Senate Memorial 115

Task Force Report

<u>Summary Version</u>

November 16, 2015

INTRODUCTION

Senate Memorial 115 was introduced by Senator Gerald Ortiz y Pino in the First Legislative Session of 2015. The Memorial requested that a Task Force perform an independent evaluation of the Sequoyah Adolescent Treatment Center (SATC) and make recommendations to the interim Legislative and Human Services Committee.

Memorial 115 identified **5 areas of concern** as follows:

- SATC was authorized to provide a residential treatment program designed for treating adolescents with a history of violence, who have a mental disorder and who are amenable to treatment.
- SATC treatment goals included clients developing skills necessary for successful transition in the community.
- SATC had operated in compliance with these mandates from 1992 – 2012 when the average daily census had been 35 clients and there was a waiting list for admission.
- Since 2012, there had been a precipitous drop in the average daily census (at times as low as 13 clients) and there was no waiting list for admissions.
- The reduction in census and lack of a waiting list indicated that adolescents who need these services were not being served.

Memorial 115 requested that an **independent evaluation** of SATC occur by a Task Force under the direction of the Chairman of the University Of New Mexico School Of Medicine's Department of Psychiatry & Behavioral Sciences (or designee) in **four areas**:

1. The therapeutic model
2. Resident services
3. Staffing levels and qualifications
4. After-care services

Memorial 115 requested that the Task Force make **recommendations addressing**:

1. Ways to strengthen the program and services provided.
2. A plan to improve the financial status of SATC.
3. A plan to build a statewide system of after care for residence upon discharge.
4. Proposed legislation, if any, necessary to implement the recommendations.

TASK FORCE MEMBERS

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*Jane McGrath	Pediatric Adolescent Medicine, UNM
Babak Mirin	Psychiatrist, SATC
David Mullen	Child & Adolescent Psychiatrist, UNM
David Graeber	Child & Adolescent Psychiatrist, UNM
*Cynthia "Sam" Murphey	Mother of adolescent client at SATC
Lori Ponge	Executive Director Child Psychiatry, UNM
Carmela Sandoval	Administrator, SATC
Tres Hunter Schell	New Mexico Department of Health
*David Schmidt	Executive Director, NM Council On Crime & Delinquency
*Anita Westbrook	Former Director, SATC
Stephen Dorman	Chief Medical Officer, DOH
*Javier Aceves	Pediatrician & Director of YCHC, UNM
Joseph Andrade	Director of Outpatient Child Psychiatry, UNM
*Jeremy Averella	Health Office of Facilities Management (OFM) and the Chief Facilities Officer/OFM Division Director
*George Davis	Child & Adolescent Psychiatrist/CYFD JJ Division
*Henry Gardner	Former Director, SATC
Shauna Hartley	Administrator, DOH
Desiree Gathings	Finance & Administration, UNM
Vanessa Hawker	Finance & Administration, UNM
Candice Cannady	Task Force Observer; Advocate, Disability Rights New Mexico

***Reflects required Task Force Membership as outlined in Senate Memorial 115.**

RECOMMENDATIONS

CLINICAL CARE

1. SATC should continue to focus on admitting and treating youth with mental health disorders and aggression.

2. Improve the process for obtaining AIMS (abnormal involuntary movements scale) evaluations and documentation of results.

3. Improve the process for monitoring weight gain tracking and possible interventions when weight gain is present. Suggest using growth charting of height, weight and BMI as an aid to identification of significant weight gain. One indicator of potential problematic weight gain is an increase of 7% of body weight since admission; this indicator can be used to flag a clinical review by the treatment team led by the psychiatrist.

4. Implement Bright Futures Recommendations. (Majority of the recommended best practices are already in place at SATC). Areas that may benefit from additional focus include HIV testing, Immunization (HPV specifically) and implementation of a comprehensive health education program for all residents focusing on the major causes of morbidity including; substance abuse and tobacco, STD and HIV risk reduction, healthy relationships, comprehensive sexuality education & interpersonal violence reduction.

5. Medical assessment and physical assessment should be conducted within the first 24 hours of admission, unless physician determines that an examination within the week prior to transfer to the facility is sufficient (per American Academy of Child and Adolescent Psychiatry recommendations for RTCs).

6. Given the high proportion of LGBT youth in detention centers nationally SATC should develop written policies including staff training to ensure an inclusive and supportive environment. Recommend adherence to national guidelines such as the Child Welfare League guidelines for LGBT youth[i].

STAFF & PROFESSIONAL PERSONNEL

1. Recruit (if possible) a Board Eligible or Certified Child & Adolescent Psychiatrist. This may be limited by financial limitations on available salary as well as high demand and low supply of Child & Adolescent Psychiatrist locally and nationally.

2. Develop a well-defined clinical relationship with the Department of Psychiatry at the University of New Mexico School of Medicine to encourage consultation with BE/BC Child & Adolescent Psychiatry Faculty on challenging or high risk clinical cases. This may involve the development of a Memorandum of Understanding.

3. Create a "Clinical Learner's Group" with local (and possible future expansion to statewide representation) entities providing psychiatric care to adolescents in a residential treatment setting. The goal of this group will include increased interaction, collaboration and learning via a shared educational format. This will include psychiatrists, psychologist, counselors/therapists and nursing personnel. Initial participation include SATC, UNM, Presbyterian, YDC and Desert Hills behavioral health personnel. Meetings will occur quarterly and will start in early 2016.

4. Change the reporting structure of the SATC Psychologist's so they are supervised by the Psychiatric Medical Director. The goal of this change is to strengthen programmatic cohesion and alignment of clinical treatment plans as client's progress toward discharge goals.

5. Identify additional resources for strengthening ongoing education and training on trauma informed model of care. This may include collaboration with the SAMSHA funded ACTION Program in the Department of Psychiatry at UNM.

OUTREACH AND STAKEHOLDER RELATIONSHIPS

1. Re-establish the SATC Advisory Board with a primary goal being to obtain feedback and input from community stakeholders.

2. Develop a process to reach out proactively to current and prospective stakeholders (including Juvenile Justice and Public Defenders) to communicate the mission and program of SATC including inclusion and exclusion criteria for admissions and to update these referral sources on admission availability (census) on an ongoing basis.

AFTER CARE & OUTCOMES

1. Recommend that the Managed Care Organizations (MCO) have Care Coordinators attend the final discharge Team Meeting to ensure that follow up care is in place.

2. Also recommend that SATC, in collaboration with the MCO's (if patient has Medicaid coverage), adopt the Building Bridges Initiative Post-Residential Performance Indicators for tracking client outcomes. These are broken into two settings.

   a. SATC should track the following indicators prior to discharge:

      - Percent of youth and families who are discharged when planned.
      - Percent of transition plans that include a mutually agreed upon crisis response plan to support the youth and family in the community.
      - Percent of youth and families who receive services while in residential treatment from at least one of the same providers who will provide services following discharge. *This may be satisfied by MCO's Care Coordinator's participation in the final discharge planning meeting.
      - Percent of youth and families who have been contacted by the residential treatment and support provider within 48 hours of discharge.

   b. SATC (along with the MCO's Care Coordination Services) should track the following indicators post discharge using the form attached:

      - Percentage of youth and families who receive a care-coordination visit within 7 days post-discharge.
      - Percentage of youth and families who continue to receive planned aftercare services for three months post-discharge.
      - Rates of readmissions to the same/similar or higher level of care a) within 90 days, and, b) within one year of discharge.
      - *Did the client spend any days in a Juvenile Justice Facility (or an adult facility if the client is over the age of 18) in the past 90 days and if so – how many days and where?
        *This is not included in the BBI Performance Indicators but is pertinent to DOH's mission regarding SATC.

FINANCES

Continue on current trajectory of maintaining the average census above 27 which is the financial "break even" mark given current level of reimbursement and operating expenses. The average daily census goal should be 33-35 with an option of a wait list when clinically appropriate.

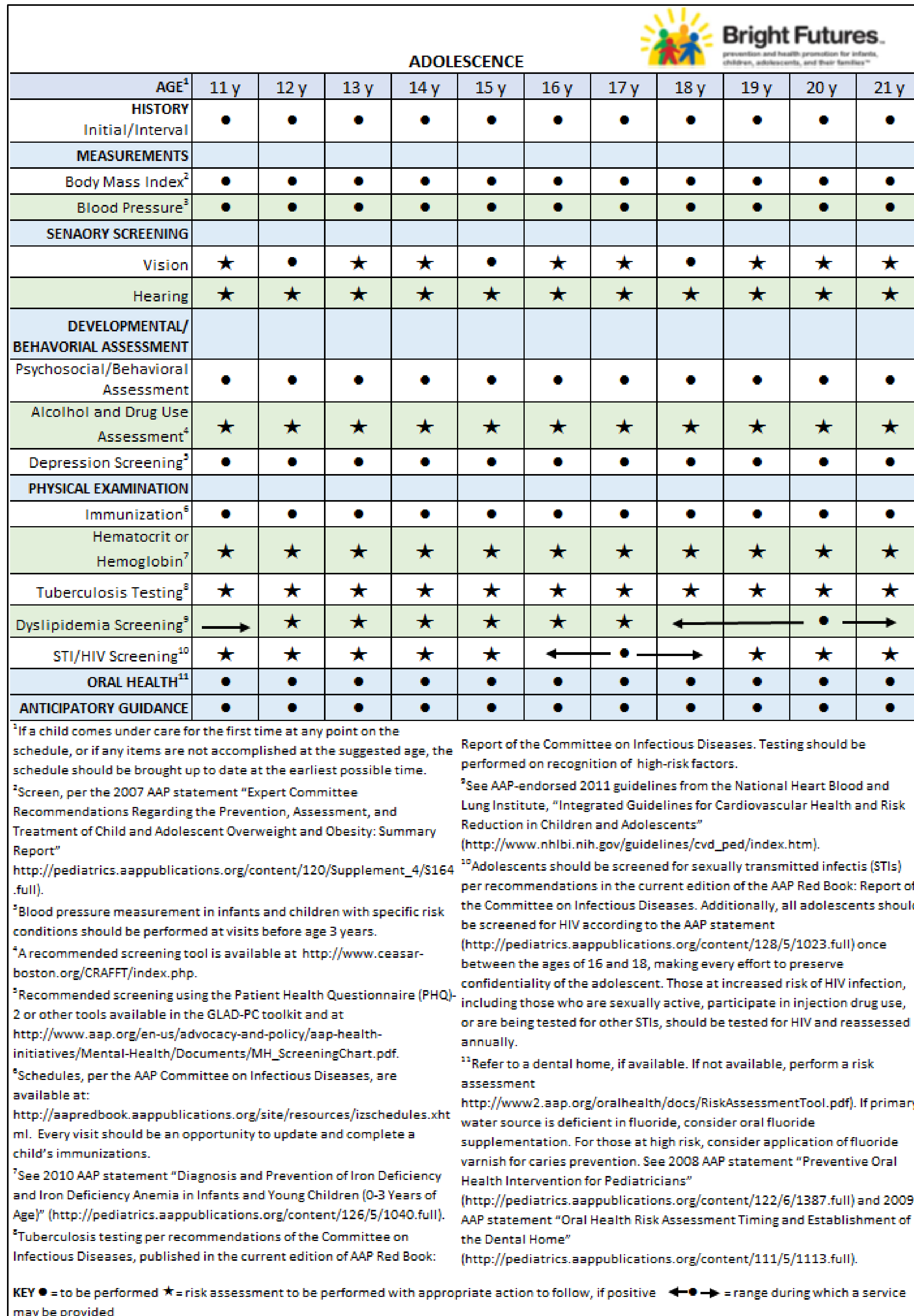
FUTURE CONSIDERATIONS

These two items were discussed by the Task Force and are included as issues for future discussion:

1. Should female adolescents with a mental disorder and aggression be served by a "female equivalent" of SATC?

2. Should SATC expand their program to offer a "day treatment program" to serve males with a mental disorder and aggression who are discharged from SATC or those who might not require a full residential program. This would add a "step down" level of care for those clients who live close enough for the transportation logistics to be practical.

ATTACHMENT 1 – BRIGHT FUTURES



ADOLESCENCE

AGE[1]	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS											
Body Mass Index[2]	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[3]	●	●	●	●	●	●	●	●	●	●	●
SENAORY SCREENING											
Vision	★	●	★	★	●	★	★	●	★	★	★
Hearing	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/ BEHAVORIAL ASSESSMENT											
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●
Alcolhol and Drug Use Assessment[4]	★	★	★	★	★	★	★	★	★	★	★
Depression Screening[5]	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION											
Immunization[6]	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[7]	★	★	★	★	★	★	★	★	★	★	★
Tuberculosis Testing[8]	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[9]	→	★	★	★	★	★	★	←	—	●	→
STI/HIV Screening[10]	★	★	★	★	★	←	●	→	★	★	★
ORAL HEALTH[11]	●	●	●	●	●	●	●	●	●	●	●
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●

[1]If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

[2]Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).

[3]Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

[4]A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.

[5]Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.

[6]Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.

[7]See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).

[8]Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.

[9]See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

[10]Adolescents should be screened for sexually transmitted infectis (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

[11]Refer to a dental home, if available. If not available, perform a risk assessment http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). If primary water source is deficient in fluoride, consider oral fluoride supplementation. For those at high risk, consider application of fluoride varnish for caries prevention. See 2008 AAP statement "Preventive Oral Health Intervention for Pediatricians" (http://pediatrics.aappublications.org/content/122/6/1387.full) and 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←●→ = range during which a service may be provided

ATTACHMENT 3 – MCO TRACKING FORM FOR CLIENT'S DISCHARGED FROM SATC

Tracking form for Clients discharged from Sequoyah Adolescent Treatment Center

Client's Name:____
Client's DOB: ____
Person collecting data and date of collection: ___________________/___________
MCO and name of Care Coordinator: _____________________________________
SATC Discharge Date: ___________________________________
Post-Discharge Follow-up Date:
7 days: Date: ____
90 days: Date: ____
12 months: Date: ____
Information collected:

1. Did client and family who receive a care-coordination visit within 7 days post-discharge? Yes or No.
   (7 day visit only).
   Date and with whom:
2. Is client and family receiving the discharged planned aftercare services?
   (3-month post-discharge date only).
   - Services recommended at discharge:
   - Services received in the past 90 days and agency/individual providing those services; indicate if services remain active at this time.
   - Has client been readmitted to a similar or higher level of care within the past 90 days and if yes – where?
   - Did the client spend any days in a Juvenile Justice Facility (or an adult facility if the client is over the age of 18) in the past 90 days and if so – how many days and where?
3. Has client been readmitted to a similar or higher level of care within the past 12 months and if yes – where?
   (12-month post-discharge date only).
   - Did the client spend any days in a Juvenile Justice Facility (or an adult facility if the client is over the age of 18) in the past 365 days and if so – how many days and where?