Reward Willow Treatment Center
Update to the Commission on Behavioral Health
July 13, 2018

Desert Willow Treatment Center (DWTC) is a 58-bed mental health treatment hospital located in Las Vegas. DWTC is operated by the Department of Health and Human Services, Division of Child and Family Services (DCFS). It is licensed by the Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance (BHCQC). DWTC's mission is to provide quality, individualized mental health services in a safe and culturally sensitive environment, collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

This update outlines the comprehensive evidence-based services offered to youth with behavioral health diagnoses and developmental disabilities, youth in need of partial hospital services and youth who have been victims of sex trafficking. It also includes the total number of clients served, length of stay, waitlist, quality of treatment, engagement with support systems, discharge planning, follow-up and readmission, and clinical assessment instruments and outcome measures that include client and family satisfaction tools.

Number of Clients Served and Length of Stay

Please see below for clients served at DWTC during SFY17 and SFY18 to-date. Both average and median lengths of stay are given as the median is less influenced by extreme scores, such as youth with very long lengths of stay.

Table 1. Clients Served and Length of Stay

	SFY17 Census	Length of Stay (in days) SFY17	SFY18 To Date Census	Length of Stay (in days) SFY18 to date
DWTC Acute Unit (8 beds)	132	Average = 10.9 Median = 8.0 Range = 0* to 74	82	Average = 16.1 Median = 10.0 Range = 1 to 99
DWTC Residential Treatment (12 beds)	44	Average = 154.3 Median = 127.5 Range = 13 to 411	29	Average = 158.2 Median = 153.0 Range = 16 to 350

*Please note that one youth on the acute unit during SFY17 had a length of stay of 0 days due to a parent/guardian discharging the youth against medical advice less than 24 hours after they were admitted. Child Protective Services was called and DWTC reported medical neglect of this youth.

Of clients served at DWTC Acute from 7/1/17 through 6/25/18, 13% had a comorbid intellectual or developmental disability (ID/DD). The average length of stay for ID/DD youth was 38 days, considerably longer than the overall average length of stay. Possible reasons include more complex needs or difficulty locating an appropriate discharge placement. Fourteen percent of youth served in the residential unit from 7/1/17 through 6/25/18 had a comorbid ID/DD. The

average length of stay at 114 days was slightly shorter for ID/DD residential youth than the overall average.

Waitlists

DWTC does at times maintain a waitlist. Data from the electronic medical record system, myAvatar, indicates that in SFY17 there were 132 clients placed on the waitlist for the acute unit and 44 clients placed on the waitlist for residential treatment. In SFY18 there were 82 clients placed on the waitlist for the acute unit and 29 clients placed on the waitlist for residential treatment. DCFS is currently working with Information Management Systems to address procedural issues within our medical record system that cause our waitlists to appear longer than is consistent with actual wait times for youth. Anecdotally, there are currently 5 youth on the waitlist for the residential unit which is more consistent with a typical waitlist for DWTC residential. In practice, there is never a waitlist for the acute unit because when there are no open beds at DWTC, youth in need of inpatient hospitalization are sent to another hospital.

Services

Youth admitted to DWTC have access to an array of comprehensive evidence-based services, including psychiatric evaluation, psychiatric nursing services, care coordination, therapeutic recreation, Cognitive-Behavioral Therapy (CBT; Beck, 1964; Beck, 2011), Dialectical Behavioral Therapy (DBT; Linehan, 1993), Motivational Interviewing (MI; Miller & Rollnick, 2002), Solution-Focused Brief Therapy (SFBT; Trepper et al., 2013), Strategic Family Therapy (Madanes, 1981), Structural Family Therapy (Minuchin, 1974), Trauma Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino & Deblinger, 2012), and Positive Behavior Interventions and Supports (PBIS; OSEP Technical Assistance Center on PBIS, 2015; nevadapbis.org), which is implemented with ongoing support and consultation from the University of Nevada, Reno. Treatment quality is monitored via multiple methods:

- q15 minute monitoring; camera observation audits are conducted 2 times monthly.
- Medication administration audits; daily chart audits; camera observation audits are conducted 2 times monthly.
- Treatment team meetings are convened weekly regarding each youth; the treatment team reviews youth progress towards treatment goals, addresses parents' questions/comments, and discusses additional interventions to assist the youth and family towards a successful discharge. *See attachments: DWTC 105 Transdisciplinary Treatment Review; DWTC 128 Patient Self Inventory*.
- Youth may express concerns about treatment quality at any time via a consumer complaint process. *See attachment DWTC 170 Consumer Complaint Form*.

Client and Family Satisfaction Tools

Treatment quality is also ensured through consumer satisfaction measures. Each youth and their parent/guardian are offered the opportunity to anonymously provide consumer satisfaction feedback at discharge. Consumer satisfaction results are utilized at DWTC's Performance Improvement Team meeting to direct internal program improvement efforts. Aggregate SFY17 survey results indicated that the highest positive responses for Parents/Caregivers were in the areas of Cultural Sensitivity (92%), General Satisfaction (90%), and Access to Services (89%). The

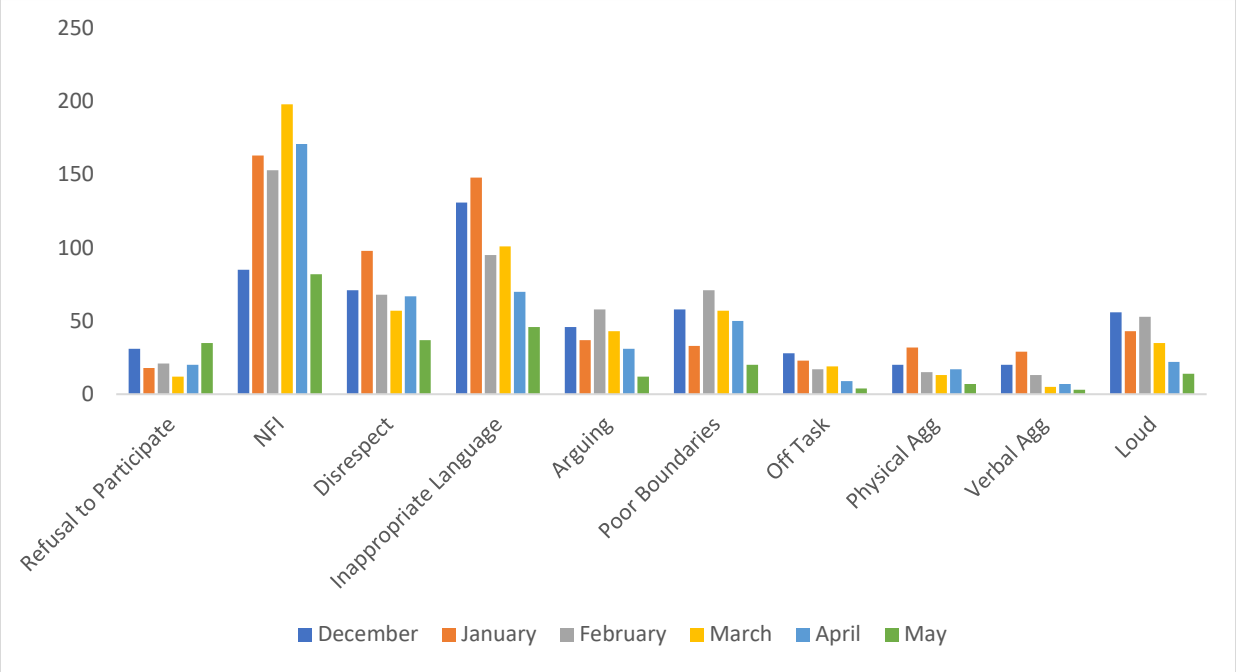
highest positive responses for youth were in the areas of Cultural Sensitivity (90%), Positive Outcomes (89%) and Functioning (89%). The areas with the greatest room for improvement as rated by parents/caregivers were Positive Outcomes (66%) and Functioning (67%). The areas with the greatest room for improvement as rated by youth were Participation in Treatment (83%), Access to Services (88%) and General Satisfaction (88%). No responses were less than 63% positive.

Assessments

During a youth's stay at DWTC, their progress in the program is measured with formal clinical assessments and outcome measures. Licensed psychologists utilize a variety of clinical tools when indicated for testing and case formulation, including intelligence tests, achievement tests, tests of adaptive functioning, personality and projective tests, and specific symptom inventories. Additionally, each youth is assessed at admission with the Child and Adolescent Needs and Strengths Tool (CANS), a communimetric tool used in child welfare and children's mental health case planning throughout the US and internationally. In Nevada, we use the Nevada Child and Adolescent Needs and Strengths tool, or NV-CANS, which was developed with the input of statewide stakeholders, including consumers. The NV-CANS assesses child and family needs and strengths in the areas of potentially traumatic or adverse childhood experiences, behavioral and emotional needs, life functioning, strengths, cultural factors, risk behaviors, and caregiver resources and needs. Additionally, there are age-specific domains for early childhood and transition-age youth. Finally, there are content-specific modules in cases where additional in-depth information should be captured, such as in the case of substance use, developmental disabilities and other specific areas of need. The NV-CANS is updated every 90 days and at discharge.

In addition to the NV-CANS, a great deal of data is collected through the Positive Behavior Interventions and Supports (PBIS) program. DWTC's consultants at the University of Nevada, Reno assist DWTC in utilizing the data to understand how PBIS implementation is affecting both youth and staff behavior. Data analysis and program evaluation focus on areas of programming where staff behavior change can positively influence youth behavior. Please see the graph below for an example of PBIS outcomes that the PBIS consultants review with DWTC on a recurring basis. This graph indicates that in the residential treatment unit, there have been large decreases over time in all undesirable behaviors selected for analysis (i.e., refusal to participate, not following instructions, disrespect, inappropriate language, arguing, poor boundaries, off-task behavior, physical aggression, verbal aggression, and being too loud). There was an increase in refusal to participate in the month of May; however, further analysis indicated that this increase was primarily due to one patient who exhibited this behavior frequently.

Figure 1. PBIS Outcomes: RTC Target Behaviors by Month



Finally, the third-party outcomes management vendor Treatment Outcome Package (TOPS) is used at DWTC. TOPS collects and aggregates outcomes data on a monthly basis for all DWTC youth. *See attachments AAP TOPS FY17, AAP TOPS FY18, RTC TOPS FY17, and RTC TOPS FY18.* Results of the TOPS are monitored monthly and any areas appearing to need program-wide improvement are addressed.

Support Systems and Discharge Planning

Youth at DWTC engage with support systems throughout their stay by participating in family therapy. As available, families are actively involved in weekly treatment team meetings in person or by telephone. Discharge planning begins at admission and focuses on discharge to the least restrictive setting. Until recently, the population of youth served by DWTC has been unable to access partial hospitalization upon discharge due to a lack of resources. Either youth have been uninsured or undocumented, or parents have seen the cost of partial hospitalization—which may be minimally reimbursed or not covered by insurance—as prohibitive. DCFS is now exploring the possibility of using placement prevention funding to establish partial hospitalization as a discharge option for families who do not have other means of accessing it. Additionally, Senate Bill 325 (79th Legislative Session) has removed the waiting period for Medicaid funding for lawfully residing immigrant youth, which will allow for greater flexibility in matching youth to the appropriate level of care upon discharge. Medicaid funding for all resident children would further facilitate access to appropriate care.

There is one staff member at DWTC dedicated to discharge planning. Currently, DWTC does not have a formal follow-up process for engaging with discharged youth after they leave the facility. Readmission rates to the facility are available below:

Table 2. Readmission Rates

	30 days	180 days
SFY17		
Acute	7 (5%)	17 (13%)
Residential	3 (7%)	3 (7%)
SFY18		
Acute	2 (2%)	8 (10%)
Residential	1 (3%)	1 (3%)

Private Provider

The Legislature approved a plan for DCFS, Children's Mental Health to reduce the number of state-funded beds for residential and acute care at DWTC and work with a private provider to deliver services in the remaining space at DWTC. On August 14, 2017, DCFS released the Request for Proposal (RFP) as the first step in selecting a provider to deliver services in the remaining 38 beds not currently in operation at DWTC. On September 26, 2017, DCFS offered First Med the opportunity to enter into a contract for services at DWTC.

The RFP outlined that the provider will contract with the Division of Child and Family Services to provide acute and or residential treatment services within the current DWTC hospital. The provider will be a federally qualified health center (FQHC) or a not-for-profit provider and will be able to be licensed as a hospital or RTC provider. The provider will have a continuum of care to include physical health services for DCFS clients and families, partial hospitalization, residential treatment center, and acute care. The services will focus on the following subsets of clients: 1) youth at risk of out-of-state placement; 2) youth with a dual diagnosis of behavioral health/developmental disabilities; 3) youth that have been commercially sexually exploited; or 4) youth in or at risk of being in the juvenile justice or child welfare agency services.

DCFS, the Nevada Division of Health Care Finance and Policy (DHCFP) and BHCQC continue to work with First Med in reviewing a public-private partnership and funding options through Medicaid.

A review of licensing and accreditation requirements is underway and the feasibility of incorporating the costs involved in building modifications required by the licensing agent are being considered. State Public Works has provided information about the cost of firewalls in similar projects. They indicated that DWTC Occupancy is I-2 and Construction Type is III-A and installing walls in the building will most likely involve the permitting department and an Architect to draw up the plans. A formal estimate has been requested from State Public Works based on the building plan submitted by the provider. Another meeting with DHCFP has been offered to First Med to review funding options in greater detail. Decisions made after this review will drive next steps for the provider and DCFS.

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