Senate Memorial 115

Task Force Report

October 25, 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 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.

The Task Force convened for the original meeting on May 7, 2015. The Task Force met on a monthly basis through September of 2015 and also appointed two smaller work groups (clinical and administrative) which convened outside of the monthly meetings. The Chairman of the Department of Psychiatry & Behavioral Sciences (Dr. Mauricio Tohen) appointed Dr. David Graeber as his designee to Chair the Task Force.

TASK FORCE MEMBERS

*Brad McGrath	New Mexico Department of Health
*Jane McGrath, MD	Pediatric Adolescent Medicine, UNM
Babak Mirin, MD	Psychiatrist, SATC
David Mullen, MD	Child & Adolescent Psychiatrist, UNM
David Graeber, MD	Child & Adolescent Psychiatrist, UNM
*Cynthia "Sam" Murphey	Mother of adolescent client at SATC
Lori Ponge, RN	Executive Director Child Psychiatry, UNM
Camela 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
*Javier Aceves, MD	Pediatrician & Director of YCHC, UNM
Joseph Andrade	Director of Outpatient Child Psychiatry, UNM
*Jeremy Averella	SATC
*George Davis, MD	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.

REVIEW

BACKGROUND

Sequoyah Adolescent Treatment Center

Sequoyah Adolescent Treatment Center (SATC) has been providing treatment services to adolescent boys since July 1, 1992 when the center was officially transferred from the New Mexico Youth Authority to the New Mexico Department of Health.

Historically, Sequoyah (originally called Secure Treatment Center) was conceived in July 1982, as a psychiatric hospital for adolescent clients who could not be treated in a traditional psychiatric facility because of their violence. Funds were appropriated to build the center in 1984, but did not include funding for staff. Thus, the Secure Treatment Center did not open until 1990 when the New Mexico Youth Authority used it as a nine-bed treatment center for juvenile delinquents.

Community needs, as expressed through the legislature, suggested the need to open the center to both adjudicated and non-adjudicated youth. As a result, the legislature formally transferred the center to the Department of Health, Division of Mental Health, and effective July 1, 1992. Admission standards were changed, treatment rather than incarceration became the primary purpose and the center was officially opened as Sequoyah Adolescent Treatment Center. In the ensuing years, it expanded from the original nine beds to its current capacity of 36 beds.

- SATC completed its last JCAHO full survey on 9/13/2013 and had its last on-site survey on 3/21/2014 and is currently fully accredited.

- SATC was last surveyed by the Children, Youth and Families Department Licensing and Certification Authority from March 9th to March 15th, 2015. SATC was granted licensing for an 18-month period.

THERAPEUTIC MODEL

Admission Screening

Admission to Sequoyah is a multi-stage process that begins with the adolescent being referred to Sequoyah. Referrals come from throughout New Mexico, most come from Juvenile Probation Officers. Referrals also come from other providers, the public defender's office, and family/legal guardians. Upon referral, a packet on the potential client is assembled. This packet includes evaluations and the Individual Education Plan (if available). The prospective client packet is reviewed by the Sequoyah admissions team.

Admission Criteria

1. Students are admitted to Sequoyah only under the provisions of the New Mexico Children's Mental Health and Developmental Disabilities Code.
2. The adolescent must be violent or have a history of violence, have a mental disorder.
3. The adolescent must be between thirteen (13) and seventeen (17) years old at admission.
4. The adolescent must have the cognitive capacity to benefit from verbal therapies and milieu programming offered at Sequoyah.
5. Need for services is the primary consideration and services are offered without discrimination by reason of race, sexual preference, religion, or national origin.
6. Clients cannot be ordered here under criminal or delinquency codes and Sequoyah does not do court-ordered, forensic evaluations for competency.
7. The Adolescent has not benefited from a regular education setting and likely meets criteria for special education.

If, after the initial screening, the admissions team determines that placement at Sequoyah could be merited, then the psychiatrist reviews the packet. If the psychiatrist is in agreement that placement may be appropriate, an assessment interview is conducted. It is preferable to have this interview conducted in person, but a phone interview is acceptable. During the interview the potential client's history is taken, he is asked if he is willing to come to Sequoyah, and what does he wish to work on if he were placed at Sequoyah? The legal guardian is then consulted. If the legal guardian is not available, then the Juvenile Probation Officer is spoken with.

The admissions team strives for one week to conduct the entire initial screening and interview. All compiled information is then assembled and presented to the admissions team. If the client is approved for admission, Sequoyah applies for insurance approval. If the adolescent is currently in detention, the appropriate managed care organization (MCO) has 24 hours to approve or deny the request. If the adolescent is not in detention, the MCO has 5 days to respond. If the MCO denies admission, Sequoyah and the referral source work to address the

denial. Typically the referral source is the entity filing the appeal to the MCO. It should be noted that MCOs rarely deny admission to Sequoyah.

If the potential client does not have insurance, Sequoyah works with the legal guardian to file for Medicaid. The application for Medicaid takes approximately one week. Sequoyah will not refuse a potential client due to the client not being covered by insurance.

If the admissions team determines that Sequoyah is not appropriate for the referred adolescent, they provide suggestions for other placements.

The Task Force reviewed consecutive referrals and admissions for the time period from April – June of 2015. There were 53 referrals during this time period with 22 being admitted to SATC. Below is the breakdown of referrals and reasons for non-admission:

22	Admitted to SATC
3	JPO/Judge decision to not admit
3	Did not meet age requirement
8	Placed elsewhere
3	No aggression
3	IQ cut-off not met
3	Parent/student not invested in treatment at SATC
4	No appropriate milieu openings
1	Lower level of care not tried
2	No longer needed placement
1	No response

The task force found that SATC admitted youth who met admission criteria, including youth that had a history of violence. The task force did not find evidence of failure to admit overly aggressive youth.

The Average Monthly Census for January 2015 thru August 2015 was 27.25. The Task Force reviewed this data which is summarized below:

Average Monthly Census - 2015							
Jan	Feb	Mar	Apr	May	June	July	Aug
29	27	26	25	25	30	30	26.2

Admission Process

When an adolescent is admitted to Sequoyah, his legal guardian should be present. If they cannot be, the appropriate forms are faxed to the Juvenile Probation Officer or the referral source. The appropriate individual is required to sign the form. The preadmission team is prepped for the adolescent prior to his arrival. This prepping includes information on the triggers the adolescent has. Admissions occur on any week day.

1. The psychiatrist assesses the patient. This psychiatric assessment is part of the history and physical for each patient.
2. The nurse assesses the patient and also obtains information on preexisting relationships with a primary care provider. If the adolescent does not have a relationship with a local Albuquerque primary care provider, one is selected for the adolescent. If the adolescent has not had a physical examination within the past year, arrangements are made for a visit to the selected primary care provider for a physical examination
3. Urine and drug screens are completed.
4. The adolescent is taken to their lodge for initial orientation.

Treatment

The first treatment plan meeting is within 72 hours of the adolescent's admission. The comprehensive treatment plan is developed within 14 days of admission. All plans are included in the adolescent's electronic medical record.

- Initial discharge planning is included.
- The adolescent participates in developing the treatment plan.
- The comprehensive plan is reviewed after 30 days, unless it is clinically indicated to review sooner. The psychiatrist is included in the review.
- If the adolescent behaves in such a way so as to require either seclusion or physical restraint for safety, there is a review of the treatment plan.
- The psychiatrist receives regular feedback on each adolescent from the nurses and Sequoyah from other clinical staff (therapists, psychologists & teachers).

The treatment model is based on a Trauma Informed Care model; specifically, the nationally recognized Building Bridges Initiative. This model has been implemented over the past year. All newly hired staff receives training in this model. There are morning rounds and a 2 p.m. shift change every day. During the rounds and the shift change, the onboarding staff reviews what transpired in the concluding shift.

The Task Force appointed a clinical working group (Drs. Davis, Graeber, Mullen, Dorman and Lori Ponge) to review what they felt were key indicators of the clinical care at SATC. This

working group reviewed a sample cohort of students (N = 6) admitted in a 30 day period in December of 2014 and reviewed the following data for the time period ending in June of 2014:

- Medication by Month
- Labs & Dates
- History & Physicals
- Height/Weight & Dates
- AIMS Dates
- Assessment/Follow Up – Dates with Psychiatry, Therapists & Psychologists
- Pretreatment/Treatment Team Meeting Dates and Staffing by Discipline
- Monthly Summary of Events of Aggression, Property Destruction, Rule Violation, etc.
- Discharge Dispositions by month for April, May and June of 2015.
- Referrals from April – June of 2015 and reason for non-admission.
- Sequoyah Model of Care – Revised 8/25/15.
- Sequoyah Mid/High School Schedule for 2014-2015 School Year.

The data from this review is summarized below:

1. **Medications by Month** – Number of medications: 3 patients admitted on more medications than at discharge; 2 discharged on same number of medications as at admission and one admitted on 1 medication and discharged on 2 medications.

2. **Labs** – nothing remarkable – one patient started on an antipsychotic in January and did not have repeat labs as of April.

3. **History & Physicals** – 2/6 had full H&P off site within 30 days; 1 had an offsite exam in 90 days; 3 had H&P done only by SATC Psychiatrist. All 6 had H&P by SATC Psychiatrist upon admission.

4. **Weight Gain** – Patient 1: 13% weight gain on antipsychotic; Patient 2: No with gain on antipsychotic but no weights recorded the last 3 months on antipsychotic; Patient 3: 2 pound weight loss not on antipsychotic; Patient 4: 14% weight gain on antipsychotic (and Depakote and lithium); Patient 5: 7% weight gain not on antipsychotic; Patient 6: 10% weight gain on antipsychotic.

5. **Abnormal Involuntary Movement Scale (AIMS)** – per reported SATC protocol – AIMS to be done every 30 days: Patient 1 – had 2 done in 2.6 months (on AP); Patient 2 – had 2 done 4 months (on AP); Patient 3 had 3 done in 6 months (not on AP); Patient 4 – had 4 done in 4 months (on AP); Patient 5 – had 3 done in 5 months (not on AP); Patient 6 – had 4 done in 4 months (on AP).
   *Note: AP = Antipsychotic Medication.

6. **Assessments** – Patients are seen very regularly by Psychiatry and therapist – sporadically by Psychologist but this is in alignment with role of psychologists. Treatment Teams: very well attended by Psychiatry – Psychiatrist present at 29/30 treatment team meetings (not counting Preadmission Team Meetings which psychiatrist does not attend).

7. **Monthly Summary of Events of Aggression, Property Destruction, Rule Violation, etc.** – Aggressive events: Aggregated data concerning aggressive events, destruction of property and rule violation is maintained and reviewed. Task force review data from a 6-month time period reflecting that the patient population regularly engaged in aggressive acts against property and persons. This is not unexpected given the patient population and the demands of a highly structured residential program.

Seclusion and Restraints

An important focus of the SATC and BBI model is to decrease aggression and events requiring seclusion and restraint events. SATC does not use seclusion under any circumstances currently. We reviewed the seclusion and restraint data for calendar year 2015 and it is summarized below:

Event	Jan	Feb	Mar	Apr	May	June	July	Aug
Physical	29	15	26	17	9	6	3	6
Mechanical	0	0	0	0	0	0	0	0
Seclusion	0	0	0	0	0	0	0	0

The Task Force did not identify any obvious issues or trends in this data except for a decrease in physical restraints over the past 4-month period.

The average length of stay is between 3 – 6 months. Some adolescents have stayed for 9 months. No length of stays has been shorter than 1 month. There is not a set policy on the length of stay as each adolescent has an individual treatment plan which serves to guide the expected length of stay.

HEALTH CARE REVIEW – LEAD BY DR. JANE MCGRATH

The Sequoyah Secure Treatment Facility is accredited as a Residential Treatment Center (RTC) by the Joint Commission and undergoes additional licensing and certification by the New Mexico Children, Youth and Families Department. These entities provide some guidance for healthcare of residents.[i]

In developing healthcare recommendations for Sequoyah residents the SM 115 committee has reviewed best practice guidelines for adolescent healthcare promulgated by national organizations such as the American Academy of Pediatrics (AAP)[ii] and the Society for Adolescent Health and Medicine (SAHM).[iii] Healthcare guidelines for Residential Treatment Centers have been developed by the American Academy of Child and Adolescent Psychiatry (AACAP)[iv] in order to supplement the Joint Commission standards for RTCs and are included in this review.

Many residents at Sequoyah have been adjudicated in the juvenile justice system prior to coming to the RTC. In national studies adolescents in the juvenile justice system report markedly higher levels of risk behaviors and related health conditions than their not incarcerated peers specifically; substance abuse, trauma, injury related to violence, accidents, coercive sexual experiences, rape, incest, sexually transmitted infections including HIV and mental health problems. In addition LGBT youth comprise approximately 13% of youth in detention nationwide. LGBT youth are particularly susceptible to harassment and abuse within juvenile justice settings where they are often not recognized and do not receive appropriate care and protection. The national data provide an important context for how we approach providing healthcare to residents at Sequoyah. They are clearly at higher risk for acute and chronic health conditions than their peers and some of these health risks can be mitigated by appropriate screening and health education.

Specific recommendations for healthcare screening and intervention for Sequoyah residents include:

1. Bright Futures Recommendations for Adolescents *(Attachment 1)*

   Most of the recommended best practices are already in place at Sequoyah. There are a couple of specific things that are not routinely done and we would like to point them out:

   a. HIV testing is now recommended for every adolescent between the ages of 16-18 and for adolescents over the age of 11 with risk factors. As many Sequoyah residents have risk factors for HIV it would be reasonable to include HIV screening as a standard admission lab. We would recommend that Sequoyah nursing and medical staff work with Truman Health Services at the University of New Mexico, Health Sciences Center to ensure that best practice guidance is available regarding HIV testing and that staff are familiar with the support services provided by that program in the likely event that an HIV positive resident will be identified.
   b. Immunizations should include not only those required for school attendance but also the HPV vaccine which is now recommended for males as well as females.
   c. Anticipatory guidance/health education – Sequoyah has the opportunity to address risk behaviors with residents during their stay. We recommend the implementation of a comprehensive health education program for all residents focusing on the major causes of morbidity including; substance abuse and tobacco, STI and HIV risk reduction, healthy relationships, comprehensive sexuality education, violence reduction, and other pertinent topics.

   American Academy of Child and Adolescent Psychiatry recommendations *(Attachment 2)* for RTCs are in addition to the Joint Commission Standards and include:

   d. Registered nurse on site at least 8 hours per day to manage medication and other medical treatment as well as general health status of residents. SATC has on-site nursing coverage 24 hours per day.
   e. On-site primary care physician or nurse practitioner to provide care for physical illness and well child care. Such care can also be provided by pre-arranged contracted community based services – which is the option SATC currently uses.
   f. Medical assessment and physical assessment 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.
   g. The RTC must have 24 hour access to EMS services. SATC has access to EMS services via 911 24 hours per day.

2. In addition we would recommend that any newly admitted resident would receive a comprehensive nursing assessment including a detailed medical history and assessment of any current physical complaints. If concerns are uncovered then the resident should be referred for a complete evaluation by the PCP. The recommendation of 8 hours/day of nursing services is less than current Sequoyah staffing levels. Current Sequoyah staffing levels are more in line with the needs of the patient population.

3. We did not identify any specific challenges regarding the treatment of LGBT youth at SATC but given the high proportion of LGBT youth in detention centers nationally, Sequoyah should have written policies, staff training and procedures in place to create an inclusive and supportive environment and to address any harassment and bullying by staff and residents. We recommend adherence to national guidelines such as the Child Welfare League guidelines for LGBT youth.[v] Specific policies should address:

    a. Prohibiting all forms of discrimination including; jokes, slurs and name calling by residents and staff
    b. A formal grievance procedure should be in place that allows confidential complaints and neutral third-party investigations
    c. Implementation of specific programs to address family acceptance and reconciliation
    d. Identification of community supports for the family. These community supports should be included in the discharge plan for the resident
    e. Bathroom use and showering protocol for LGBT youth
    f. Confidentiality

SERVICES PROVIDED

Services provided were reviewed by the Task Force. Services include a highly structured milieu which follows a model of care outlined by the BBI. Other services provided include: psychiatric assessment and care, nursing assessment and care, individual, group and family therapy, art therapy, recreational therapy and a therapeutic school program. These services are consistent with accepted standards for a Residential Treatment Center.

STAFFING LEVELS AND QUALIFICATIONS

The Task Force appointed an administrative working group to review what they felt were key indicators of the staffing levels and qualifications SATC.

The staffing follows CMS PRTF (Psychiatric Residential Treatment Facility) provider standards. Staffing levels vary based on the acuity of patient mix but milieus are generally staffed at 5 to 1 (residents to mental health care technician) per lodge. PRTF regulations allow up to 6 residents per 1 staff. At full capacity, the facility can accommodate 9 residents per lodge (4) or total of 36 with a current census on July 29th of 30 patients.

The lodge staffing model consists of a combination of dedicated and shared staff. Nurses, therapists, techs, and social workers are assigned by lodge. The teachers, art therapist, recreation therapist, etc. are shared among lodges.

DETAILS ON STAFF POSITIONS AND VACANCIES ARE AS FOLLOWS

Therapists:
There are 5 therapist positions (including the Clinical Director) with 1 therapist assigned per lodge with a case load of 4 to 7 patients.

- There are no current Therapist vacancies.

Nursing:
There are 9 nurse positions (including the Director of Nursing) and at least one Nurse is present on Campus 24/7. Nurse staffing levels are highest during peak incident times which have historically been morning to noon and 4-6 PM. Four nurses are on duty during these peak times. Staffing is lowest overnight from 10 PM to 6:30 AM. Nursing shift changes are at a different time than milieu shift changes in order to maintain continuity of care.

- There are currently 2 RN vacancies which are filled with agency nurses; these agency nurses are consistent with minimal changes in individual nurses providing coverage.

Mental Health Techs:
There are 57 tech positions (including Mental Health Tech supervisors) with staffing rations of 5:1.

- There are currently 6 Mental Health Tech vacancies which are covered through casual pool and overtime.

Psychiatric Providers/Prescribers:
There are currently 2.5 (approximately) FTE positions available for staffing at SATC. Current providers include Dr. Mirin .5 FTE and Dr. Sobhani (PRN). SATC has hired a FTE Prescribing Psychologist - Dr. Entezari .6 FTE.

- There is currently a 1.0 Psychiatry/Prescribing Vacancy

Psychologists:
There are two psychologist positions at SATC.

- There is 1 psychologist vacancy currently.

Social Work:
There are 3 Social Work Positions at SATC. One serves as the Discharge Planner.

- There are currently 2 Social Work vacancies at SATC.

Other Therapy Positions:
There is 1 Art Therapy, 1 Recreation Therapy and 1 Recreation Therapy Assistant position at SATC.

- There are no vacancies in Art or Recreation Therapy positions.

Teachers/Principal Staffing:
There are 4 Teacher and 1 Principal Positions at SATC.

- There are no current Teacher or Principal vacancies.

Staff Turnover:

- For FY15, the staff turnover has been very low - 3%.

REVIEW OF EDUCATION, TRAINING, PERFORMANCE EVALUATIONS

New hire orientations are led by the full time trainer. Training topics include CPR, seclusion and restraint management, BBI and trauma informed care and biohazard safety. New hire orientation takes place over 1.5 weeks at time of hire and include 3 days of "side-by-side" training.

There are yearly continuing education training requirements which include CPI (crisis prevention) training every six months.

Orientation and other training is recorded and tracked.

Additionally, clinical supervision is conducted weekly in accordance with regulations. It is led by the clinical and medical directors. There is a standard checklist of content areas covered.

An area of concern regarding education and training is sustainability of resources for training on trauma informed care. Possible resources identified were federal grant funding and free CME credit through Project ECHO.

Staff performance evaluations are competency based and were characterized as very good.

NCQA (National Committee for Quality Assurance) incident management metrics are used to measure performance and track: use of seclusion and restraint, average time in the hold, aggressive incidents, self-harm incidents, staff injury (attributed to patient aggression) and medical incidents.

FINANCIAL REVIEW

FY15 came in under budget with a $470K surplus. It was noted that a census of 27 residents is breakeven. Sequoyah rolls up under DOH program area 6. The average monthly census for months of January 2015 thru August of 2015 was 27.25.

The work group focused on the following expense lines:

- Professional services: $1.1M includes contract labor, mainly nursing
- Medical services: $500K includes psychiatrists (Dr. Sobhani and Dr. Mirin who has shifted from contract to permanent)
- Other Services: includes summit food contract
- IT services: includes Avatar upgrades and annual maintenance
- Overall none of the expenses were felt to be excessive.

On the revenue side, Sequoyah bills Medicaid and other medical insurance as appropriate. It was reported that, although uncommon, there are some unpaid (uncompensated care) days. The staff is working to improve collection rates. The facility does not have an in-house pharmacy. Prescriptions are filled by external pharmacies that bill directly to insurances. There is no cost to the facility for prescriptions. Other revenue comes from a federal education grant that supports the music program.

DISCHARGE PLANNING & AFTER CARE SERVICES

Discharge planning begins upon the adolescent's admission to Sequoyah. The adolescent discharge planner takes the lead in locating services to which the adolescent would have access upon discharge. When the adolescent has had a sustained decrease in aggression and unsafe behaviors for at least 30 days, a discharge date is planned. The focus then shifts to the development of a safety plan and transition to home or hopefully a lower level of care.

In planning discharge, Sequoyah identifies the least restrictive discharge treatment plan. If this plan cannot be operationalized, Sequoyah must identify why this plan is not available to the adolescent. The MCO care coordinators are typically present during discharge planning process/meeting. After discharge, Sequoyah follows up with the adolescent/family by phone at 30, 60, and 90 days post discharge. This data does not appear to be aggregated and analyzed in a systematic fashion.

The clinical work group reviewed SATC discharges for the months of April – June of 2014. There were 14 discharges during this time period. Below are the summary data for these discharges:

- 8 Returned home to live with outpatient services
- 1 Open Skies Transitional Living Program
- 1Provo Canyon, Utah – RTC with a special brain injury program
- 1 Humphrey House in Hobbs, NM – Group Home; SATC working with CYFD to find adoptive parents
- 1 Albuquerque Boys Reintegration Center – client did not want to return home to live
- 2 Elopements

We requested information from the Discharging Teams at SATC regarding any significant challenges or concerns regarding the placement/disposition of any of these admissions. No specific challenges where reported. There were several discussion about a general scarcity of outpatient wrap around or intensive outpatient services in New Mexico, especially for more rural adolescents.

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 2 - AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY RECOMMENDATIONS

Certification Regulations

7.20.11.23 INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

A. The agency establishes criteria for admission, conducts ongoing clinical assessments, and develops reviews, revises treatment plans and provides ongoing discharge planning with the full participation of the treatment team.

B. Clinical decisions are made only by qualified clinical personnel.

C. Intake and screening:

(1) The agency establishes and follows written criteria for admission to its program(s) and service(s), including exclusionary criteria.

(2) The agency establishes and follows written intake procedures to address clinical appropriateness for admission.

(3) The agency's eligibility criteria are consistent with EPSDT requirements and Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC.

D. Assessments: The following applies to all certified services, except case management services. Each client is assessed at admission and reassessed at regularly specified times to evaluate his or her response to treatment, and specifically when significant changes occur in his or her condition or diagnosis. The assessment process is multidisciplinary, involves active participation of the family or guardian, whenever possible, and includes documented consideration of the client's and family's perceptions of treatment needs and priorities. Assessment processes include consideration of the client's physical, emotional, cognitive, educational, nutritional, and social development, as applicable. At a minimum, the following assessments are conducted and documented:

(1) An initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment; and assessment of risk of behavior that is life-threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

(2) A full EPSDT screen (tot-to-teen health check) within 30 days of the initiation of services, unless such an examination has taken place and is documented within the 12 months prior to admission. The documented content of the history and physical examination must meet EPSDT requirements.

Physical Plant Licensing

7.20.12.49 MEDICAL CARE:

A. A residential facility licensed pursuant to these regulations arranges for a general medical examination by a physician for each child in care within 30 calendar days of admission unless the child has received such an examination within 12 months before admission and the results of the examination are available to the facility. These examinations conform to the requirements of the EPSDT screen.

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?

END NOTES

[i] CYFD Certification regulations for RTC 7.20.11.23 and 7.20.12.49

[ii] https://pediatriccare.solutions.aap.org/DocumentLibrary/Periodicity%20Schedule_FINAL.pdf

[iii] Health Care for Incarcerated Youth a Position Paper of the Society for Adolescent Medicine JAdol Health Care July 2000 pp73-75

[iv] Principles of Care for Treatment of Children and Adolescents with mental Illnesses in Residential Treatment Centers, American Academy of Child and Adolescent Psychiatry June 2010

[v] Best practice guidelines : serving LGBT youth in out-of-home care/ Shannan Wilber, Caitlin Ryan, and Jody Marksamer. Child Welfare League of America 2006