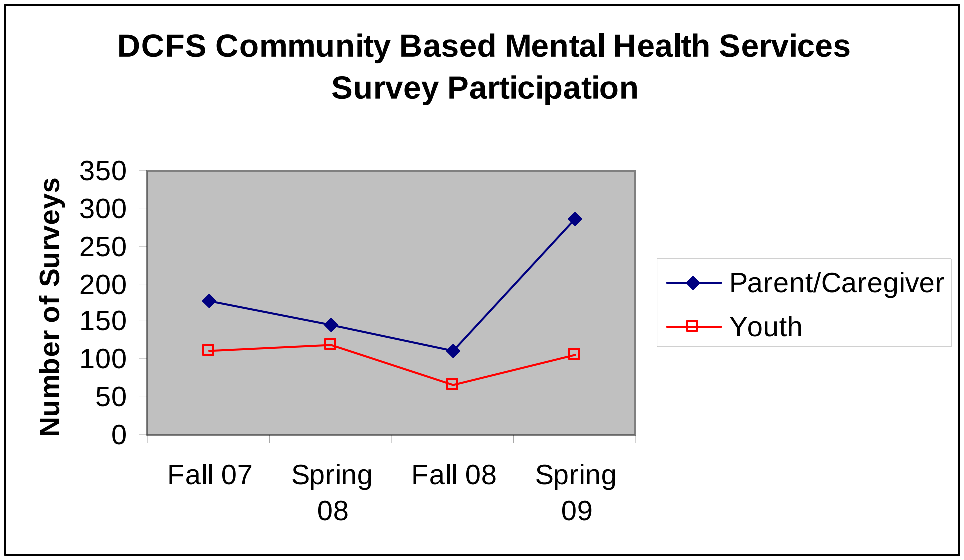
needs.		

Parent / Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? • Family support • A phone call away • Starting the process to get a diagnosis • Learning to behave at home and school • We've only come a few times. Too early to tell • The opportunity to dialogue one on one with the therapist. • Learning how to be a better parent • Counselor is amazing, very knowledgeable & supportive • The caring and concern • Better coping skills • It's helped me to understand what's wrong with my child and how I can help him • To deal with behavior • Sticking with us, trying new strategies, understanding and acknowledging feelings • Better able to calm child down • The positive reinforcement of our counselor. then being there in hard times when needed someone. • Someone my child can talk to and understand his needs • Better able to speak • He has not been here long enough to see any changes • Everything overall. Dealing with his frustrations and how to communicate • This is helping (client) to play w/ his mommy and not get so mad at her and hit her. (Staff) is doing a wonderful job • My child now has someone he can open up to and express his concerns to • In helping understand reasons our foster child may act out and ways to help her through her emotions • Helping with his temper and behavior issues • Understanding his emotional needs so we don't have as much of a power struggle • Autism diagnosis • We have learned how to give positive attention before negative attention is needed • More open to talking	1. What has been the most helpful thing about the services you received? • NA
2. What would improve services your child and the family received? • Not sure. Everything works well and everyone is so supportive • The day treatment program would be nice for my child since she's starting school in July • Time • For the child to be more consistent in listening and minding. Overall the services have been very good. To learn self discipline. • Nothing • Closer location • What are the age appropriate expectations of children? • It seems excellent to me so far • Parenting skills, Help me understand why my son act out when he gets frustrated. • I feel that you are doing a wonderful job • We are progressing by seeing the way the children all interact with each other • At this point I do not feel any part of the process needs improvement. I believe we are all on the correct path, just slow moving. • We were on a waiting list for a long time • Maintain an open dialog. Knowledge of all services in the surrounding area that are available • Closer to home locations for those that do not have transportation and some occasional in-home visits to see children in an everyday environment • Need more options, education for children and parents of children w/ autism and autism spectrum disorders	2. What would improve services you received? • NA

3. Additional Comments	3. Any additional comments?
• There's a day treatment program in effect. I think the older children that are getting ready to start Kindergarten should be able to have first dibs on getting in. • God bless you all and thank you • I like the services • My child very much enjoys his time with and feels safe with (staff) • You guys are great. Wish there were more of you • In the brief time, it is nice to know this service has been available. Wish we knew of this service when we first became foster parents over a year ago • Schools also need education on children with these disorders	• NA

Survey participation

This current survey is the fourth statewide children's community-based services survey to date conducted by DCFS. The following graph depicts parent/caregiver and youth participation over the past four surveys.



The current survey shows a statewide increase (156%) in parent/caregiver participation and a corresponding increase (65%) in youth participation when compared to the same survey conducted in the Fall of last year.
When combining respective agency parent/caregiver and youth survey production totals, NNCAS realized a 46% jump in respondent participation over that agency's Fall survey total. SNCAS realized an impressive 186% jump in their respondent totals. Staff from each agency are to be commended for their efforts in securing wider survey distribution.

An Hispanic version of the parent/caregiver survey instrument was again available for this project. Of the 287 parent/caregiver surveys returned statewide, 22 were in Spanish. The Fall survey garnered six Spanish surveys statewide.

As always, the Division of Child and Family Services Planning and Evaluation Unit extends its appreciation to all youth and parents/caregivers who participated in this survey. Equal appreciation goes to DCFS program area staff for the absolutely essential support they provided in carrying out this quality assurance project. Thanks to all.

ATTACHMENT C

DCFS Residential and Psychiatric Inpatient Services Survey – Fall 2009

DCFS Residential and Psychiatric Inpatient Services Parent / Caregiver – Youth Survey Results Statewide Fall 2009

From mid October to the end of November, 2009, the Division of Child and Family Services (DCFS) conducted its fall survey of children's residential and psychiatric inpatient mental health service programs offered through the Northern Nevada Child and Adolescent Services (NNCAS) and the Southern Nevada Child and Adolescent Services (SNCAS). Parent/caregivers with children in treatment and youths themselves (if age 12 or older) from both agencies were solicited to voluntarily participate in completing the survey instrument.

Participants were asked to disagree or agree with a series of statements relating to nine focal areas or domains that reflect residential and inpatient participant experience. These domains include those areas deemed by the Federal Mental Health Statistical Improvement Program as reflective of mental health programming effectiveness. The nine domains covered by the survey include convenience in receiving services (Access); whether services being received are acceptable (General Satisfaction); do participants have a directive role in the course of their treatment (Treatment Participation); is important information being shared during treatment (Treatment Information); is the physical environment seen as safe and comfortable (Environment and Safety); are staff respectful of participant religion, culture and ethnicity (Cultural Sensitivity); are client educational needs being met adequately (Education); do clients feel supported in the program and are they aware of community-based support (Social Connectedness); and how well do clients see themselves functioning in daily life (Positive Outcomes).

Survey Report Format

For this report, residential and psychiatric inpatient services survey results are in table format and are presented by service type and facility name under each of the DCFS children's mental health programs (NNCAS and SNCAS). NNCAS currently has residential programs only. SNCAS has both residential and psychiatric inpatient programs. Parent/caregiver and youth responses for each program appear together under each domain.

The Parent/Caregiver and Youth Positive Response numbers appearing under each domain are reported in percentages. A percentage number represents the degree to which a particular domain statement was endorsed or rated positively by respondents. Since not every survey respondent answers every statement, each statement's percentage numbers are based upon the actual number of responses to that particular statement.

A domain statement percentage number followed by an (*) indicates the percentage number as having matched or exceeded the rating for that item found on the last residential/inpatient survey.

You will notice, too, that statements on the survey with less than a 60% Positive Response number are "courtesy highlighted". Courtesy highlights call attention to any survey item having a respondent endorsement rate that is approaching the lower end of the frequency scale. Programs having courtesy highlighted items should monitor these particular items in subsequent surveys should similarly low endorsement rates re-occur. Programs should give special attention to a highlighted statement's subject matter when considering if any programmatic or other corrective action might be taken.

Following each service area's domain results, you will find listed whatever remarks respondents offered regarding what was the most helpful thing about the services they received, what would improve upon the services they received and any additional comments they might have had. A final section on survey participation concludes the report.

Survey Participants

Participants in the fall survey included parents or caregivers with children receiving residential or psychiatric inpatient mental health treatment and the youths themselves where age appropriate. The youth survey is completed by youth ages 12 and older. Twenty two parent/caregivers statewide completed the survey in addition to 73 youth statewide who were still in treatment. Planning and Evaluation Unit staff or other non-direct treatment staff solicited survey participants at the different program sites providing the clients' mental health services. Survey questionnaires were self-administered and when completed put into secure containers. Some parent/caregivers chose to complete the surveys at home and mail them to Planning and Evaluation Unit offices. Survey participation was entirely voluntary and survey responses were both anonymous and confidential.

The table on the next page presents the number of parent/caregiver and youth surveys received from each program site. The table also includes the percentage of clients served who were sampled by the respective program's parent/caregiver survey. Youth percentages are not given since not all clients served were age eligible for survey participation and any percentage would be non representative.

Following the table, residential and psychiatric inpatient services survey results are presented by service type and facility name.

	SURVEYS			
	Parent/Caregiver			**Youth**
AGENCY & SITE	Number of Surveys	Number of Clients Served	Survey Sample Percent	Number of Surveys
NNCAS				
Residential: ATC	7	18	39	11
Residential: FLH	4	18	22	7
Total	11	36	31	18
SNCAS				
Residential: OASIS	6	32	19	15
Inpatient: DWTC	5	59	9	40
Total	11	91	12	55
Statewide Total	22	127	17	73

Note: ATC = Adolescent Treatment Center
FLH = Family Learning Homes
OASIS = Oasis On-Campus Treatment Homes
DWTC = Desert Willow Treatment Center

DCFS Residential Services
Parent / Caregiver – Youth Survey Results
Statewide Fall 2009

Note: The Parent/Caregiver and the Youth surveys share questions 6 through 31 in the same numerical sequence. The Parent/Caregiver survey has three additional questions (marked "caregiver") that do not appear on the Youth survey.

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES		
ATC		
Parent/Caregiver N=7; % Total Served = 39 Youth N=11	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	100*	36
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	86	45
The people helping my child and family stick with us no matter what.	100*	36
I feel my child and family have someone to talk to when he/she is troubled.	100*	55
The services my child and family receive are right for us.	100*	45
My family gets the help we want for my child.	100*	55 *
My family gets as much help as we need for my child.	100*	45
TREATMENT PARTICIPATION		
I help to choose my child's services.	100*	18

MEDICAID REPORT 2010
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2009 SUMMARY

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES
ATC

Parent/Caregiver N=7; % Total Served = 39 Youth N=11	Parent/Caregiver Positive Response %	Youth Positive Response %
I help to choose my child's treatment goals in the treatment team meeting.	100*	55
I participate in my child's treatment.	100*	64
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	100*	20
Staff explain my child and family's rights and confidentiality issues.	100*	36
I am learning helpful parenting skills while in services. (caregiver)	100*	n/a
I have information about my child's developmental expectations and needs. (caregiver)	100*	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	100*	27
Visitation rooms are comfortable and provide privacy with my child.	86*	40
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	100*	64 *
Staff respect my family's religious/spiritual beliefs.	83	33
Staff speak with me in a way that I understand.	100*	73 *
Staff are sensitive to my cultural and ethnic background.	80	44
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	86	80
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	100*	55
Our family is aware of people and services in the community that support us.	86	45
POSITIVE OUTCOMES		
My child is better at handling daily life.	71	63
My child gets along better with family members.	86*	50
My child gets along better with friends and other people.	86*	78 *
My child is doing better in school and/or work	71	56
My child copes in difficult situations much better.	86*	70
I am satisfied with our family life right now.	43	40
I am better able to handle our family issues. (caregiver)	83	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• Being able to have family sessions. Working on his levels to earn privileges for his positive behaviors. • Communications with others • The tools my son are learning are helping • Helping him think when angry • Tools to help her change her attitude • (Client) has been there for a short time but I'm glad she's able to start the help.	• Nothing • My family can't get hold of me. • Staff trying to make us respect them when they don't show us respect • Undecided at this moment • That staff are not giving up no matter what, and they help you the best they can. • To get as much help • Nothing at all for me. • Self control and a better understanding of things • I am getting my problems solved

What would improve services your child and the family received?	What would improve the services you receive?
• Don't know at this time • Continued working together on solutions. • Nothing • That she knows that there is someone there to talk to when she can't talk to me.	• The body space thing is retarded. I mean we should be able to touch each other in an appropriate way, even if we have emotional feeling person • I would listen more • More Freedom! • The food • The food could be better • I want the food to be good but it isn't at all. • More freedom, more privs • Less time in rooms
Additional Comments	**Additional Comments**
• Continued family support • I think this program will help (client). She knows a little that you guys are there to help her in her mood swings, mania, and other issues she's dealing with.	• No • Staff abuse their power rights. • Thank you so far for helping me. • The food is not good at all. • No body space issues • Need to work on school more and have better teachers. Need to work on Plato more

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES
FLH

Parent/Caregiver N= 4 % Total Served = 22 **Youth N= 7**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	100*	86 *
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	100*	71*
The people helping my child and family stick with us no matter what.	100*	86 *
I feel my child and family have someone to talk to when he/she is troubled.	100*	57
The services my child and family receive are right for us.	100*	86 *
My family gets the help we want for my child.	100*	71
My family gets as much help as we need for my child.	100*	71 *
TREATMENT PARTICIPATION		
I help to choose my child's services.	100*	71 *
I help to choose my child's treatment goals in the treatment team meeting.	100*	83 *
I participate in my child's treatment.	100*	86 *
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	100*	83 *
Staff explain my child and family's rights and confidentiality issues.	100*	100 *
I am learning helpful parenting skills while in services. (caregiver)	86*	n/a
I have information about my child's developmental expectations and needs. (caregiver)	86*	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	100*	86 *
Visitation rooms are comfortable and provide privacy with my child.	86*	67 *
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	100*	86 *

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES
FLH

Parent/Caregiver N= 4 % Total Served = 22 **Youth N= 7**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
Staff respect my family's religious/spiritual beliefs.	100*	100 *
Staff speak with me in a way that I understand.	100*	86 *
Staff are sensitive to my cultural and ethnic background.	100*	86 *
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	100*	100 *
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	100*	57
Our family is aware of people and services in the community that support us.	100*	71 *
POSITIVE OUTCOMES		
My child is better at handling daily life.	75*	71
My child gets along better with family members.	100*	83
My child gets along better with friends and other people.	100*	86
My child is doing better in school and/or work	50*	86 *
My child copes in difficult situations much better.	100*	71
I am satisfied with our family life right now.	75*	57
I am better able to handle our family issues. (caregiver)	100*	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• Basically I feel that your services are teaching me how to have hope and give boundaries! • He doesn't talk back. He gets along with his brother better. • Staff at the home are really wonderful, supportive, sympathetic and a great resource. • The help we're receiving is helping the whole family - which was needed.	• The fact that my family and I… • Staff are helping me with my problems • That I have been able to go out into the community and get a job and be with my family • I'm getting help with my behavior • The school and with my family • Nothing at all. It's all f******g stupid • A safe place to stay
What would improve services your child and the family received?	What would improve the services you receive?
• I feel very satisfied with all of the services that my family is receiving! • The ability of the learning home to ensure that it can offer educational services commensurate with a child's ability - Sierra Vista is not a good educational choice	• The point system • My behavior and school • Giving me some privacy and more independent time and minding their own business when it doesn't concern them. • More trustable staff
Additional Comments	Additional Comments
• My family and I feel that you are all doing a super job.	• We should have internet • We need better food and more space

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES
OASIS

Parent/Caregiver N=6; % Total Served = 19 **Youth N= 15**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	83	93 *
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	100*	87 *
The people helping my child and family stick with us no matter what.	100*	93 *
I feel my child and family have someone to talk to when he/she is troubled.	100*	87 *
The services my child and family receive are right for us.	100*	80 *
My family gets the help we want for my child.	83*	87 *
My family gets as much help as we need for my child.	67*	80
TREATMENT PARTICIPATION		
I help to choose my child's services.	83	42 *
I help to choose my child's treatment goals in the treatment team meeting.	100*	83 *
I participate in my child's treatment.	100*	85
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	100*	67
Staff explain my child and family's rights and confidentiality issues.	100*	93 *
I am learning helpful parenting skills while in services. (caregiver)	67	n/a
I have information about my child's developmental expectations and needs. (caregiver)	100*	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	83	93
Visitation rooms are comfortable and provide privacy with my child.	80*	73
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	100*	87 *
Staff respect my family's religious/spiritual beliefs.	83*	100 *
Staff speak with me in a way that I understand.	100*	100 *
Staff are sensitive to my cultural and ethnic background.	100*	100 *
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	100*	93
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	100*	87
Our family is aware of people and services in the community that support us.	100*	93 *
POSITIVE OUTCOMES		
My child is better at handling daily life.	83	73 *
My child gets along better with family members.	83	79
My child gets along better with friends and other people.	60	73
My child is doing better in school and/or work	80*	79 *
My child copes in difficult situations much better.	67	87 *
I am satisfied with our family life right now.	67	67
I am better able to handle our family issues. (caregiver)	80	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• Parent Supervisor (staff) very supportive! Treatment Home always available w/ help from therapist (staff) at "Oasis" when & if help needed to take back child in emergency • Family sessions, other options I can have with my child • The staff at oasis and the family are on the same page and they talk to us whenever we needed to know anything. • The staff briefing me on my child's development while in the program.	• Everything has been helpful • Safe environment • Seeing my family • Everything has been helpful • They take time out of their time when I need it • Staff support • Helping to control anger • Staff and parent support • I get to see my family. I eat, I sleep and I get to go to school, and I listen to my CD player • I don't know • Staff helps me understand things
What would improve services your child and the family received?	What would improve the services you receive?
• All is well • More healthy foods avail. & given. Less high fats, salty & carbs (as child getting chubby!) affects health, especially when on meds ex: Lithium • Oasis staff is one of the best (client) ever had while in treatment.	• Nothing • Better rewards and stricter consequences for the 'troubled' ones. • Nicer staff • I would like to have talked to family. • I don't know
Additional Comments	Additional Comments
• Would like to see more long term or institutions available in community. Need more funding avail. for mental health svc's. ex. So can have staff transport kids to med. appts, hosp., etc. (parent & therapist doing it mostly to ex: horse therapy). Funding for an additional outside psych. soc. wkr / basic skills worker as a 'therapeutic big bros. / sister for example! Less turnover for staff / 'helpers'. Too many part-timers (kids get attached & need regulars can count on & most play the 'splitting game' /s (he said, she said) game with! • Staff members were kind and were willing to listen and give advice • The staff here at Oasis is very supportive, respectful, and mindful of my child & family needs	• No • I love it here

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES
DWTC

Parent/Caregiver N= 5; % Total Served = 7 **Youth N=40**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	80	78 *
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	80	63
The people helping my child and family stick with us no matter what.	60	67*
I feel my child and family have someone to talk to when he/she is troubled.	80	68*
The services my child and family receive are right for us.	80	73*
My family gets the help we want for my child.	80	69*
My family gets as much help as we need for my child.	80	79
TREATMENT PARTICIPATION		
I help to choose my child's services.	75	54

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES
DWTC

Parent/Caregiver N= 5; % Total Served = 7 **Youth N=40**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I help to choose my child's treatment goals in the treatment team meeting.	80	70
I participate in my child's treatment.	80	71
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	80	78 *
Staff explain my child and family's rights and confidentiality issues.	80	90 *
I am learning helpful parenting skills while in services. (caregiver)	50	n/a
I have information about my child's developmental expectations and needs. (caregiver)	60	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	80	65
Visitation rooms are comfortable and provide privacy with my child.	80*	58*
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	80	69*
Staff respect my family's religious/spiritual beliefs.	40	81
Staff speak with me in a way that I understand.	80	80*
Staff are sensitive to my cultural and ethnic background.	60	79
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	75	73 *
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	80	68*
Our family is aware of people and services in the community that support us.	60	71
POSITIVE OUTCOMES		
My child is better at handling daily life.	80	79 *
My child gets along better with family members.	60	72*
My child gets along better with friends and other people.	40	68
My child is doing better in school and/or work	50	74 *
My child copes in difficult situations much better.	60	62
I am satisfied with our family life right now.	40	65*
I am better able to handle our family issues. (caregiver)	60	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• The isolation • Everything good, care about my son • the friendly staff and the care of the people here at desert willow • long term treatment instead of a private facility that send them home too soon • I feel that we have been very fortunate to have the contact and interaction with staff that we have had. This has really helped us to understand (client)'s treatment better	• That I'm over all getting help and treated nicely • To relax and be less anxious • They help me a lot • Coping skills • That no matter what people would always be their for me • The staff is sometimes helpful • DBT • Having someone else recognize that I'm getting angry and help me to take a few minutes to calm down • Recreational therapy • My time to express my feelings with my family session • None • I haven't really gotten all the help I need as of now • Loves I am getting to talk about my things I do wrong and I get

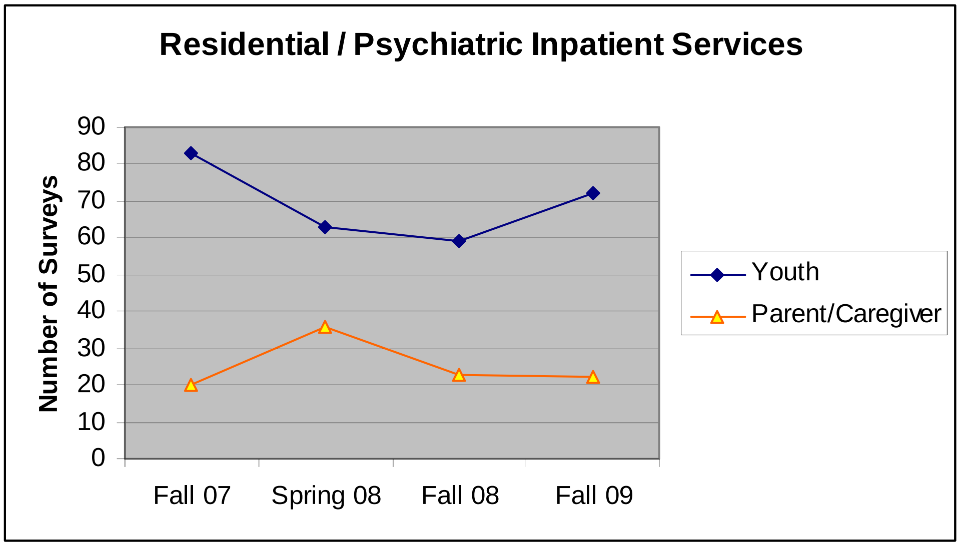
	to work with my problems • My therapy sessions • Advice • Staff showing me right for wrong and patience • Treatment team and staff helping me • I get the help I need and tell me positive things that can help me in life • Family therapy • Staff helps me when I am upset, or sad. • People have been helping me get over my Mother's death and the bad things I've gone through. • I feel more comfortable with the staff • They are trying to get me back on track and my family as well • My counselor • Treatment • To be able to tell my dad the truth, and not lying to him any more • They help me learn what I did and now need to do • I learned not to do what I did again • How my cycle starts and how to stop it. • How to treat 1 lady • Staff and my MHT Primary have helped me I needed it most. • Getting help with my assignments • Knowing how to control my sexual deviant thought • I have learned about how to help myself • They're there for me whenever I need to talk about something or need help. • Talking about my crime • The staff have taught me a little to control my anger • The treatment team is always there if you need to talk to someone and they really care about helping you

What would improve services your child and the family received?	What would improve the services you receive?
• Longer evaluation time for comfort of patient and parents • The doctor is very good, and staff very understanding with the parent. • the public being more aware that a long term facility is in southern Nevada	• That I could be more open with them • Staff should be more patient and understanding • None. They do good • Talking more, feeding less, not as much fitness group! • If I had the family support • That there would be more groups & treatment • Better food. More food. • More therapy. They should give us more responsibilities and freedom. • More therapy/treatment and actual experienced therapists • My following directions and being defiant • Being able to control my means of treatment better • I would improve my problems and to start to share my bad (?) ideas. • By doing the right things • To go to a drug rehabilitation place. Talk to therapist and doctors more, do more activities that are beneficial, get better food. • More sessions • Clean environment • If I could talk to my therapist when needed • Give the staff more money • To see my therapist more, that would help. • More therapy • My interactions in the community • JJS girls and boys touch • Nothing really • More exercise, and able to read bible anywhere • I get more one on one help • The way reunification is run • it's everything I wanted • More art and things to do and to have communication • All the staff being respectful • More staff that listen

	• Me learning to follow unit rules and also getting along with peers. • To focus hard and do what I need • Maybe the food? But other than that everything was perfect for my needs
Additional Comments	Additional Comments
• This is a good program • Thank you • (Staff) is amazing and has been wonderful with (client). (Staff) has been very approachable and engaged in (client)'s treatment. (Staff) was our first and most constant form of contact and always made me feel like someone was really watching out for (client). (Staff) has worked wonders with (client). (Client) has learned a lot about appropriate and inappropriate behavior from him. (Staff) has really worked with our family as far as (client) goes and has really kept us in the loop about what is going on with him. Everyone here has been wonderful.	• No thank you • Food is terrible • Change food and staff stop putting hands on us • We should lock the doors at bedtime • Does the survey affect the treatment services here? • Not getting enough therapy • I like this treatment center Than the other ones I've gone to. • Great place • I just want to say thank you for helping me achieve my goals in life • Just because we are sex offenders does not mean that we have to be treated different. Every sex offender you ask will think that.

Survey participation

This current survey is the fourth statewide residential and psychiatric inpatient services survey conducted by DCFS. The following graph depicts parent/caregiver and youth participation over the past four surveys.



This Fall 09 survey is the first to be conducted under a new twelve month survey interval schedule. Hoping in part to encourage greater respondent participation, DCFS changed its survey intervals from six months to a full twelve after the completion of the Fall 08 survey. The most recent survey results do indeed show a 15% increase statewide in the combined total of youth and parent/caregiver participating. That difference however is due entirely to increased youth participation (up 24%). Parent/caregiver participation rates remained constant.

Prior to next year’s survey, programs may want to focus on developing strategies for increasing the survey participation of the adults who care for the children those programs serve.

The Division of Child and Family Services / Planning and Evaluation Unit once again extends its appreciation to all residential and psychiatric inpatient youth and parents/caregivers who participated in this survey. Our gratitude goes as well to residential and psychiatric inpatient staff statewide for their support in carrying out this quality assurance project. Thanks to all.

ATTACHMENT D

Risk Measures / Departure Conditions Report: Oasis

Division of Child and Family Services
SNCAS Oasis Program
Risk Measures and Departure Conditions Report - 2009

INTRODUCTION

Risk measures are areas of risk identified to conduct program improvement in order to decrease risk behavior by children and adolescents in specialized foster care placement and improve safety outcomes. The collection of risk measures data commenced statewide in the first quarter of 2008.

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 within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period. The collection of departure conditions data began in September 2008.

The 2009 reports reflect the collection and data analysis of risk measures and departure conditions for the reporting period of January 2009 through December 2009.

All of the risk measure and departure conditions data is self-reported by each specialized foster care provider which presents some risk that a true count of incidences goes unreported or under-reported. In order to mitigate this risk and to ensure improved validity of the data submitted, the Division of Child and Family Services, Planning and Evaluation Unit (PEU) staff started the process of monthly data clean up and provider education whenever the need for clarification was identified in the data submission; this process started in late 2008 and continued throughout the 2009 reporting period.

Oasis submitted all their data timely and is to be commended for their willingness to share this very important information.

RISK MEASURES AND DEPARTURE CONDITIONS

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 asked to track and report departure conditions on children and adolescents discharged from services during the 12-month reporting period. 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 home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

Collecting departure conditions data for analysis is a 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.

SNCAS OASIS PROGRAM INFORMATION

This individual report is the analysis of risk measures and departure conditions on data collected from January 2009 though December 2009.

Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity count reported by Oasis was 27. In the January 2008 through December 2008 reporting period, the provider reported an average monthly bed capacity of 27.

The average monthly number of youth served was 30.33.

Suicide

Specialized foster care providers were asked to track and report incidents of attempted and completed suicides.

Attempted suicide was 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.

Oasis reported one suicide attempts during this reporting period. (In the 2008 reporting period, the provider reported four incidents of attempted suicide.)

Descriptive information of the one suicide attempt:
- A male 17-year-old, Caucasian youth of non-Hispanic origin.

Clinical and suicide attempt information:
- The youth was diagnosed with Personality Change due to unknown reason.
- CASII score was 24 and the CASII level was 5.
- Suicide means reported was attempted suffocation using a plastic trash bag.
- The youth has a history of previous suicide attempts.

- Staff intervened and there was no need to access emergency services. Youth was placed on 15 minute checks.

Highlights:
- Oasis staff implemented a suicide protocol and the staff members had received required training in suicide prevention.

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).

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.

Oasis reported 11 medication errors in 2009. In the 2008 reporting period, the provider reported 7 medication errors.

The 11 incidents of medication errors reflect the following descriptive information:
- 64% (7) were male and 36% (4) were female
- Average age was 11.54 with an age range of 8 to 16 years.
- 45% (5) were Caucasian, 36% (4) were African-American and 9% (1) was Native Hawaiian/other Pacific Islander, 9% (1) was of mixed race
- 18% (2) were of Hispanic origin.

Clinical and medication error information:
- The most frequent diagnosis was Bipolar Disorder and the second most frequent was Depressive Disorder.
- Average CASII score was 25.45, ranging from a score of 21 to 27; the mean CASII level was 4.1.
- Type of medication error
    - 55% (6) omission error
    - 9% (1) improper dose error
    - 18% (2) compliance error
    - 18% (2) any medication error that does not fall into one of the predefined categories

- Most (82% or 9) medication errors were with psychotropic medication. Two (or 18%) were with non-psychotropic medication.
- Medication error outcome
    - 100% (11) were errors that occurred that reached the client but did not cause the client harm.

Opportunities for improvement:

- 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.
- 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.

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, 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 timely by the legal guardian/custodian (code #2)

The 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. The 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.

AWOL

Specialized foster care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs).

Oasis reported 15 incidents of AWOL during this reporting period. In the 2008 reporting period, the provider reported 5 incidents of AWOL.

The 15 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 33% (5) were male and 67% (10) were female.
- The average age was 15.6, ranging from 14 to 17 years old.
- 40% (6) were Caucasian, 40% (6) were African American, 7% (1) was Asian, 7% (1) was Native Hawaiian/other Pacific Islander and 7% (1) was unknown.
- 27% (4) youth were of Hispanic origin.

Clinical and AWOL information:

- The most frequent diagnoses were Affective Disorders.
- The average CASII score was 25.27, ranging from 23 to 30.
- The average absence was for 4.8 days.
- All of the youth had a history of AWOL.
- Type of supervision at AWOL
  - 6.7% (1) youth left from school or work
  - 86.7% (13) left home during the day
  - 6.7% (1) other
- Behavior during AWOL was unknown for both youth.
  - 7% (1) sexual misconduct
  - 93% (14) unknown
- Outcome
  - 20% (3) returned within 72 hours
  - 20% (3) were absent indefinitely – did not return to treatment home
  - 7% (1) returned through juvenile detention
  - 20% (3) found with family
  - 33% (5) other (after AWOL, 4 of the 5 went to higher level of care)

Highlight:

- Almost half (47%) returned to Oasis after the AWOL incident to continue treatment.

Opportunities for improvement:

- Develop a crisis plan at admission for children that have a known history of AWOL.
- 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
- Ensure a complete AWOL history of each child and adolescent is shared with providers as early in the pre-placement process as possible.

Safety Holds

Specialized foster care providers were asked to track and report on restraint and manual guidance 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.

Oasis reported 120 incidents of safety hold during the 2009 reporting period. (Oasis reported 72 incidents of safety hold for 2008.) Oasis uses the Conflict Prevention and Response Training (CPART or CPAR) model.

The 120 reports of the use of safety holds reflect the following descriptive information:

- 47% (57) were male and 53% (63) were female.
- Average age was 10.7 with an age range of 6 to 17 years.
- 49% (59) were Caucasian, 43% (52) were African-American, 5% (6) were Native American/Alaskan Native, 1% (1) was Native Hawaiian/other Pacific Islander and 2% (2) were of mixed race.
- 8% (11) were of Hispanic origin.

Clinical and Safety Hold Information:

- The 3 most frequent diagnoses were Affective Disorders (68% or 82), and Reactive Attachment Disorders (11% or 13) and Adjustment Disorder (7% or 8).
- 84% (101) of children and adolescents had a safety hold used on them previously.
- Average length of safety holds was 11.43 minutes, ranging from .5 minute to 55 minutes.
- Type of supervision prior to use of safety hold
    - 23% (28) Group – 4 or more
    - 32% (38) Group-2 or 3
    - 39% (47) One-on-one
    - 2% (2) line of sight
    - 3% (4) Other
- Injury report
    - 34% (41) Client injured
    - 3% (3) Staff injured
    - 63% (75) No one injured
    - 1% (1) staff and client injured

Highlights:

- Over the 12-month reporting period of 2009, Oasis averaged 5 safety hold incidents per month. During 6 month reporting period of 2008, Oasis averaged 12 safety hold incidents per month. This represents a large decrease in safety hold incidents.

Opportunities for improvement:

- There were 42 reported client injuries and 4 staff injuries. This suggests the need to reduce the use of safety holds as much as possible.
- Staff will be receiving 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

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster home and admitted to another specialized foster home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

Oasis reported 61 discharges in this reporting period. During the September 2008 through February 2009 reporting period, the provider reported 18 discharges.

The 61 departures reflect the following descriptive information.

- 44% (27) were male and 56% (34) were female.
- Average age was 13.38 with an age range of 0 to 18 years.
- 59% (36) were Caucasian, 30% (18) were African American, 2% (1) was Asian, 2% (1) was Native Hawaiian/other Pacific Islander, 7% (4) were mixed race and 2% (1) was unknown.
- 10% (6) of the youth were of Hispanic origin.

Custody Status:

- 41% (25) were in child welfare custody
- 8% (5) were in DCFS youth parole custody/supervision
- 11% (7) parental with juvenile probation
- 40% (24) parental custody and no juvenile probation involvement
- 89% (54) were Medicaid or SCHIP recipients

Clinical and departure information:

- The most frequent diagnosis at admission was Affective Disorders. The second most frequent diagnoses were Attention Deficit Hyperactivity Disorder and Adjustment Disorder.
- The average CASII composite score at admission was 24.75, with an average level of intensity of 5.01.
- The average CASII composite score at discharge was 23.33, with an average level of intensity of 4.61.
- Reason for departure
    - 34% (21) reunified with biological family
    - 5% (3) adopted/adoptive placement
    - 23% (14) placed in a less restrictive setting

  - 15% (9) placed in a more restrictive setting
  - 18% (11) youth ran away from placement (AWOL)
  - 3% (2) other
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 11.56 which equals the restrictiveness score of individual-home emergency shelter. During the 2008/2009 reporting period, the restrictiveness of living environment scale averaged 11.1, which equals the restrictiveness score of specialized foster care.
  - 36% (22) home of birth parents for a child
  - 5% (3) home of a relative
  - 7% (4) adoptive home
  - 2% (1) supervised independent living
  - 7% (4) family-based treatment home
  - 16% (10) group treatment home
  - 5% (3) group emergency shelter
  - 2% (1) youth correction center
  - 3% (2) county detention center
  - 16% (10) state and private mental hospital
  - 1% (1) unknown
- 59% (36) completed treatment.
- Who recommended departure
  - 7% (4) provider agency
  - 5% (3) parole/probation officer
  - 33 (2) parent
  - 2% (1) relative/guardian
  - 3% (2) judge/hearing master
  - 5% (3) child's mental health practitioner
  - 62% (38) child and family team
  - 13% (8) NA-Youth went AWOL

Highlight:
- 56% (34) of youth were placed in a less restrictive setting.

Opportunities for improvement:
- While 62% of departures were recommended by Child and Family Teams (CFT), CFTs are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers should consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.

Summary

Oasis submitted these data timely and accurately. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

2009 SUMMARY

This 2009 Risk Measures and Departure Conditions report reflects opportunities for improvement in the area of medication error reporting and safety holds conditions and departure conditions/child and family teams.

In partnership with the Provider Support Team, the Planning and Evaluation Unit has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed best practice research to the provider community and would encourage the provider's consideration of this research in developing a plan to address some of the areas identified in their 2009 risk measures data submission. Also, at the request of the provider, the PEU is available to offer technical assistance in any of these areas.

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ATTACHMENT E

Risk Measures / Departure Conditions Report: Adolescent Treatment Center

Division of Child and Family Services
Adolescent Treatment Center
Risk Measures and Departure Conditions Report - 2009

INTRODUCTION

Risk measures are areas of risk identified to conduct program improvement in order to decrease risk behavior by children and adolescents in specialized foster care placement and improve safety outcomes. The collection of risk measures commenced statewide in the first quarter of 2008.

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 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 collection of departure conditions data began in September 2008.

This 2009 report reflects the collection and data analysis of risk measures and departure conditions for the reporting period of January 2009 through December 2009.

All of the risk measure and departure conditions data is self-reported by each specialized foster care provider which presents some risk that a true count of incidences goes unreported or under-reported. In order to mitigate this risk and to ensure improved validity of the data submitted, the Division of Child and Family Services, Planning and Evaluation Unit (PEU) staff started the process of monthly data clean up and provider education whenever the need for clarification was identified in the data submission; this process started in late 2008 and continued throughout the 2009 reporting period.

ATC has submitted all their data timely and is to be commended for their willingness to share this very important information.

RISK MEASURES AND DEPARTURE CONDITIONS

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 asked to also track and report departure conditions on 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.

ATC PROGRAM INFORMATION

This analysis is based on data collected from January 2009 though December 2009.

Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity count reported by ATC was 15.5, ranging from 13 to 16 beds.

The average monthly number of youth served was 18.25, ranging from 16 to 21.

Suicide

Specialized foster care providers were asked to track and report incidents of attempted and completed suicides.

Attempted suicide was 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.

ATC reported zero incidents of attempted or completed suicide. In the reporting period of June 2008 through December 2008, ATC also reported zero incidents of attempted or completed suicide.

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).

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.

ATC reported 1 medication error in the reporting period. In the reporting period of June 2008 through December 2008, ATC reported zero medication errors.

The 1 incident of medication errors in this reporting period reflects the youth was a 15-year-old male of Caucasian race and non-Hispanic origin.

Clinical and medication error information:

- The youth had a diagnosis of Bipolar Disorder NOS with a CASII score of 24 and CASII level of 5.
- The type of medication error was an improper dose error of a psychotropic medication.
- The error occurred at 8:00 PM.
- The medication error outcome was a medication which reached the patient but did not cause patient harm.

Opportunities for improvement:

- 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 specialized foster care 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.

  ATC has reported less than expected medication errors. 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 this 12-month reporting period, given the definitions noted in the table below.

[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.

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, 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 timely by the legal guardian/custodian (code #2)

The 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. The 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.

AWOL

Specialized foster care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs).

ATC reported eight AWOLs during this reporting cycle. In the reporting period of June 2008 through December 2008, ATC reported zero incidents of AWOL.

The eight incidents of child and adolescent absence of more than 24 hours in this 2009 reporting period reflect the following descriptive information:

- 75% (6) were male and 25% (2) were female.
- Average age was 15.75 with an age range of 13 to 17 years.
- 100% (5) were Caucasian
- 87.5% (7) were of non-Hispanic origin, 12.5% (1) was of Hispanic origin.

Clinical and AWOL information:

- The most frequent diagnosis was Posttraumatic Stress Disorder (62.5%) followed by Bipolar Disorder, Mood Disorder, and Major Depressive Disorder, Single Episode, Moderate.
- Average CASII score was 24.25, ranging from a score of 23 to 26; the mean CASII level was 5.
- Average length of absence was 10.38 days with a range of 2 to 16 days.
- 100% (8) of children and adolescents absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL
    - 50% (4) left the home during the day
    - 50% (4) left from specialized foster care home at night – staff awake Behavior during AWOL
    - 12.5% (1) substance abuse
    - 25% (2) criminal activity

  - 62.5% (5) unknown
- Outcome
  - 37.5% (3) absent indefinitely – did not return to specialized foster care home
  - 12.5% (1) returned within 72 hours
  - 25% (2) returned through juvenile detention
  - 25% (2) Other: found after 14 days and discharged to a higher level of care; returned after 7 days

Highlights:

- 100% of the youth who ran away had a history of AWOL.
- One half (50%) of the youth ultimately returned to the specialized foster care home, either voluntarily or through juvenile detention.

Opportunities for improvement:

- Focus on AWOL prevention at night; one half of AWOLs occurred with night staff awake.
- Ensure a complete AWOL history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Ensure 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 in the home; one half of the AWOLs occurred during the day.
- 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.
- Develop a crisis plan at admission for children that have a known history of AWOL.

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 model of safety hold employed at ATC is Conflict Prevention and Response (CPAR). ATC reported 3 incidences of safety holds during this reporting period. ATC reported all staff present during the safety holds was trained in April 2009. The three incidences of safety holds occurred, one each, in September 2009, October 2009, and
December 2009. Two of the incidences of safety holds appear to have involved the same youth.

The 3 reports of the use of safety holds reflect the following descriptive information:

- 2 were male and 1 was a female.
- Average age was 13.7 with an age range of 12 to 17 years.
- 1 youth was Caucasian and the 2 other youth were African American.

Clinical and Safety Hold Information:

- 2 youth had a diagnosis of Posttraumatic Stress Disorder, 1 youth had a diagnosis of Oppositional Defiant Disorder.

- Average CASII composite score was 23 with a range of 22 to 25. Mean CASII level of intensity was 4.3.
- 1 youth had a safety hold used on them previously.
- Average length of safety holds was 16.7 minutes, ranging from 15 minute to 20 minutes.
- In all incidences, the type of supervision prior to use of safety hold was group – 2 or 3
- Injury report
    - 33% (1) Staff injured
    - 67% (2) No one injured

Highlights:

- In the 2008 reporting period of June 2008 through December 2008, ATC reported 4 incidents of safety holds. The reported 3 incidents over the 12 month reporting period in this 2009 report represents a decrease in safety hold incidents for ATC.

Opportunities for improvement:

- Ensure a complete safety hold history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Research and implement best practices in restraint to include de-escalation techniques in order to reduce its use and to increase safety outcomes.
- Ensure that ATC staff receives ongoing and regular training in best practices in restraint and de-escalation techniques.

Departure Conditions

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster home and admitted to another specialized foster home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

ATC reported forty-two (42) discharges in this reporting period. In the September 2008 through December 2008 reporting period, ATC reported thirteen (13) discharges.

The 42 departures reflect the following descriptive information.

- Average age was 14.9 with an age range of 13 to 18 years.
- 50% (21) youth were female, 50% (21) youth were male.
- 76.2% (32) youth were Caucasian, 7.1% (3) youth were Black/African-American, 7.1% (3) youth were Native Hawaiian/Other Pacific Islander, 4.8% (2) were American Indian/Native Alaskan, and 4.8% (2) youth were of mixed race.
- 11.2% (5) youth were of Hispanic origin.
- Custody Status
    - 40.5% (17) youth were in child welfare custody
    - 33.3% (14) youth were in parental custody and on probation
    - 26.2% (11) were in parental custody with no juvenile probation involvement
- 81% (32) of the discharged youth were on Medicaid. During the 2008 reporting period of June through December, ATC reported 42.1% of the discharged youth were on Medicaid.

Clinical and departure information:

- The 3 most frequent diagnoses at admission were Posttraumatic Stress Disorder (26.2% or 11 youth), Mood Disorder NOS (16.7% or 7 youth), and Bipolar Disorder (12% or 5 youth)
- The most frequent diagnosis at discharge was Conduct Disorder, Childhood-Onset Type (16.7% or 7 youth)
- The average CASII composite score at admission was 23.7, with a range from 20 to 27. The average CASII level of intensity score was of 4.9, with a range from 4 to 6.
- The average CASII composite score at discharge was 19.9. The average CASII level of intensity score at discharge was 3.2.
- Reason for departure
  - 38.1% (16) reunified with biological family
  - 33.3% (14) placed in a less restrictive environment
  - 9.5% (4) placed in a more restrictive environment
  - 9.5% (4) AWOL
  - 2.4% (1) relative placement
  - 2.4% (1) new specialized foster home, different agency
  - 2.4% (1) independent living program
  - 2.4% (1) Other: against medical advice
- Setting in which child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 10.8, which equals the restrictiveness score of specialized foster care.
  - 33.3% (14) home of birth/adoptive parents, for a child
  - 23.8% (10) group treatment home
  - 14.2% (6) county detention center
  - 9.5% (4) family based treatment home
  - 4.8% (2) home of a relative
  - 4.8% (2) adoptive home
  - 2.4% (1) home of birth/adoptive parents, for an 18 year old
  - 2.4% (1) residential treatment center
  - 2.4% (1) specialized foster care
  - 2.4% (1) supervised independent living
- 71.4% (30) youth had completed treatment at discharge.
- 76.2% (32) of the discharges were recommended by Child and Family Teams,

Highlights:

- Child and Family Teams recommended discharge in slightly more than 75% of the cases. In the September 2008 through December 2008 reporting period, Child and Family Teams recommended discharge in 100% of the cases.
- Upon discharge, 71.4% of the youth had completed treatment. In the September 2008 through December 2008 reporting period, 92.3% of the youth had completed treatment.
- Upon discharge, 81% of the youth were going to a less restrictive environment, with almost half returning to live with family members. In the September 2008 through December 2008 reporting period, 69.2% of the youth were going to a less restrictive environment.

Opportunities for improvement:

- Child and Family Teams are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers should consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.

Summary

ATC submitted all of its 2009 risk measures and departure conditions timely and, for the most part, completely and accurately. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2009 Risk Measures and Departure Conditions report reflects substantial opportunities for improvement in the areas of medication errors, AWOLs, and Child and Family Teams.

In partnership with the Provider Support Team, the Planning and Evaluation Unit has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed best practice research to the provider community (see attached) and would encourage the provider's consideration of this research in developing a plan to address some of the areas identified in their 2009 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

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ATTACHMENT F

Risk Measures / Departure Conditions Report: Family Learning Homes

Division of Child and Family Services
DCFS Family Learning Homes (NNCAS)
Risk Measures and Departure Conditions Report - 2009

INTRODUCTION

Risk measures are areas of risk identified to conduct program improvement in order to decrease risk behavior by children and adolescents in specialized foster care placement and improve safety outcomes. The collection of risk measures commenced statewide in the first quarter of 2008.

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 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 collection of departure conditions data began in September 2008.

This 2009 report reflects the collection and data analysis of risk measures and departure conditions for the reporting period of January 2009 through December 2009.

All of the risk measure and departure conditions data is self-reported by each specialized foster care provider which presents some risk that a true count of incidences goes unreported or under-reported. In order to mitigate this risk and to ensure improved validity of the data submitted, the Division of Child and Family Services, Planning and Evaluation Unit (PEU) staff started the process of monthly data clean up and provider education whenever the need for clarification was identified in the data submission; this process started in late 2008 and continued throughout the 2009 reporting period.

Family Learning Homes has submitted all their data and is to be commended for their willingness to share this very important information.

RISK MEASURES AND DEPARTURE CONDITIONS

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 asked to also track and report departure conditions on 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.

FLH PROGRAM INFORMATION

This analysis is based on data collected from January 2009 though December 2009.

Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis The average monthly bed capacity count reported by FLH was 16.2, ranging from 10 to 20 beds. In the reporting period of June 2008 through December 2008, the average monthly bed capacity reported was 21.

The average monthly number of youth served was 17.5, ranging from 13 to 22.

Suicide

Specialized foster care providers were asked to track and report incidents of attempted and completed suicides.

Attempted suicide was 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.

FLH reported zero incidents of suicide attempts during this reporting period. In the reporting period of June 2008 through December 2008, FLH reported one incident of attempted suicide.

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).

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.

FLH reported three (3) incidents of medication errors in 2009. In the reporting period of June 2008 through December 2008, FLH reported 2 incidents of medication errors.

The 3 incidents of medication errors reflect the following descriptive information:

- Two were female, one was male.
- Average age was 12 with an age range of 9 to 14 years.
- 100% (3) were Caucasian and none were of Hispanic origin.

Clinical and medication error information:

- Two youth had a diagnosis of ADHD and one youth had a diagnosis of Bipolar Disorder.
- Average CASII score was 22, ranging from a score of 20 to 25; all 3 youth had a level of intensity score of 4.
- The type of medication error for all 3 youth was an omission error.
- Two of the medication errors were with psychotropic medication, one was with non-psychotropic medication.
- Medication error outcome
    - One outcome was circumstances or events that have the capacity to cause error.
    - One outcome was an error occurred but the error did not reach the patient (An "error of omission" does reach the patient).
    - One outcome was an error occurred that reached the patient but did not cause patient harm.

Opportunities for improvement:

- 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.

  FLH has reported less than expected medication errors. 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 this 12-month reporting period, given the definitions noted in the table below.

[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.

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, 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 timely by the legal guardian/custodian (code #2)

- 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.

The 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. The 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.

AWOL

Specialized foster care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs).

FLH reported eight (8) incidents of AWOL during this reporting period. In the September 2008 through February 2009, FLH reported three incidents of AWOL.

The 8 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 100% (8) were female.
- Average age was 14.25 with an age range of 12 to 17 years.
- 100% (8) were Caucasian.

Clinical and AWOL information:

- The 3 most frequent diagnoses were Oppositional Defiant Disorder, Mood Disorder, and Major Depressive Disorder.
- Average CASII score was 23.4, ranging from a score of 20 to 26; the mean CASII level was 4.6. One CASII score and one level of intensity score were missing data.
- Average length of absence was 12 days with a range of 2 to 15 days.
- 87.5% (7) of the youth absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL
    - 37.5% (3) left from school or work
    - 25% (2) left from treatment home at night – staff awake
    - 25% (2) left home during the day
    - 12.5% (1) were other
- Behavior during AWOL
    - 37.5% (3) substance abuse
    - 62.5% (5) unknown
- Outcome
    - 25% (2) returned to treatment home within 72 hours
    - 37.5% (3) absent indefinitely – did not return to treatment home
    - 37.5% (3) other

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.
- 25% of AWOL children and adolescents returned to the treatment home within 72 hours.

Opportunities for improvement:

- Develop a crisis plan at admission for children that have a known history of AWOL.
- Focus on developing protocols regarding supervision between the school and/or work and the specialized foster care home
- Focus on AWOL prevention at night; a quarter of AWOLs occurred with night staff awake.
- 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.
- Ensure a complete AWOL history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Ensure 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.

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.

FLH reports it uses CPART as its model of safety holds. FLH reported seven (7) incidents of safety holds during this reporting period. In the reporting period of June 2008 through December 2008, FLH reported 2 incidents of safety holds.

The 7 reports of the use of safety holds reflect the following descriptive information:

- 57.1% (4) were male and 42.8% (3) were female.
- Average age was 8.3 with an age range of 7 to 10 years.
- 85.7% (6) were Caucasian, 14.3% (1) were of mixed race.
- None of the youth were of Hispanic origin.

Clinical and Safety Hold Information:

- The 2 most frequent diagnoses were Conduct Disorder and Posttraumatic Stress Disorder.
- Average CASII composite score was 21.3, ranging from 20 to 24; average CASII level of intensity score was 4.3, ranging from 4 to 5.
- 100% (7) of children and adolescents had a safety hold used on them previously.
- Average length of safety holds was 2.14 minutes, ranging from 2 minutes to 6 minutes.
- Type of supervision prior to use of safety hold
    - 71.4% (5) Group – 4 or more
    - 14.3% (1) One-on-one
    - 14.3% (1)
    - Other
- There were no injuries reported for any incidents of safety holds during this reporting period.

Highlights:

- All the youth placed in safety holds had previous episodes of safety holds.
- There were no injuries reported as a result of youth placed in safety holds.

Opportunities for improvement:

- Ensure a complete safety hold history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Research and implement best practices in safety holds to include de-escalation techniques in order to reduce its use and to increase safety outcomes.
- Ensure that provider agencies receive ongoing and regular training in best practices in safety holds and de-escalation techniques.

Departure Conditions

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster home and admitted to another specialized foster home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

FLH reported thirty-five (35) discharges in this reporting period. In the reporting period of September 2008 through December 2008, FLH reported 4 discharges.

The 35 departures reflect the following descriptive information.

- Average age was 12.4 with an age range of 6 to 18 years.
- 54.3% (19) were male, 45.7% (16) were female.

- 91.4% (32) were Caucasian, 2.9% (1) were Native Hawaiian/Pacific Islander, and 5.7% (2) were of mixed race.
- 5.7% (2) of youth were of Hispanic origin.
- 28.6% (10) of youth were in child welfare custody, 42.9% (15) of youth were in parental custody and on probation, and 28.6% (10) of youth were in parental custody and no juvenile probation involvement.
- 60% (21) were Medicaid or SCHIP recipients.

Clinical and departure information:

- The most frequent diagnosis at admission was Posttraumatic Stress Disorder (15.6%), followed by Oppositional Defiant Disorder (11.4%), and followed by Bipolar Disorder, Reactive Attachment Disorder, and Bipolar Disorder (8.6% each).
- The most frequent diagnosis at discharge was Oppositional Defiant Disorder (44.4%) followed by Reactive Attachment Disorder (22.2%).
- The average CASII composite score at admission was 24.7, ranging from 18 to 27. The average CASII level of intensity score was 4.6, ranging from 3 to 6. One CASII composite score and one level of intensity score were missing.
- The average CASII composite score at discharge was 20.4; the average CASII level of intensity score at discharge was 3.3.
- Reason for departure
  - 48.6% (17) reunified with biological family
  - 5.7% (2) adopted/adoptive placement
  - 2.9% (1) emancipated
  - 8.6% (3) placed in a less restrictive setting
  - 14.3% (5) placed in a more restrictive setting
  - 11.4% (4) youth ran away from placement (AWOL)
  - 2.9% (1) removed by placing agency
  - 5.7% (2) other
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 7.6, which equals the restrictiveness score of the home of a family friend.
  - 2.9% (1) independent living by self
  - 22.9% (8) home of birth/adoptive parents, for an 18-year old
  - 37.1% (13) home of birth/adoptive parents, for a child
  - 2.9% (1) home of a relative
  - 2.9% (1) adoptive home
  - 2.9% (1) specialized foster care
  - 2.9% (1) individual home emergency shelter
  - 5.7% (2) group treatment home
  - 5.7% (2) residential treatment center
  - 5.7% (2) state and private mental hospital
  - 8.6% (3) unknown
- 65.7% (23) completed treatment.
- Who recommended departure
  - 2.9% (1) provider agency
  - 2.9% (1) child welfare case manager
  - 8.6% (3) parent

  - 2.9% (1) child's mental health practitioner
  - 77.1% (27) child and family team
  - 5.7% (2) N/A; youth went AWOL

Highlights:

- Upon discharge, 65.8% of youth returned to a less restrictive environment, with over half returning to live with family members. In the September 2008 through December 2008 reporting period, 50% of the youth were going to a less restrictive environment.
- Well over half of the youth completed treatment at discharge. In the September 2008 through December 2008 reporting period, 50% of the youth discharged completed treatment.
- Slightly more than 75% of the discharges were recommended by Child and Family Teams. In the September 2008 through December 2008 reporting period, 50% of the discharges were recommended by the child and family team.

Opportunities for improvement:

- CFTs are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers should consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.

Summary

Throughout 2009, Family Learning Homes submitted these data timely and accurately. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2009 Risk Measures and Departure Conditions report reflects substantial opportunities for improvement in the area of medication errors, AWOLs, safety holds, and child and family teams.

In partnership with the Provider Support Team, the Planning and Evaluation Unit has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed best practice research to the provider community (see attached) and would encourage the provider's consideration of this research in developing a plan to address some of the areas identified in their 2009 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

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Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide. *Model program's guide version 2.5*. Retrieved April 27, 2009 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?ID=292

U.S. Pharmacopeia. (2000, December). *USP Medmarx data analyzed – first annual report provided.* Retrieved April 28, 2009 from http://www.usp.org/audiences/volunteers/members/private/memos/2000-12.html

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ATTACHMENT G

Children’s Mental Health Direct Service Delivery Clinical Supervisor Checklist

CHILDREN'S MENTAL HEALTH - DIRECT SERVICE DELIVERY CLINICAL SUPERVISOR CHECKLIST

Name of Practitioner
Review Date
Intake Date

Chart #
Program

Name of Supervising QMHP
Date of Discharge

	STANDARD	MET		Comments
	Client Rights/Privacy	YES	NO	
1.	Informed Consent/Clients Rights signed and dated on or before first session.	**Y**	**N**	
2.	HIPAA acknowledgement signed and dated on or before the first session.	**Y**	**N**	
3.	Release of Information completed properly by addressing the source and the nature of information needed with an expiration of 1 year or less, signed and initialed.	**Y**	**N**	
4.	DCFS Freedom of Choice form, signed and dated at the time of or following the clinical assessment.	**Y**	**N**	
	Children's Uniform Mental Health Assessment			
5.	Children's Uniform Mental Health Assessment is completed at the first session to include minimally the diagnosis, level of intensity, SED determination in order to treat the child.	**Y**	**N**	
6.	Children's Uniform Mental Health Assessment is entered into Avatar within 10 working days of the first session.	**Y**	**N**	
	Discharge Planning at admission			
7.	The anticipated duration of the overall services.	**Y**	**N**	
8.	Discharge criteria	**Y**	**N**	
9.	Required aftercare/transition services	**Y**	**N**	
10.	Identified agency (ies) or independent providers to provide the aftercare services.	**Y**	**N**	
11.	A plan for assisting the client and family in selecting and accessing these services.	**Y**	**N**	

	Treatment Plan/Rehabilitation Plan			
12.	Each child has an initial treatment/rehab plan completed during the assessment session.	**Y**	**N**	
13.	Each child has a full clinical treatment/rehab plan completed within 30 day of the initial session, entered into Avatar and approved by supervisor within 45 days from intake.	**Y**	**N**	
14.	Treatment/rehab goals and objectives are expressed in the words of the child (when developmentally appropriate) and the family.	**Y**	**N**	
15.	Family/Caregiver is involved in developing the treatment/rehab plan as evidenced by their signature on the plan.	**Y**	**N**	
16.	Child/adolescent is involved in developing the treatment/rehab plan (when developmentaly appropriate) that is individualized to the child's needs.	**Y**	**N**	
17.	Treatment/rehab plan is reviewed and authorized by QMHP in Avatar.	**Y**	**N**	
18.	Include on the treatment/rehab plan the child's name & 11-digit Medicaid billing number	**Y**	**N**	
19.	Strengths & Needs of the child and his/her family	**Y**	**N**	
20.	Intensity of Needs determination	**Y**	**N**	
21.	Goals are specific, measureable (observable), achieveable, realistic, and time-limited (SMART)	**Y**	**N**	
22.	Discharge/transition criteria for each treatment goal are reflected in the treatment/rehab plan.	**Y**	**N**	
23.	Specific treatment goal/objective includes the frequency, amount, scope, duration and the anticpated provider of service	**Y**	**N**	
24.	Coordinating QMHP signs the treatment/rehab plan	**Y**	**N**	

	Monitoring of Treatment - *Progress Notes and Billing Codes*	MET		Comments
		YES	NO	
25.	Progress notes that follow a standardized format (DAP) document the data, assessment, and plan necessary for treatment and service care coordination that includes the amount, scope, duration and name of the service provider.	**Y**	**N**	
26.	Progress notes relate to the treatment/rehab plan goals and objectives and document progress or lack thereof in the DAP format.	**Y**	**N**	
27.	Progress notes are documented in Avatar within 72 hours of service delivery.	**Y**	**N**	

	Monitoring of Treatment - *90 day review*		
28.	90 day review summarizes treatment/rehab goals and objectives and progress made (or lack of progress) in therapy; addresses revised goals and objectives of the treatment.	**Y N**	
29.	90 day review includes updated assessment; CASII/NECSET/ECSII, CAFAS/PECFAS, diagnostic changes etc.	**Y N**	
30.	Involvement of the family/caregiver in 90 day reviews.	**Y N**	
31.	Education status information and juvenile justice involvement information if child is school age.	**Y N**	
	Monitoring of Treatment - *30 day progress report for rehab services only*		
32.	Rehab Service provider sends 30 day progress report to the coordinating QMHP	**Y N**	
	Discharge Summary - *Rate only if this is a discharged case*		
33.	Discharge Summary completed within 30 days when planned, 45 days when unplanned, and 7 days when transferred, following discharge.	**Y N**	
34.	Date of last service contact	**Y N**	
35.	Diagnosis at admission and discharge	**Y N**	
36.	Reason for transition/discharge stated clearly	**Y N**	
37.	Current level of functioning description and measurement CASII/NECSET/ECSII	**Y N**	
38.	Summary of effectiveness of treatment modalities, progress toward treatment/rehab goals and objectives as documented in the treatment/rehab plan.	**Y N**	
39.	Recommendations for further treatment and how child has been transitioned to these services.	**Y N**	
40.	Education status information and juvenile justice involvement information if child is school age.	**Y N**	

Notes:

Supervisor

Date

ATTACHMENT H

Children's Mental Health Targeted Case Management Supervisor Checklist

CHILDREN'S MENTAL HEALTH - TARGETED CASE MANAGEMENT SUPERVISOR CHECKLIST

Name of Practitioner ______________________________ Name of Supervisor ____________________

Chart # ________________________________ Program ______________________

Intake Date ____________________________ Discharge Date ______ Review Date ____________

	STANDARD Client Rights / Privacy	Met Yes	 No	Comments
1.	Informed Consent/Client Rights signed and dated on or before the first session.	Y	N	
2.	HIPAA Acknowledgement signed and dated on or before the first session.	Y	N	
3.	Release of Information completed properly by addressing the source and the nature of information needed with expiration of 1 year or less, signed and initialed.	Y	N	
4.	DCFS Freedom of Choice form signed and dated after completion of the clinical assessment recommending targeted case management.	Y	N	
	Medical Necessity			
5.	Children's Uniform Mental Health Assessment is complete and recommends TCM. Level of intensity measure meets level of service needs for TCM. SED determination is completed	Y	N	
	Targeted Case Management Assessment			
6.	Targeted Case Management Assessment is completed and entered into Avatar within 10 working days of the initial targeted case management contact.	Y	N	
7.	Strengths, Needs and Cultural Discovery includes strengths and needs related to the culture of the family. It is reviewed by the family before the initial 30 day Child and Family Team meeting. (When the case manager is not a clinician)	Y	N	

8.	Medical, social, educational, emotional and other support services including housing and transportation needs are addressed.	**Y**	**N**	
	Targeted Case Management Care Coordination Plan	Met Yes	No	Comments
9.	The initial Care Coordination Plan is completed and signed within 30 days of admission and . before initiating services.	**Y**	**N**	
10.	Care Coordination Plan is developed at the Child and Family Team meeting.	**Y**	**N**	
11.	The child/family's needs and care coordination recommendations are addressed through the life domains.	**Y**	**N**	
12.	Care Coordination Plan is reviewed and updated in Child and Family Team meetings.	**Y**	**N**	
13.	Confidentiality Form that identifies and is signed by all participants is attached to the Care Coordination Plan.	**Y**	**N**	
14.	Care Coordination Plan reflects a planned action for addressing and meeting the identified needs of the child/family.	**Y**	**N**	
15.	Care Coordination Plan is individualized to reflect the child's age, gender, ethnic background, primary language in the home, life experience, culture, etc.	**Y**	**N**	
16.	Care Coordination Plan goals are expressed in the words of the child (when developmentally appropriate) and the family.	**Y**	**N**	
17.	Children, when developmentally appropriate are involved in developing the Care Coordination Plan.	**Y**	**N**	
18.	Family/Caregiver is involved in developing the Care Coordination Plan as evidenced by their signature on the plan.	**Y**	**N**	
19.	Care Coordination Plan goals, objectives and actions address the medical, social, educational, emotional, and other needs.	**Y**	**N**	
20.	Care Coordination Plan addresses specific services and treatments that include the amount, scope, duration, and names of the service providers.	**Y**	**N**	
21.	Anticipated aftercare/transition plan	**Y**	**N**	
22.	Crisis Plan	**Y**	**N**	

	Monitoring of Care Coordination Progress Notes and Billing Codes	Met Yes	 No	Comments
23.	Progress notes that follow a standardized format (DAP) document the data, assessment and plan necessary for service care coordination that includes the name of the individual receiving services, the dates of service, timeline for providing services and reassessment, and the name of the service provider.	**Y**	**N**	
24.	Progress notes relate to the Care Coordination Plan goals and objectives and document progress or lack thereof as evidenced by attaching CCP goals to notes	**Y**	**N**	
25.	Progress note documents the nature, content and units of case management services received.	**Y**	**N**	
26.	Progress notes are documented in Avatar within 72 hours of service. WIN also enters notes in UNITY by the following Friday after services are provided.	**Y**	**N**	
27.	The need for and occurrences of coordination with case managers of other programs	**Y**	**N**	
	Monitoring of Care Coordination - 90 day review			
28.	Whether the goals specified in the Care Coordination Plan have been achieved.	**Y**	**N**	
29.	90 day written review for each child that includes all the objectives/goals of the Care Coordination Plan that addresses all the relevant life domains of the child and family and progress or lack of in the CCP.	**Y**	**N**	
30.	Review explains updated/revised Care Coordination Plan goals, objectives, and anticipated time of goal achievement/progress and discharge/transition plan.	**Y**	**N**	
31.	Review includes updated assessment and medical necessity data; CASII/NECSET/ECSII/CAFAS/PECFAS.	**Y**	**N**	
32.	Education status information and juvenile justice involement information if child is school age	**Y**	**N**	
	Discharge/Transition Summary *(Rate only if this is a discharged case).*			
33.	Discharge Summary completed within 30 days when planned; 45 days when unplanned;			

	and 7 days when transferred, following discharge.	**Y N**	
34.	Date of last service contact.	**Y N**	
35.	Diagnosis at admission and discharge.	**Y N**	
36.	Reason for transition/discharge stated clearly	**Y N**	
37.	Implementation steps toward transition/ discharge addressed.	**Y N**	
38.	Current level of functioning description and measurement-CAFAS/PECFAS CASII/NECSET/ECSII.	**Y N**	
39.	Summary of effectiveness of services, progress or lack of towards service goals as documented in the Care Coordination Plan.	**Y N**	
40.	Recommendations for further services and how child has been transitioned to these services.	**Y N**	
41.	Education status information and juvenile justice involvement information if child is school age	**Y N**	

*Supervisor*____________________________ *Date*____________________