

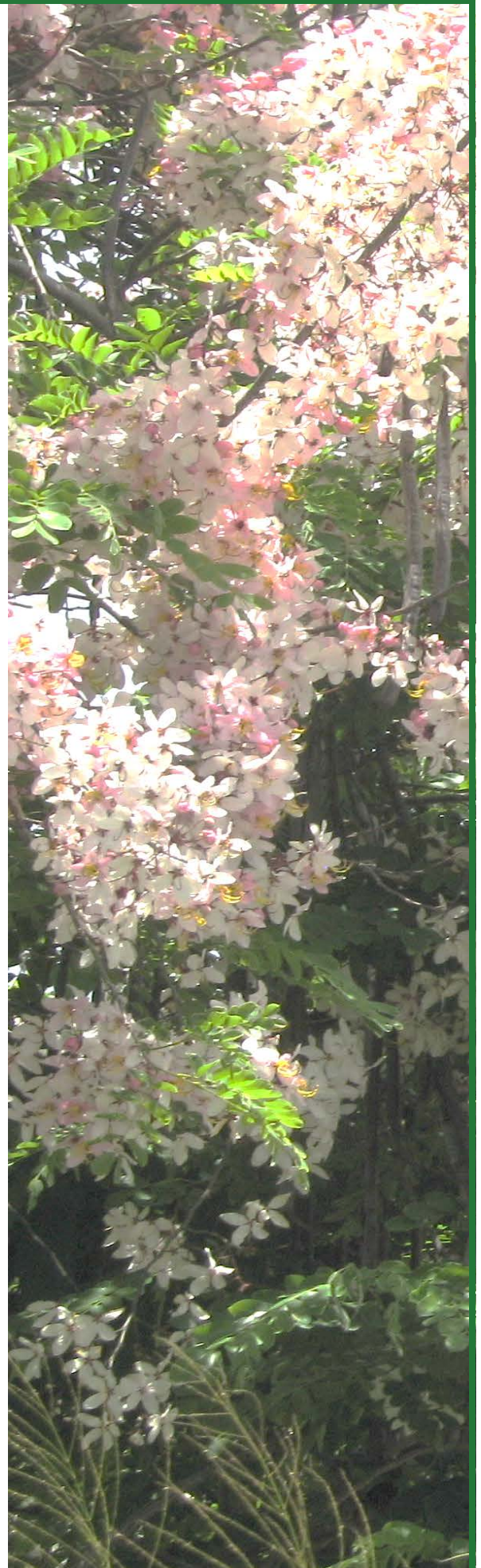
Child and Adolescent Mental Health Division Strategic Plan 2015-2018

and

**Biennial Review of Progress
Made on the
2011-2014 Strategic Plan**



**Hawaii Department of Health
November 2014**



EXECUTIVE SUMMARY

This report is submitted pursuant to section 321-175 and 321-176, Hawaii Revised Statutes, which require the Department of Health to submit to the legislature and the governor a statewide children’s mental health services plan every four years and a biennial review of progress on the plan every two years.

Section I presents the Statewide Children’s Mental Health Services Plan as required by statute.

Section II presents the Biennial Review of Progress Made on the Child and Adolescent Mental Health Division’s (CAMHD) Four-Year Strategic Plan during 2011-2014.

Substantial progress was made in all four areas of the 2011-2014 Strategic Plan.

Goal 1:	Integrate Health Information Technology
Goal 2:	Strengthen Clinical Services
Goal 3:	Implement a Strategic Financial Plan
Goal 4:	Strengthen Effective Collaborations to Increase Early Access to Care

Section III presents Child and Adolescent Mental Health Division’s Strategic Initiatives for 2015-2018.

Over the next four years, CAMHD will continue to advance ongoing initiatives in order to take advantage of mounting momentum in key areas. CAMHD aims to continue to enhance the utility of health information technology by progressively moving toward “meaningful use” in the electronic health record, continue to improve the family experience by incorporating family support into the clinical setting, transition toward more holistic care, and continuing to collaborate with other child serving agencies to better serve shared populations.

When the last Strategic Plan was developed, CAMHD closely aligned itself with the goals of the federal funding agencies. This created advantages for Hawaii, as CAMHD was able to benefit from the expertise at the national level and technical assistance from federal agencies. The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) recently unveiled its new Strategic Initiatives in late 2014. Those strategic initiatives are relevant to Hawaii’s needs and relevant to CAMHD’s current direction and goals. CAMHD will, therefore, closely align its strategic initiatives with those of SAMHSA.

CAMHD's new Strategic Initiatives for 2015-2018 are:

Goal 1:	Promote access to clinically driven mental health services and reduce disparities
Goal 2:	Promote behavioral health integration into primary health care
Goal 3:	Promote mental health capacity and systems change in the juvenile justice system
Goal 4:	Promote family support for individuals with behavioral health issues and their families
Goal 5:	Promote technological advancement and adoption

SECTION I

HAWAII STATEWIDE CHILDREN’S MENTAL HEALTH SERVICES PLAN

STATUTORY REQUIREMENT

According to section 321-175, Hawaii Revised Statutes, every four years the Department of Health (DOH) is required to develop and present to the governor and legislature, as well as release for public comment, a statewide children’s mental health services plan.

The mission of CAMHD is to provide timely and effective mental health prevention, assessment, and treatment services to children and adolescents with emotional and behavioral challenges and their families. These services are provided within a system of care that integrates Hawaii Child and Adolescent Service System Principles (CASSP), evidence based services, continuous quality monitoring, and Medicaid requirements. CAMHD provides services monthly to approximately 1,000 children and adolescents between the ages of three (3) to twenty (20) years of age who meet the eligibility criteria and their families, statewide.

CAMHD MISSION

The mission of the Child & Adolescent Mental Health Division is to provide timely and effective mental health prevention, assessment and treatment services to children and youth with emotional and behavioral challenges, and their families.

CAMHD VISION

Happy and Healthy Children and Families Living in Caring Communities

GUIDING PRINCIPLES - HAWAII CHILD AND ADOLESCENT SERVICE SYSTEM PRINCIPLES (CASSP)¹:

Respect for Individual Rights

The rights of children and youth will be protected, and effective advocacy efforts for children and youth will be promoted.

Individualization

Services are children and youth and family centered and culturally sensitive, with the unique needs of the youth and family dictating the types and mix of services provided.

Early Intervention

Early identification of social, emotional, physical, and educational needs will be promoted to enhance the likelihood of successful early intervention and lessen the need for more intensive and restrictive services.

¹ Stroul, B.A. & Friedman, R. E. (1986). System of Care for Children and Youth with Severe Emotional Disturbances. Washington, D.C.: Georgetown University Center for Child and Human Development.

Partnership with Youth and Families

Families or surrogate families will be full participants in all aspects of the planning and delivery of services. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

Family Strengthening

Family preservation and strengthening, along with the promotion of physical and emotional well-being, is a primary focus of the system of care. Services that require removal of children and youth from their home will be considered only when all other options have been exhausted, and services aimed at returning the children and youth to their family or other permanent placement are an integral consideration at the time of removal.

Access to Comprehensive Array of Services

There will be access to a comprehensive array of services that addresses each child's unique needs.

Community-based Service Delivery

Service availability, management and decision-making rest at the community levels.

Least Restrictive Interventions

Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

Coordination of Services

The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that children and youth can move throughout the system in accordance with their changing needs, regardless of point of entry.

CORE COMPONENTS OF CURRENT CAMHD SYSTEM

These core components underlie the values CAMHD strives to operationalize in its practices. CAMHD expects the same commitment from contractors to support these components in their respective practices.

1. Commitment to the Hawaii CASSP Principles

Nationally, the CASSP principles (Stroul, B.A. and Friedman, R.M., 1986) were developed in accordance with the original work of Jane Knitzer in an effort to provide a framework of principles for newly created systems of care. Early in the 1990s, Hawaii communities and stakeholders made minor language revisions to these CASSP principles to effectively address the relevant cultural issues as they presented in Hawaii. CAMHD is committed to the CASSP Principles and expects the same commitment from contracted providers.

2. Commitment to Interagency Collaboration & Coordination

Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other DOH Divisions, including Alcohol & Drug Abuse (ADAD), Developmental Disabilities Division (DDD), and Early Intervention Services (EIS). A large percentage of the CAMHD population is enrolled in QUEST health plan services, which requires linkages to the primary healthcare providers. The CAMHD system is committed to work with all other child-serving agencies to integrate services and programs across agencies in the best interest of youth and their families.

3. Commitment to Evidence-Based Practices

Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data. The proposed array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services. All treatment planning for psychosocial and pharmacological intervention should stem from careful consideration of the most current research. In addition, agencies are encouraged to gather and evaluate their own data on child outcomes and functioning to further inform clinical decisions and the design of appropriate interventions.

See the following links for the (a) CAMHD Biennial Evidence-Based Services Report:

<http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs013.pdf> and

the evidence-based child and adolescent psychosocial intervention matrix from the American Academy of Pediatrics:

<http://www.aap.org/commpeds/doch/mentalhealth/docs/CR%20Psychosocial%20Interventions.F.0503.pdf>

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION ORGANIZATION

The Child and Adolescent Mental Health Division is situated in the Behavioral Health Administration of the Hawaii State Department of Health. The Behavioral Health Administration is the home to the Adult Mental Health Division, Child and Adolescent Mental Health Division (CAMHD), Alcohol and Drug Abuse Division and the Developmental Disabilities Division.

CAMHD recently reorganized its organizational structure. The reorganization aligns organizational components and positions to reflect the operational structure necessary to provide accessible, high-quality behavioral health services. This reorganization enables the development of a system that integrates operational and clinical functions, enables providers to communicate across disciplines, documents progress and medical necessity, authorizes services and invoices for services rendered, makes data driven decisions at different levels from individual clientele to the statewide system, and conforms to the mandates set by the federal government.

Previously, CAMHD included five staff offices--Clinical Services Office, Research & Evaluation Office, Quality Management Staff, Financial Resources Development Staff and Administrative Support Staff; seven regional Family Guidance Centers; and a Family Court Liaison Branch.

The reorganized CAMHD has four staff offices—Clinical Services Office, Program Improvement and Communications Office, Healthcare System Management Office and Central Administrative Services Office; and three branches—Oahu Services Branch and Neighbor Island Services Branch and Family Court Liaison Branch.

The Clinical Services Office has overall responsibility for providing clinical services and will continue to be responsible for providing clinical leadership, oversight, technical assistance, and training.

The Program Improvement and Communications Office is responsible for planning, grant writing, special studies, research activities, internal and external communications, developing written operational policies and procedures and developing and maintaining a statewide reporting system.

The Administrative Support Staff is renamed the Central Administrative Services Office.

The Healthcare System Management Office is responsible for providing understanding and knowledge of Medicaid and healthcare reform to the CAMHD staff, ensuring operations and business practices are developed, coordinated, structured, and maintained to comply with federal and state health records, billing and credentialing standards and requirements, to include maximizing on-going and alternative sources of funding to support an array of comprehensive mental health services to children, adolescents, and their families.

An Oahu Services Branch will be established to have responsibility for overseeing, planning, directing, and coordinating the Central Oahu Family Guidance Center, Honolulu Family Guidance Center and Leeward Oahu Family Guidance Center operations. The community-based Family Guidance Centers are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The Family Guidance Centers are strategically located in geographic areas that correspond with the Department of Education school districts. Each Family Guidance Center, under the leadership of a Mental Health Supervisor, is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators who provide intensive case management. Services provided by the centers include facilitating access to care coordination (intensive case management), direct service provision, service procurement, utilization and quality monitoring. The Family Guidance Centers work in partnership with youth and their families to design and implement individualized service plans.

The Neighbor Island Services Branch, located on Oahu, is responsible for planning, directing, and coordinating the operations of the East Hawaii Family Guidance Center, West Hawaii Family Guidance Center, Kauai Family Guidance Center and the Maui Family Guidance Center.

The Family Court Liaison Branch is responsible for providing services to children and adolescents involved in the juvenile justice system. The Family Court Liaison Branch (FCLB) provides screening, assessment, evaluative, diagnostic, treatment and consultative services to youth with mental health challenges in the state juvenile justice system. FCLB provides mental health treatment linkages between the Family Court, Hawaii Youth Correctional Facility, and the State's Detention Home. The FCLB works in partnership with families and the court system to design and implement individualized service and treatment plans suitable to the specialized needs of children and youth involved with the Hawaii juvenile justice system. FCLB differs from CAMHD's other branches because it does not have a geographical limitation, and provides direct services in collaboration with other state agencies and Family Court.

SERVICE ELIGIBILITY

CAMHD is committed to providing timely service planning and access to an array of services. Services are provided by employees or contracted providers. These services are expected to be initiated and provided in a timely and consistent manner, as guided by the standards and practice guidelines defined in the Child and Adolescent Mental Health Performance Standards, also known as the "Orange Book".

<http://health.hawaii.gov/camhd/files/2013/07/Orange-Book.pdf>

CAMHD has three means of eligibility. Eligibility determination as well as service array varies according to type of eligibility. Youth may be eligible in more than one category.

1. Educationally Supportive (ES) Services

Access for ES services is done through DOE and the Individualized Education Program (IEP) process for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific support via their IEP. Students who have been identified as requiring intensive mental health services are enrolled with the CAMHD Branch located in the school district of their home school. They are assigned a Care Coordinator (CC) at that time. The student may, and often will, continue to receive School-Based Behavioral Health (SBBH) services and supports in conjunction with the intensive services provided through the CAMHD Branch. The service array for this population is described in the Orange Book, under Educationally Supportive (ES) Intensive Mental Health Services.

2. Support for Emotional and Behavioral Development (SEBD) Program Services

Access and determination of eligibility for SEBD services is through the SEBD referral process. The SEBD referral is submitted to the CAMHD Branch within the youth's home district. A determination of eligibility is then made. CAMHD provides services to youth who meet the eligibility requirements for the SEBD program. These services are based on team input and

clinical determinations of what each youth needs in order to improve his/her emotional and/or behavioral functioning, including considerations of medical necessity. The service array for this population includes services under both Educationally Supportive (ES) Services and Support for Emotional and Behavioral Development (SEBD) Program services in the CAMHD Orange Book.

3. Juvenile Justice Involvement

Youth who are not eligible through the methods of entry above and have contact with the juvenile justice system, may be referred via the Office of Youth Services to CAMHD, and specifically the Family Court Liaison Branch. This most commonly occurs with identification and referral from probation or from the Hawaii Youth Correctional Facility.

Co-Occurring Disorders

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, mild intellectual impairments, secondary diagnoses of developmental disorders, or medical impairments (e.g. blindness, deafness, diabetes, etc.) The presence of co-occurring disorders is assessed with all youth at the point of initial assessment, as well as routinely during the course of ongoing treatment. CAMHD does not provide services that are appropriate for youth with moderate or severe intellectual disabilities or severe autism spectrum disorders. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. It is required that all Contractors will provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments.

PREVALENCE ESTIMATE

According to the President's New Freedom Commission's report, *Achieving the Promise: Transforming Mental Health Care in America*, about 5% to 9% of children ages 9-17 have a serious emotional disturbance². Using the 2010 census, the prevalence of SED by county for individuals aged 10-19 is shown in the table below, and is expected to be 8,375 – 15,077 statewide.

² Friedman, R. M., Katz-Levey, J. W., Manderschied, R. W., & Sondheimer, D. L. (1996b). Prevalence of serious emotional disturbance in children and adolescents, cited in R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71–88). Rockville, MD: Center for Mental Health Services.

Estimated Range of Number of SED Youth Aged 10-19 Years by County, based on 2010 Census			
County	Total Youth	Lower SED Number (5%)	Upper SED Number (9%)
Hawaii	23,610	1,180	2,125
Honolulu	116,491	5,824	10,484
Kauai	8,201	410	738
Maui	19,231	961	1,730
STATE	167,533	8,375	15,077

The distribution of children and youth registered with CAMHD from July 1, 2012 to June 30, 2013:

Honolulu	251
Central Oahu	296
Leeward Oahu	303
Family Court Liaison Branch	88
Hawaii	770
Maui	225
Kauai	186
Total	2,119

*Kauai High End Only is 97

Through the Felix Consent Decree, the populations served by the Department of Education and the Department of Health were defined. The Department of Education provides mental health and other supports to students to take advantage of their public education. The youth who require more intensive services are referred to Department of Health CAMHD to receive intensive case management with access to CAMHD's comprehensive array of services. According to the Hawaii Department of Education's Annual Performance Report for 2012, there were 17,142 students with an Individualized Education Program (IEP) aged 6 through 21.

CHILD AND ADOLESCENT MENTAL HEALTH PERFORMANCE STANDARDS

The Child and Adolescent Mental Health Performance Standards (CAMHPS) is a manual developed by the Hawaii State Department of Health (DOH), Child and Adolescent Mental Health Division for use in the development and provision of behavioral health services for youth. The manual is part of the contractual agreement between CAMHD and its contracted provider agencies for delivering behavioral health services to youth and families in Hawaii. In Hawaii's integrated system, supports and services are provided in accordance with all regulations as required by Individuals with Disabilities Educational Improvement Act 2004 (IDEA) and Medicaid with active involvement of families and communities in alignment with the

Hawaii Child and Adolescent Service System Program (CASSP) principles. These standards and guidelines are designed to define service content standards, and to assure the efficiency and effectiveness of services. The “Orange Book” can be accessed at:
<https://www.doh.hawaii.gov/sites/camhd/Documents,%20Forms,%20and%20Resources/Orange%20Book.pdf>

TEAM-BASED DECISIONS

All behavioral health services with the exception of emergent services are the result of clinically informed team-based decisions regarding medically necessary care and made in collaboration with the youth and family/guardian. The IEP or Coordinated Service Plan team utilizes assessment information, evidence based services information, practice guidelines and performance standards to make decisions.

SERVICE PLANNING

Each youth’s treatment will be directed by a service plan that supports the use of medically necessary evidence-based interventions in the least restrictive environment. CAMHD service planning is an individualized and ongoing process that is youth-guided and family/guardian-centered.

Planning for a youth’s transition to adulthood should begin early (ages 15-17) and will be documented in the youth’s CSP for all youth seventeen (17) years and older. When the goals and needs in the CSP revolve primarily around increasing independence, the Mental Health Treatment Plan (MHTP) will include strategies to address the following six (6) areas:

- Living arrangement/personal management
- Vocational/educational
- Mental health and medical
- Community/social experiences
- Financial support and
- Employment.

1. Coordinated Service Plan (CSP)

The CAMHD Care Coordinator will convene a Coordinated Service Plan (CSP) meeting within thirty (30) days of youth’s eligibility determination. The CSP process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key individuals involved in the youth’s life including existing or potential service providers. The CSP will use resources available through the service system and shall include some naturally occurring resources in the youth’s family and community. Its purpose is to coordinate efforts across public agencies and other supports and services. CSP planning is guided by a long-term holistic view of the youth’s life. The CSP identifies the specific strategies that will achieve broadly defined goals for the youth and family, and integrates strategies across all those involved.

2. Mental Health Treatment Plan (MHTP)

The contracted service provider is responsible for the development, implementation, review, revision and adjustments to the MHTP. The MHTP should be individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth that includes the Contractor, family and the Care Coordinator. In out-of-home care, the MHTP goals should identify realistic, measurable outcomes that are directly related to the youth's ability to move into a more normalized, less restrictive setting. The MHTP will identify evidence-based treatment interventions that are the most promising options for meeting a youth's individual goals and objectives. Progress on plans shall be tracked continuously and treatment revised as necessary with youth, family/guardian and Branch collaboration. The treatment planning process begins with the pre-admission meeting and culminates in a document that includes expected intensity of treatment and treatment timelines, crisis and discharge plans.

a. Crisis Planning

The crisis plan documents the individual's problematic behaviors, setting events, triggers, the youth's preferred methods of calming and regaining control, and the steps caregivers will take in the event that behaviors begin to escalate out of control. The crisis plan is an expected component of the MHTP that builds on available information about the youth and the youth's personal safety plan. A personal Safety Plan should be developed in collaboration with the youth when possible and should detail his/her preferences for handling potential crises. Crisis plan components must focus on early intervention for any problematic behavior to reduce the need to take reactive steps.

b. Discharge Planning

Discharge planning begins at the time of the pre-admission meeting to ensure that any potential obstacles to discharge are recognized and addressed before the anticipated discharge date. Contractors, Care Coordinators, youth/family/guardian and other involved parties are expected to work together in this process. The discharge component of the MHTP should spell out specific, realistic, measurable discharge criteria that are consistent with behaviors/symptoms that resulted in the admission, describe a projected timeline for meeting them, and identify any aftercare resources needed.

INTENSIVE CASE MANAGEMENT

All CAMHD youth will have their services coordinated by a care coordinator to ensure timely, appropriate and coordinated service delivery.

The Care Coordinator (CC) is the case manager who is responsible for engaging the youth and family and assisting parents with coordinating the youth's education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. CCs are responsible for referring the youth for appropriate CAMHD services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality

services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The youth's CC is responsible for convening an initial Coordinated Service Plan (CSP) meeting within thirty (30) days of eligibility determination or immediately if the youth has immediate needs and assuring service delivery within thirty (30) days of identification for routine services. The CC coordinates regular home visits, school visits, and community contacts as indicated in the CSP. When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services and other state and community agencies. The CC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and for communicating important clinical developments to the Branch Utilization Review Team.

Contractors are expected to participate in the CSP development and meetings when they are involved with the youth. Contractors are responsible for coordination of services that are provided within their agency and regular communication about their services to the CC. Coordination and communication are particularly important in settings where there are multiple staff providing services for a youth. Contractors are also expected to coordinate efforts with the youth's school and community settings. Ongoing engagement, communication and coordination with families are a necessary practice as families are an integral part of the therapeutic process.

MEDICATION MONITORING

Youth on psychoactive and other prescription medications require careful coordination and oversight.

For contracted services that include medication monitoring, careful coordination and oversight by the out-of-home service Contractor is required including at least monthly monitoring for:

1. Drug interactions,
2. Side effects,
3. Medical complications,
4. Lab test requirements, and
5. Follow-up requirements.

REFERRAL TO CAMHD CONTRACTED SERVICES

CAMHD provides an array of mental health services through its branches and contracted providers. The CC is a vital link in the referral process and makes referrals to contracted provider agencies based on a full review of the youth's current strengths and needs as indicated by the admission criteria in the service specific standard as described in the Orange Book. The referral must be made within three (3) business days after the determination of strengths and needs through the youth's CSP and/or IEP and with written consent from the youth/family to release information. The CC will ensure that services are initiated in a timely manner. Routine services must be initiated within thirty (30) days of need identification.

All contracted services require prior authorization from CAMHD before any service can be provided, with the exception of Emergency Services that must be provided immediately. It is expected that all youth will have access to needed services. The role of the CC is to make referrals to agencies based on a full review of the youth's current strengths and needs and to ensure that services are initiated in a timely manner. If CAMHD youth from one island is referred to and accepted by an out of home provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD Branch approved therapeutic passes.

CAMHD Referrals

The Contractor is expected to accept all appropriate service referrals in accordance with contractual requirements. All referrals will include explanation of the purpose of treatment, the goals to be achieved via treatment, anticipated duration of treatment, and the discharge/transition criteria.

Contractors are expected to provide all youth accepted for contracted services with continuity of care until the youth meets the criteria for appropriate discharge or transition to another level of care indicated in team decisions.

PROVIDERS OF MENTAL HEALTH SERVICES

For a list of community-based providers which have Purchase of Service contracts to provide mental health services to CAMHD youth, please see: Appendix A.

CREDENTIALING REQUIREMENTS

CAMHD is committed to ensuring that staff is competent and qualified to provide the intervention/services to students/youth as evidenced by meet the following departmental credentialing requirements.

Credentialing requirements apply to all individuals providing direct services including subcontractors of a Contractor. All Contractors shall have written policies and procedures that reflect their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, and clinical supervisory staff prior to provision of services. Contractors shall be guided by CAMHD's credentialing policies and procedures in developing their policies and procedures.

All professionals contracted or employed by Contractors to provide direct services to youth and families must be fully credentialed prior to provision of services to youths. They must have completely met initial credentialing requirements through submittal of required documents and satisfactory verification of primary sources including, but not limited to, employment history, reference verification, criminal background checks and child abuse and neglect checks. Re-credentialing shall occur at least every two (2) years to ensure continued compliance with credentialing requirements including but not limited to internal provider and CAMHD reporting

on performance, grievances, and involvement in sentinel events, licensing requirements, malpractice coverage and claims history, as well as child abuse and neglect clearances.

SUPERVISION

CAMHD is committed to quality service through regular, ongoing, strength-based, skill building supervision of all staff that provide direct services to youth. CAMHD and each Contractor shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors. All direct service employees and subcontractors must have an individualized supervision plan based on a needs assessment completed annually by their respective supervisor.

EVALUATION OF STAFF PERFORMANCE

All CAMHD employees and Contractor shall have a process for evaluation of staff performance that includes a review of qualifications (i.e., an assessment of the employee's capabilities, experience, and satisfactory performance), reports of complaints received including resolutions, corrective actions taken, and supports provided to improve practice and to continue to monitor the staff evaluation process.

PROFESSIONAL DEVELOPMENT

CAMHD has partnerships and contracts with the University of Hawaii to support the development of the mental health workforce. Through these contracts, graduate students in the Department of Psychology can receive clinical therapy and assessment training or can participate in mental health research and evaluation. A John A. Burns School of Medicine contract provides child psychiatry residency opportunities, training residents on various levels of clinical psychiatric treatment. CAMHD also contracts with the Schools of Nursing and Social Work to provide specialty mental health tracks for their students.

YOUTH RIGHTS AND CONFIDENTIALITY

CAMHD recognizes the rights of all youth and families accessing behavioral health services.

Consumer Rights

All Contractors and their employees or subcontracted professionals are required to recognize CAMHD Consumer Rights and Responsibilities.

CAMHD Consumer Rights:

- You have the right to be treated with respect. You also have the right to your privacy.
- You have the right to treatment no matter what your situation is. You have this right regardless of your age, race, sex, religion, culture, ability to communicate, or disability.
- You have the right to know about the CAMHD services you can receive and who will provide the services. You also have the right to know what your treatment and service choices are.
- You have the right to know all of your rights and responsibilities.
- You have the right to get help from CAMHD in understanding your services.

- You are free to use your rights. Your services will not be changed or you will not be treated differently if you use your rights.
- You have the right to receive information and services in a timely way.
- You have the right to be a part of all choices about your treatment. You have the right to have your treatment plan in writing.
- You have the right to disagree with your treatment or to ask for changes in your treatment plan.
- You also have the right to ask for a different provider. If you want a different provider, we will work with you to find another provider in our network.
- You have the right to refuse treatment.
- You have the right to get services in a way that respects your culture and what you believe in.
- You have the right to look at your records and add your opinion when you disagree. You can ask for and get a copy of your records. You have the right to expect that your information will be kept private within the law.
- You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.
- You have the right to be free from being restrained or secluded unless an allowed doctor or psychologist approves, and then only to protect you or others from harm. Seclusions and restraints can never be used to punish you or to keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

All CAMHD employees and Contractors must adhere to these rights in the provision of behavioral health services to eligible youth. Each Contractor is to identify a Behavioral Health Rights Advisor within their organization who will ensure that all youth and families are made aware of their rights, and that the provider respects and upholds these rights.

GRIEVANCES/APPEALS

The CAMHD respects the right of any youth or family to disagree with aspects of planning or service delivery and will make every effort to resolve these disagreements directly with the family. If resolution is not possible in direct exchange, families and providers have additional recourse through the CAMHD's Grievances and Appeals Process. Youth and/or families are informed of these processes upon registration at a CAMHD Branch. If a service is going to be denied, terminated or reduced, CAMHD provides at least ten (10) days notice to the youth/family and Contractor (if applicable). This notice includes appeal rights and appeal process information.

RISK MANAGEMENT

All CAMHD Contractors must have policies and procedures that address critical risk management activities that include the following:

1. Criminal, Child Abuse, and Background Screening

CAMHD requires a background check on each employee that has direct contact with children and youth receiving contracted services. This includes a Criminal History Record Check through the Hawai'i Criminal Justice Data Center and Hawai'i Child Protective Services System, a Child Abuse and Neglect screening, a driver's license screening, and references from all employers for the previous three (3) years of employment. Annually a Child Abuse and Neglect screening must be conducted. Every two (2) years a local criminal records check must be conducted. This is documented in the employee's personnel file.

2. Safety

CAMHD requires Contractors to have procedures to ensure the safety and well-being of youth at all times. Safety is relative to known risks, and no procedure can provide an absolute protection from all possible risks. Contractors shall manage, control, or alter potentially harmful conditions, situations, or operations, including those leading to abuse, neglect and sexual exploitation, or induced by youth's high-risk behaviors to prevent or reduce the probability of physical or psychological injuries to youth. Safety from harm extends to freedom from unreasonable intimidation and fear that may be induced by other children, line staff, treatment professionals, or others.

3. Restraints and Seclusion

The State of Hawai'i is committed to fostering violence-free and coercion-free treatment environments for children and adolescents. As part of this commitment, CAMHD advocates that Contractors seek to minimize the use of restraint and seclusion, and work to increase the effective use of positive behavioral support strategies. Each youth has a right to be free from restraint or seclusion in any form that is used as a means of coercion, discipline, convenience, or retaliation.

SECTION II

PROGRESS MADE ON THE 2011-2014 STRATEGIC PLAN

Goal 1:	Integrate Health Information Technology
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Objective 1.1: Use electronic health information to increase real-time decision making

- CAMHD has completed its upgrade from the Veterans Health Information Systems and Technology Architecture (VistA) to the Resource and Patient Management System (RPMS), which is an upgraded version of VistA that has achieved meaningful use compliance in other states. “Meaningful Use” is an emerging set of federal standards to improve the safety, quality, and efficiency of health care. The upgrade from VistA to RPMS improves CAMHD’s position in demonstrating data sharing/compatibility with various systems across the country and to engage in sharing initiatives at the local level. RPMS currently provides access to client data such as client progress notes across multiple disciplines, clinical measures and outcomes, provider’s treatment and progress summary data, and historical service utilization.
- CAMHD is currently working to upgrade the RPMS EHR to a new version that is compliant with EHR 2014 edition federal certification requirements for Meaningful Use Stage 2. The RPMS EHR instance is also in the process of being reconfigured and moved from legacy physical servers into the DOH virtual machine environment, with advances anticipated in system capacity, reliability / disaster recovery, and server maintenance.

Objective 1.2: Use electronic health information to increase quality of care

- Data collected in CAMHD’s Electronic Health Record (EHR) is used to establish baseline data and evaluate services. The Meaningful Use of EHR Guidelines available in RPMS will assist the Division in developing methods for promoting and monitoring the quality of care using the information systems.
- Technological upgrades and improvements to the electronic health record (EHR) allow CAMHD the ability to better monitor measurable objectives as defined by CAMHDs Workflow Procedures and Business Guidelines. Automated clinical notifications along with supporting Financial Cost Analysis are to provide check and balance support structures to validate the effectiveness of the quality measures.
- CAMHD set up Oracle Business Intelligence (OBI) to be a part of its computer system and developed its first draft report, “Child and Adolescent Functional Assessment Scale (CAFAS) Scores Over Time”.
- A new position was created and filled (Report Writer) which is co-supervised by the Management and Information Systems and Research, Evaluation and Training offices. The Report Writer is able to provide targeted and aggregate performance reports throughout the CAMHD system. The Report Writer provides tailored reports of real

time operational data based on the specifications of branch chiefs and other leaders, which can be used to improve performance.

- CAMHD is engaging in a process of standardizing workflow and procedures across the FGC, providers, and administration / billing. This evolution will enable increased clinical focus on services, as well as streamlining the reporting process, will allow the Division to make gains in care quality and patient outcomes.

Objective 1.3: Increase the accuracy of standard outcome and practice measures

- Reporting technology has streamlined reporting of information to Family Guidance Center Branch staff. Outcomes can now be reviewed in matching to services received. EHR notifications are transmitted on a regular basis, and additional use cases are in implementation. This allows Family Guidance Center Branch staff to more efficiently respond to client needs and stakeholder’s concerns at a quicker rate.
- The development of consistent workflows utilizing more capable, associated upgraded information systems are anticipated to positively affect outcomes and measures.

Objective 1.4: Increase access to care in remote and shortage areas

- Utilizing federal dollars, CAMHD developed and has fully implemented a statewide video teleconference system. CAMHD is currently working to capture electronic clinician progress notes.
- The implementation of new workflow procedures will FGCs to better service patients in remote areas.

Goal 2:	Strengthen Clinical Services
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Objective 2.1: Increase utilization of evidence-based programs and implementation of practice elements.

- a) Build local capacity to implement the evidence-based practice element approach by developing trainers among contracted agency staff and Department of Education (DOE) staff.
 - A task force of the Evidence-Based Services (EBS) committee was formed to work on developing curriculum materials to do “train-the-trainer” events with contracted agency staff and DOE staff. We held one pilot training in 2011, and have worked on developing video-taped demonstrations for providers to utilize when training staff.
 - University of Hawaii Associate Professor and Chair of the Evidence-Based Services Committee, Dr. Brad Nakamura, has received a small grant to help support this effort and has launched a research project that includes training CAMHD providers of Intensive In-Home Services on practice elements.

- b) Initiate pre-service training collaborations to increase knowledge and use of evidence-based programs and practice elements for Hawaii’s mental health workforce

- We have made excellent progress in the area of pre-service training for psychologists, but we have not had the impact we hoped to have on master's level training programs.
 - EBS pre-service task group has collected and analyzed data from a survey of students and faculty in Hawaii training programs for a range of MH disciplines, and has shared the findings in a number of venues.
 - CAMHD has become part of a training consortium with the Department of Education and the Department of Public Safety that is providing pre-doctoral internships to Clinical Psychology graduate students. This collaboration also includes the Western Interstate Commission on Higher Education (WICHE) which is supporting efforts to gain accreditation for the internship program. The first interns began their training in July 2013. These interns are being trained on evidence-based therapy in public mental health settings.
 - Through CAMHD's Clinical Services Office, providers are being trained in Dialectical Behavioral Therapy and best practices when working with disruptive behavior problems and youth in foster care.
- c) Increase the knowledge of families, consumers, and other stakeholders about evidence-based services and increase consumer advocacy/demand for implementation of EBS.
- The EBS committee's consumer-friendly website task force developed a contract, hired a website builder, and launched a website: <http://helpyourkeiki.com> during 2011-2013. The website provides information designed to help parents of youth with emotional and behavioral difficulties.
 - EBS committee continues to maintain and update the site, track "hits" on the website, distributes flyers, talks to groups about the site, etc. to increase its impact.
 - The EBS committee continues to work on developing and posting new content to the website including information focused on parents' understanding of some of the EB practice elements.
 - Through sponsorship of CAMHD's Project Laulima, Project Kealahou and CAMHD's Clinical Services Office, training on child development, emotional wellbeing and psychotropic medication has been provided to community members.
- d) Develop training materials, information, and decision-making tools for use throughout the system of care.
- A Task-Force on the CAMHD Outcomes Assessment has met regularly since 2011. The group developed a work plan focused on providing more usable information to CAMHD clinical teams to guide clinical decisions. They conducted a thorough review of available measures in 2011.
 - Members of the Assessment Task Force conducted a pilot project in all of the CAMHD branches on the use of a new parent- and youth-report measure (the Ohio Scales) during 2012. This pilot demonstrated the practical utility of the scales and the feasibility of using them.

- A second pilot project was conducted in 2013 to address questions raised by the first pilot about the concurrent validity of the Ohio scales in our population. This pilot demonstrated that there is high correlation between this measure and other, longer instruments measuring mental health symptoms in youth.
- The Ohio scales will be used to monitor progress from the consumer's perspective, through monthly administration by Care Coordinators. Use of the scales is being rolled out beginning with the Honolulu FGC, which completed their training in January 2014. Training for all FGCs will be completed by the end of 2014.
- RET is working with MIS to assure that there is a usable data report on the Ohio Scales that will be accessible to care coordinators and FGC clinicians. The first reports were generated based on Honolulu FGC data in early March 2014. Honolulu and Hawaii FGC staff members have been trained in the use of Ohio Scales data to inform clinical decision-making.
- RET has developed new Provider Feedback Reports for CAMHD's contracted providers with information on client characteristics, outcomes, and use of evidence based practice elements to help providers improve their practice.

Objective 2.2: Strengthen the quality of CAMHD's clinical services and the involvement of clinical leaders in client care.

- a) Increase direct client care by CAMHD's child psychiatrists and clinical psychologists.
 - Over the past three years, CAMHD's clinicians have been providing increasing amounts of direct care to youth in the Family Guidance Centers as evidenced by progress notes in the Electronic Health Record.
 - Since 2012, CAMHD Psychiatrists and Psychologists have been attending monthly conjoint "Clinical Lead" meetings to promote collaboration around role definition and use of best practices in the branches.
 - A Clinical Lead meeting was held in February 2013 that included training on coding for billing direct services.

- b) Increase CAMHD child psychiatrists' and clinical psychologists' involvement in co-managing CAMHD youth with provider agencies.
 - CAMHD clinicians are regularly involved in co-managing care with provider agencies including authorizing all services.
 - During 2011, CAMHD developed new Performance Standards (The "Orange Book") to guide all services provided by CAMHD contracted providers. It was issued in July 2012, and included changes from the previous standards (The "Purple Book") designed to assure a more central role for CAMHD's child psychiatrists and clinical psychologists.
 - Since July 2012, FGC Psychiatrists and Psychologists have been authorizing all CAMHD contracted services. This has led to increased communication between CAMHD clinical leaders and provider agencies regarding youths' treatment.

- A task group of FGC/branch Psychiatrists and Psychologists led by Dr. David Roth met together for several months in 2012 to discuss roles and procedures related to exerting clinical leadership in every day FGC operations. They issued a written plan to move this forward in December 2012.
 - CAMHD leaders have been working on our division re-organization plan, and the plan has been acknowledged by the Department of Health. A clearer role for the CAMHD child psychiatrists and clinical psychologists in the clinical operations on the Family Guidance Centers (FGCs) is one of the main objectives of the re-org.
- c) Revise the treatment planning process to increase congruence among the major treatment planning tools.
- A task group on Assessment has been meeting since 2011. This group has also looked at ways to improve the Monthly Treatment Progress Summary (MTPS) measure that is completed by contracted providers monthly. The task group has worked on a new version of the measure, has planned new training for providers on the MTPS, and has considered how a revised version could be made more useful for treatment planning.
 - Hawai'i Island FGC developed a task group to work on revising the Community Service Plan (CSP) in 2013. They have been piloting the new CSP form for several months and will be reporting on their progress to the CAMHD Executive Management Team later in 2014.
 - In line with new Performance Standards issued by CAMHD in 2012, FGC staff members have been holding pre-admission meetings with providers and parents regularly to assure proactive treatment and discharge planning and to improve co-management of treatment with contracted providers.
 - Revised treatment planning tools have been developed and piloting has begun, but the new tools are not yet being implemented routinely. In the future, emphasis will be on utilizing the Electronic Health Record for shared treatment planning between CAMHD and provider agencies.
- d) Implement a professional development program using telehealth
- CAMHD has established several regular training opportunities for mental health professionals available via VTC.
 - CAMHD has increased its use of video-conferencing (VTC) significantly during the past four years, including regular use for case consultation between Clinical Service Office and the FGCs and regular use by covering Child Psychiatrists to work across geographical distances.
 - A training work group including both CSO staff and branch chiefs has been meeting since fall of 2012 by VTC, collaborating to develop a training program for all FGC staff.
 - Several training events related to working with LGBTQ2s youth were sponsored in the fall of 2012 by Project Kealahou with support from SAMHSA and the TA

partnership. This included a session via VTC where staff from all islands could discuss the topic and related issues with the visiting expert.

- A CAMHD-DOE professional development event focused on School-Based Mental Health was held in March 2012 utilizing VTC connections to all the major neighbor islands.
- A VTC-based training group on Dialectical Behavior therapy (an Evidence-Based treatment for youth with complex trauma) has been meeting monthly since 2013 to facilitate Hawaii Island CAMHD staff and providers working together with CAMHD's Clinical Services Office to apply DBT to complex cases on Hawaii Island.
- In November 2013, The Evidence Based Services Committee began a series of roundtable presentations utilizing VTC to reach the Neighbor Islands. Topics will include information on promising evidence based approaches, new developments in the treatment literature, etc. These professional development opportunities are being offered quarterly.
- CAMHD Clinical Leads are meeting monthly via VTC for hour-long professional development sessions including peer-training seminars on changes in diagnostic practices related to the newly released DSM 5.

Objective 2.3: Strengthen trauma-informed clinical practice

- a) Identify best trauma-informed practice
 - Through the EBS committee and the work of the National Child Traumatic Stress Network, Trauma-focused Cognitive Behavior Therapy (TF-CBT) has been identified as a "level 1" treatment for trauma.
 - CAMHD's Project Kealahou and CAMHD's Clinical Services Office has provided training on trauma informed care to agencies across the state on request.
- b) Develop a system to introduce, monitor and evaluate the effects of trauma-informed practice
 - Project Kealahou's evaluation plan has been approved by the UH IRB and is being implemented; it will provide data re: effectiveness of this demonstration project to provide trauma informed care and trauma-specific treatment to girls on Oahu.
 - The new CAMHD Performance Standards that went into effect in July 2012 require the use of a trauma screening measure in all initial evaluations on CAMHD youth. This will provide a research opportunity to examine changes in diagnostic and treatment practices as a result of changed assessment practices.
- c) Train providers in evidence-based trauma treatment
 - A large cohort of Hawaii mental health professionals has been trained to provide trauma-informed care and/or a specific, Evidence-Based trauma treatment.
 - CAMHD was a co-sponsor of the IVAT Hawaii Conference on the Assessment and Treatment of Trauma in March 2011, 2012, 2013 and 2014. This conference was

attended by close to 500 professionals yearly. CAMHD has participated in conference planning and assured that sessions on Evidence-Based and Evidence-Informed Trauma treatments for children and youth were featured in the program. In 2013 CAMHD/UH psychiatrists provided a symposium session on utilizing psychotropic medicine as part of trauma treatment. As a result of this conference, a large number of CAMHD providers have expanded their understanding of trauma informed care and trauma treatment.

- In 2011-2012, Project Kealahou partnered with Catholic Charities to provide an intensive “Learning Collaborative” on TF-CBT on Oahu. A wide variety of youth mental health service providers participated in the training activities, including approximately 50 therapists – with a smaller number completing the whole collaborative. The project repeated this effort and has been training another large cohort of CAMHD system therapists since February 2014

Objective 2.4: Strengthen utilization management of CAMHD services

- a) Conduct reviews of services to identify those which produce positive clinical outcomes and are financially cost-effective
 - RET has developed data reports on the cost of services and data reports on clinical outcomes; these are shared with CAMHD leaders and other community members on a regular basis.
 - Performance Monitoring case reviews are performed annually in all contracted agencies. Results of these reviews are utilized to identify programs that are particularly effective.
 - CAMHD spearheaded an effort that began in 2011 to revamp the “Interagency Performance Monitoring Report” which was produced by CAMHD and DOE quarterly during the era of the Felix consent decree. The new report (called the Hawaii Youth Interagency Performance Report - HYPER) includes outcome and cost data for CAMHD programs as well as for other child serving agencies, creating an excellent resource for decision-makers.
 - Project Kealahou is conducting a “Services and Costs” study that will examine the costs of services provided to girls in the project across the Hawaii system of care, including costs borne by other child-serving agencies.
- b) Develop UM workgroups to analyze services, identify areas for improvements and develop action plans
 - The Utilization Management Committee has been revising our UM work plan and reporting structure in order to improve the usefulness of the data reports reviewed and to take more effective action. The committee has decreased the frequency of meetings in the hope of making quarterly meetings more efficient and effective.

- RET and MIS are working together toward the goal of reporting “real time” data on service utilization and client progress. This should help UM efforts shift from looking at past utilization to a more pro-active approach.
- c) Standardize branch level utilization management processes and integrate them with statewide analyses
- CAMHD is getting closer to having a comprehensive Utilization Management system, based primarily on improved procedures at the branch/FGC level.
 - Branch Chiefs have drafted a standardized protocol for Branch-level UM
 - The new version of the CAMHD performance standards includes required Branch Level Utilization Review of all above-threshold cases.
 - During 2013, UH Center for Cognitive-Behavior Therapy developed and piloted a successful system of clinical data management that can help structure and streamline case review efforts in the FGCs. This recently has been introduced to several FGCS and it has been adopted on Hawaii Island.
 - Future efforts will focus on standardizing practice across FGCs and linking to state-level Utilization Management efforts.

Objective 2.5: Identify and implement strategies to strengthen involvement of youth and family members in treatment planning and system reform

- a) Develop information resources to increase family knowledge and consumer demand for evidence-based services.
- The CAMHD Evidence Based Services committee has developed a consumer-friendly website (www.helpyourkeiki.com) for parents and the public. The committee is working to add new content all the time and to disseminate brochures about this resource.
- b) Strengthen Parent Partner participation and coordination with the branches.
- CAMHD began funding a half-time HFAA position focused on strengthening the Parent Partner role and family involvement in CAMHD in August of 2012.
 - Hawaii Family Guidance center is currently engaged in a pilot project focused on including the Parent Partner in treatment team meetings.
 - CAMHD established a task group to work on improving intake procedures which is piloting a new approach at Hawaii Family Guidance beginning in FY15. This enhances and routinizes the role of the parent partner in every new case accepted into CAMHD services.
 - CAMHD staff have begun work on a new RFP for Statewide family support. The new contract(s) will include clearer expectations for Parent Partners’ functioning in the FGCs.
 - CAMHD has provided training and technical support to the current statewide family support organization.

- c) Strengthen the role of the family support organization in the CAMHD system of care.
 - A task force was formed in 2013 to focus on family involvement at all levels of CAMHD. The group has met monthly with participation from Central Office and FGC CAMHD staff, HFAA, and providers. Ideas and materials developed by the task force are being utilized by CAMHD's Training group which is working to establish and train on new clinical procedures for the branches.
 - HFAA has been contracted by Project Kealahou to provide a number of staff positions including a parent support coordinator, youth coordinator and several youth specialists. These staff members are developing new consumer roles that are proving helpful to youth and families. PK and other CAMHD staff are working on how to sustain these practices after grant funding ends, including the possibility of billing Medicaid for peer support services.
 - CAMHD has decided to re-procure the Contract for a Statewide Family Support Organization during FY 2015; work has started on writing a new scope for these services, and a Request for Information (RFI) will be scheduled in the fall of 2014.

- d) Improve the process of obtaining and utilizing consumer feedback.
 - The CAMHD task force on outcome measures is working on rolling out the regular use of the Ohio Scales as part of CAMHD data collection efforts. The Ohio scales include a measure of client satisfaction completed by the youth and by parents; this will be collected monthly from active clients in all guidance centers.
 - RET worked with the CAMHD Family Involvement Task Force and SAMHSA evaluators to make the yearly consumer survey more user-friendly by decreasing its length and collecting some of the required data through other means (Ohio Scales). A new approach is being utilized to collect the data, with MHCCs distributing the questionnaire to families to encourage more participation. Also, new items have been added to the Consumer Survey to measure how well parents have been kept informed about services by the MHCC and feelings of empowerment from Parent Partner services.
 - Important changes to the consumer survey have been put in place.

Goal 3:	Implement a Strategic Financial Plan
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Objective 3.1: Maximize existing resources

- a. Provide ongoing training and feedback to support staff clinician provision of billable services
 - Training and education continues to be an ongoing process as CAMHD re-engineers the workflow procedures and business guidelines to reach operational goals. Training and feedback will also assist in building and maintaining standardized steps at CAMHDs remote locations statewide. Standardizing business practices will

rely on the Direct Clinical Data Entry model initiative which is currently at fifty percent completion. The percent of direct clinical data entry into VistA should increase as training initiatives are deployed to the remote Family Guidance Centers. This direct clinical data entry model initiative will improve CAMHDs alignment of client eligibility status and the delivery of services to clients. The timing of making clients eligible prior to the start date of services and CAMHDs ability to manage client eligibility while services are being rendered will increase billable services.

b. Evaluate and prioritize staff activities

- VistA notifications are system-generated messages that alert staff of important client situations. Notifications become part of the client's electronic health record and are used by supervisors to manage care coordinator's workload. The new electronic health record notification driven workflow is designed to identify priority order for staff activities, reduce redundancy, promote escalated levels of constructive oversight, document cycle activities, to communicate accurate information across multiple disciplines for clinical guidance, and to assist in team decision making. This increased level of clinical documentation in the electronic health record can create opportunities for reaching new levels of billable services.

c. Evaluate and prioritize data needs

- The streamlining of data continues to be a priority for CAMHD. Unnecessary and redundant data reporting items have been or redesigned or eliminated. New reports focused on clinical patient outcomes are in development, along with workflows for notifications and action to improve patient care.

Objective 3.2: Maximize revenue streams

a. Explore opportunities for diversifying revenue streams

- Current videoconferencing system initiatives have been deployed to enhance patient care services delivery and revenue generating initiatives. CAMHD has expanded the use of videoconferencing technology to offer services to remote areas and to enhance the collection of direct service billing data. Revenue generating initiatives include streamlining workflows for pilot sites. Clinicians are transitioning to the signing of clinical documentation in the electronic health record. This centralization of clinical data for services provided over videoconferencing is the first step to increasing billable services and ensuring superior patient care.

b. Increase the capability of the electronic health record to incorporate fiscal data

- CAMHD has increased its capacity in building better data models to demonstrate financial responsibility and to measure return on investment. The ability to feed

quality clinical data into data models will allow for improved accuracy in revenue projections and the realization of cost savings.

- c. Establish accountability measures linking billing data to clinical service records
 - Improvements and Increases in outcomes data and utilization reporting will allow clinical staff the ability to better determine the clinical appropriateness and cost effectiveness of services. Faster identifications of clinical responses to treatment will conserve resources. CAMHD staff is vigorously working with Department of Human Services MedQuest Division to enable new billable services as well as enhance existing procedure codes.

Goal 4:

Strengthen Effective Collaborations to Increase Early Access to Care

Objective 1: Collaborate with DOE to facilitate early identification of CAMHD-eligible youth

- This year, 2014, has marked a high-point in working relationships with the Department of Education (DOE) administration. Several high-profile cases that required coordination of mainland behavioral health placements demonstrated the need for coordination between CAMHD and the DOE. We have remodeled the process for these placements and shortened the timeframe by one half. This required coordinated planning from DOE and Department of Human Services. DOE has agreed to pay for educational charges for all placements, no matter the requesting agency. Out of this process has grown a formalized one-to-one accountability between the CAMHD Administrator and a Deputy Superintendent of the DOE. Policy problems will be handled at this level. The Deputy Superintendent will be a standing member of Hawaii Interagency State Youth Network of Care (HI-SYNC) which will assure decision making power on this multi-agency forum. We are now finalizing a Memorandum of Agreement with DOE concerning the process for mainland placements so all parties are held to their agreements.

Objective 2: Improve working relationship with the DHS and juvenile justice, including youth with trauma

- A process, facilitated by a grant from the Pew Charitable Trust facilitated formal discussions about the juvenile justice system and need for reform. Out of this process came a major bill, HB 2490 that restructures the probation system and how it handles youth. A major part of this bill deals with strengthening the mental health services to those who have encountered the Juvenile Justice (JJ) system. A second bill increasing funding for those services was passed, increasing support for juvenile justice therapeutic programming by over one million dollars. There have been a series of meetings with Family Court Judges in addition. Two Hawaii Supreme Court justices are advocating mental health treatment for adjudicated youth with pooled resources to run a secure mental health treatment facility in Hawaii for our most troubled youth, and to avoid a further increase in mainland

placements. These multiple agencies plan to soon to send a joint team to the mainland to look at models for this new level of care. CAMHD will have therapeutic oversight of this facility. This model is very innovative and shows the commitment of CAMHD, the Courts and the Office of Youth Services in working together for common programming.

Objective 3: Establish working relationships with primary care

- CAMHD’s two pilot projects are beginning to show organizational progress and varying degrees of effect among the four Federally Qualified Health Centers (FQHC) sites. One project is run by the Hawaii Primary Care Association, (HPCA), with sites at Kona and Kalihi-Palama, and the other project with sites at Waimanalo and Maui is run by the John A. Burns School of Medicine Department of Psychiatry. A consultative model seems to be emerging. The Kona site has seen the most eager response and clinically has touched the largest number of clients. Referrals have gone in both directions, both to and from the primary clinic. A very successful training with expertise from the mainland was held by HPCA, attended by both the grantee groups. Our model here seems to closely mirror successful models in other states. Reliance on modern communication technology has been helpful. We look forward to further gearing up of the remaining sites in the near future.

Objectives 4 and 5: Improve interdepartmental and intradepartmental coordination around multisystem youth, and Improve working relationships around statewide quality assurance.

- Progress has been made with the interagency cooperation on what was formerly known as the Statewide Interagency Quality Assurance Committee, now renamed HI-SYNC or Hawaii Interagency State Youth Network of Care. What was formerly known as the IPMR for public data release was completely restructured and made yearly rather than semi-annually. That report now will have outcomes measures from CAMHD, School-Based Behavioral Health, Special Education, Developmental Disabilities Division, Early Intervention, Office of Youth Services and Child Welfare Services. The format has been changed as well as the measures. Previously the report focused largely on compliance measures with the Court’s oversight concerns. Although still a work in progress, it will focus now on outcomes for children and clinical measures with involvement of more agencies. HI-SYNC has been increasingly recognized as an appropriate forum to discuss particularly complex, multi-agency cases. Approval of a single consent form for use by HI-SYNC was a major accomplishment that took years to develop and to get approved by all agencies involved.

SECTION III

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION'S 2015-2018 STRATEGIC PLAN

ENVIRONMENTAL SCAN

Prior to the development of the four-year strategic plan, CAMHD conducted an environmental scan, gathered input from the public and identified the following factors that may have an impact on CAMHD's service system:

- Affordable Care Act
 - Health Information Technology
 - Holistic Health
- Juvenile Justice Reform
 - Juvenile Justice Diversion
 - Therapeutic Programming
- Congressional Mandate – 5% set-aside “to support evidence based programs that address the needs of individuals with early serious mental illness, including psychotic disorders”
- Community Input – Public Hearings
- Youth Input – Keiki Caucus Youth Summit
- SAMHSA Strategic Plan, 2015-2018

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (ACA, "Affordable Care Act") aims to reform the healthcare system by giving more Americans access to quality, affordable health insurance and helps to curb the growth of healthcare spending in the U.S.; assure that all Americans with health insurance will have access to a number of new benefits, rights, and protections which ensure that they can get treatment when they need it; and spreads risk equally to all insured to end discrimination, including those with mental health challenges.

CAMHD has been and will continue to work on improving the quality of its services, operations and systems to align with some of the tenets of the Affordable Care Act. CAMHD has initiated several behavioral health/primary care integration projects to move toward more holistic health and toward a medical home model. Some of the goals of the projects include increasing the number of youth who are screened for behavioral health issues, increasing the capacity of the Federally Qualified Health Centers to manage low-level emotional or behavioral issues in their young patients, and establishing relationships between primary care providers and CAMHD to increase consultations and referrals. CAMHD has also invested staffing, time and resources to upgrade and improve its health information technology. CAMHD will continue to work on these ongoing initiatives over the next four years.

Juvenile Justice Reform

In 2013, Governor Neil Abercrombie, Hawaii Supreme Court Chief Justice Mark Recktenwald, Hawaii State Senate President Donna Mercado Kim, and Hawaii House of Representatives Speaker Joseph Souki established the Hawaii Juvenile Justice Working Group. This Group was charged with analyzing Hawaii's juvenile justice data, policies and practices; reviewing the research on national best practice and evidence-based principles; and identifying strategies to move Hawaii toward a more effective, equitable and efficient juvenile justice system.

The Working Group met each month from August through December 2013, with the technical assistance from the Pew Charitable Trusts. The group conducted a broad assessment of Hawaii's juvenile justice system, analyzing policies, practices, programs, and statutes and conducted an extensive analyses of Hawaii's juvenile justice system data. The Working Group also engaged in outreach with discussions on Kauai, Maui, and Hawaii Island. Interviews were conducted with staff from probation, the Judiciary, Office of Youth Services (OYS), the Legislature, the Department of Education (DOE), the Department of Health (DOH), and the Department of Human Services (DHS). Community surveys and focus groups were also conducted.

A key finding related to mental health in the December 2013 Final Report states:

“The Working Group received information on the critical and urgent need for enhanced access to mental health and substance abuse treatments for youth, especially at early junctures in a youth's contact with the court. Probation officers and court officials highlighted the wait times and administrative criteria that often inhibit access to treatments or severely delay needed services. Youth can languish in the system even after clear needs are identified, but those needs are left untreated and eventually impact a youth's risk to reoffend. And family courts are too often in need of crucial early interventions that are necessary for justice system-involved youth that could prevent further reoffending. Stakeholders consistently identified the significant deficiency in treatment resources across the state, and the corresponding need for greater and earlier access to proven and effective mental health and substance abuse treatments.”
Hawaii Juvenile Justice Working Group Final Report, December 13, 2013.

The Working Group developed a comprehensive set of 24 policy recommendations. Four of the recommendations were related to CAMHD and mental health services.

Recommendation 5: Review Eligibility for Mental Health Services

The Working Group found that the criteria for youth to access mental health services through CAMHD to be extremely restrictive. Many of the youth currently involved in the juvenile justice system who could benefit from mental health services are ineligible based on the current eligibility criteria, which is either Medicaid eligibility or a special education qualification. Mental health services could play a significant role in putting youth back on the right track if applied to the right youth at the appropriate time. And

the Working Group finds that failing to correct these criteria could have severe consequences for youth and their futures.

The Working Group recommends a review of the current eligibility requirements, with a focus on expanding access to services to ensure that youth determined to be at-risk and with a need for mental health services receive those services in a more comprehensive and timely manner, through DOH or their contracted mental health providers. Finally, the Working Group strongly recommends to fund or allocate the resources necessary to achieve these goals for CAMHD and ensure the agency has the fiscal and human resources necessary to adequately serve youth.

Recommendation 20: Provide for Collaboration Between the Judiciary and Mental Health Clinicians

The Working Group's findings regarding the importance of mental health and substance abuse needs in juvenile justice system-involved youth call out for greater collaboration between judges, court officials, and mental health clinicians and providers. Effectively treating these needs in youth could be facilitated by greater communication and a focus on case management and problem solving. The Working Group recommends that the members of the Judiciary and DOH meet on a regular basis to consult on specific cases and broader issues held in common between the two stakeholders. These discussions will provide an avenue to short-term resolution of specific needs and cases as well as broader, long-term gains in collaboration and services.

Recommendation 21: Provide a Pathway to Earlier Referrals and Access to Mental Health Services

Many youth in the juvenile justice system have significant mental health needs. CAMHD currently contracts with providers that deliver mental health treatment and other juvenile offender interventions such as Multi-Systemic Therapy. Access to these programs can contribute to reduced delinquency.

The Working Group recommends that, if a youth's risk and needs assessment indicates a mental health need, the probation officer should be required to immediately refer the youth to CAMHD for presumptive treatment. CAMHD should be required to begin treatment and initiate a post-referral assessment and ascertain the youth's qualification for treatment.

In addition, the Working Group recommends that judges have statutory authority to suspend delinquency proceedings for up to one year to facilitate access to and completion of mental, behavioral, or substance abuse treatment.

The Working Group also recommends that the Legislature address the urgent need for increased access to mental health and substance abuse treatments. Family courts across Hawaii need the ability to expediently refer youth to these services, and for treatment

to begin without undue delay. Untreated behavioral needs are crucial and a critically important challenge facing the juvenile justice system, and the Working Group recommends that the Legislature use these recommendations to develop legislation that would reduce administrative delays and burdens on access to treatment and increase access to quality mental health and substance abuse treatments across the state, while maintaining efforts to ensure appropriate clinical care.

Recommendation 22: Enhance Interagency Collaboration

Hawaii has developed a model for serving specific populations of youth and others in need, the interagency cluster model, in which one agency leads and coordinates a service plan with allied agencies. The Working Group recommends that this model be specifically used to serve high-need juvenile justice system-involved youth.

The coordinated service plan will be led by the Family Court, and involve regular case planning and collaboration with all involved agencies, including DOH, DHS, and DOE. The involved agencies will meet once a month to discuss all active coordinated service plans in each circuit. The judge, at his or her discretion, could involve community-based providers, as well as OYS.

The Working Group also recommends that access to mental health services for youth in the juvenile justice system be expanded, and recommend that the Legislature consider making changes that would increase DOH's contribution in ensuring the juvenile justice population is accessing needed mental health and substance abuse services.

During the 2014 Legislative session, HB2490 was introduced to support the adoption of the policy recommendations. The bill was passed and Governor Abercrombie signed Act 201 into law.

The new law establishes a Juvenile Justice Oversight Advisory Council to oversee the implementation of the juvenile justice reforms. One of the tasks of the advisory council is to review mental health eligibility requirements with a focus on expanding access to services. The Legislature appropriated \$1.2 million to the Office of Youth Services to carry out the many purposes of Act 201.

As a member of the Juvenile Justice Oversight Advisory Council, CAMHD has been active in collaborating with the Judiciary and the Office of Youth Services to implement some of the reforms, including developing models for treatment and long-term support for early diversion, developing therapeutic response systems for youth leaving detention or incarceration, and providing mental health training and technical assistance to other child-serving agencies.

Congressional Mandate

In 2014, Congress established a 5% set-aside requirement for the Community Mental Health Services block grant "to support evidence based programs that address the needs of individuals

with early serious mental illness, including psychotic disorders”. To comply with the mandate, CAMHD is taking the lead in establishing a small pilot program to treat young adults at risk for psychosis. CAMHD is developing partnerships with University of Hawaii Department of Psychology, UH John A. Burns School of Medicine, Department of Psychiatry, Ohana Care, and Adult Mental Health Division to establish the evidence-based Coordinated Specialty Care program.

Community Input

From September through October 2014, CAMHD conducted public hearings to gather input from the community. The issue that arose most often from the audience was prevention and early intervention of mental illness. The next two issues that tied for second place were the involvement of families within the care of their children, and the issue of transitioning youth to independence once they no longer qualify for CAMHD or other youth services. Other issues that arose (two comments each) included concerns about the mental health of family members, the role of care coordination, training for CAMHD staff, neighbor island service gaps, fiscal responsibility to improve outcomes, and the need to increase revenues. Finally, individual comments were made about crisis care, holistic health, patient record privacy, impact of the new *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, and the identification and treatment of pre-morbid schizophrenia.

CAMHD’s ongoing primary care integration projects will facilitate access to early identification and early intervention. CAMHD has achieved significant success in its health information technology initiatives. Continued focus on information technology will only help to improve clinical practice, improve revenue capture and ultimately improve youth outcomes. CAMHD will use the next four years to increase supports to the families of youth with emotional and/or behavioral challenges, and increase support for youth, including transition-age youth.

Youth Concerns

As a youth-serving organization, CAMHD is interested in the perspectives of Hawaii’s youth. Each year, the legislative Keiki Caucus, chaired by Senator Suzanne Chun Oakland, convenes a gathering of youth and youth advocates, to identify the issues of concern for young people. Through a consensus process, the top issues are identified, with the goal of identifying the needed resources to address the issues, including legislative action. This year’s top five issues that concern today’s youth are:

- #1 - College/career/life skills education in schools
- #2 - Increase mental health awareness in schools, including training for teachers, and supports for students with mental health issues
 - Provision of mental health services on campus, i.e. “Wellness Centers”
 - Tolerance of students with challenges
 - Mental health screening of all students
- #3 - Increase affordable housing
- #4 - Suicide prevention

- #5 - Create a safer environment for LGBTQ youth

During the last four years, CAMHD has strategically developed close ties with the Department of Education and other child-serving organizations and will continue to work collaboratively toward improving the network of services for youth, wherever the youth are. CAMHD has also initiated a “Safe Places” Coalition to create safer environments for youth identifying as LGBTQ. CAMHD will continue to support its sister agency, Department of Health Injury Prevention & Control Section, with its wide-ranging suicide prevention efforts.

SAMHSA Strategic Plan 2015-2018

The U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA recently underwent its own process of gathering stakeholders together for strategic planning, and unveiled its new strategic initiatives. Many of the issues that SAMHSA identified at the national level mirror Hawaii's issues.

Some of SAMHSA'S identified goals and objectives are provided below:

#1 Prevention of Substance Abuse and Mental Illness

- Promote emotional wellness
- Prevent or delay onset of mental illness
- Focus on high-risk populations – transition-age youth, ethnic minorities, persons with disabilities, military, LGBTQ individuals
- Reduce disparities – suicide, poverty, childhood trauma, foster care, juvenile justice, domestic violence

#2 Health Care and Health Systems Integration

- Foster integration between behavioral health, health care, social support and prevention

#3 Trauma and Justice

- Promote a trauma-informed approach throughout health and related systems
- Create capacity in the behavioral health and justice systems

#4 Recovery Support

- Engage individuals and their families in recovery through self-directed care, shared decision-making, person-centered planning, family-driven and youth-guided care
- Increase number and quality of trained peer specialists
- Increase number of support groups, parent support providers and peer-run/family-run support organizations

- Increase number of social supports for youth, young adults and families with mental illness
- Decrease negative attitudes and discrimination toward people with mental illness

#5 Health Information Technology

- Promote interoperable exchange of behavioral health data
- Support dissemination of evidence-based clinical decision support tools

#6 Workforce Development

- Increase the number of well-trained professionals, paraprofessionals and peer specialists
- Increase proportion of behavioral health providers from diverse groups

After reviewing relevant environmental factors at the federal, national and local levels, taking into consideration the tremendous progress achieved on existing initiatives, and balancing that with strategic use of limited resources, CAMHD has identified five goals that it proposes to work on over the next four years.

CAMHD Strategic Plan Goals:

1. Promote access to clinically driven mental health services and reduce disparities. (Clinical goal)
2. Promote behavioral health integration into primary health care. (Integration)
3. Promote mental health capacity and systems change in the juvenile justice system. (Juvenile Justice)
4. Promote family support for individuals with behavioral health issues and their families. (Family)
5. Promote technological advancement and adoption. (IT)

Goal 1. Promote access to clinically driven mental health services and reduce disparities.

Objective 1.1 Develop and implement a comprehensive Care Coordinator training program that includes training on providing targeted case management, engaging families, and working as part of a clinically-oriented team.

Objective 1.2 Develop and implement strong interagency collaborative agreements to improve care for children and youth with multiagency involvement.

Objective 1.3 Develop and implement evidence-based specialty programs to meet the needs of identified populations that are not being served adequately by the current service array.

Objective 1.4 Collaborate with our partner state agencies to develop and implement a plan to improve the ability of the Hawaii system of care to address the needs of transition-age youth with mental health challenges.

Objective 1.5 Improve the current CAMHD array of services through performance monitoring activities, provider training, case consultation, and pro-active clinical co-management of challenging youth.

Objective 1.6 Increase the accessibility of mental health services to youth at the detention facility.

Goal 2. Promote behavioral health integration into primary health care.

Objective 2.1 Develop improved linkages and communication with primary care providers and provide training and consultation to implement standardized screening for behavioral and social/emotional concerns.

Objective 2.2 Increase the number of mental health case consultations with primary care providers and provide resources and support to enable primary care providers to successfully manage mild to moderate mental health conditions in the primary care setting.

Objective 2.3 Improve the identification and assessment of mental health conditions in primary care and increase the number of SEBD referrals from primary care providers.

Objective 2.4 Conduct at least four cross-discipline trainings per year on primary care/behavioral health integration.

Goal 3. Promote mental health capacity and systems change in the juvenile justice system.

Objective 3.1 Develop and implement treatment and long-term support models for early diversion from the juvenile justice systems.

Objective 3.2 Develop and implement a more therapeutic environment within the youth correctional facility.

Objective 3.3 Develop a therapeutic response system for youth leaving youth detention or correction centers.

Objective 3.4 Develop a therapeutic program for youth impacted by sex assault and human trafficking.

Goal 4. Promote family support for individuals with behavioral health issues and their families.

Objective 4.1 Develop and implement procedures necessary to seek reimbursement from MedQUEST for parent partner services and young adult peer support services.

Objective 4.2 Increase parent involvement and input into all aspects of the CAMHD system, including individual youth treatment teams, local FGC leadership teams and state-level policy-making groups.

Objective 4.3 Develop and implement a process for helping parents whose children have received CAMHD services to develop as advocates and leaders and seek work as parent partners and system advisors.

Objective 4.4 Develop and implement a process for helping youth who have received CAMHD services to develop as leaders and seek employment as peer specialists.

Objective 4.5 Develop treatment teams with increasing informal support representation.

Objective 4.6 Increase integration and involvement of Parent Partners in CAMHD Treatment Teams.

Objective 4.7 Increase the number of support groups and parent support providers, as well as young adult and other peer-run and/or family-run recover support service provider organizations.

Goal 5. Promote technological advancement and adoption.

Objective 5.1 Support development, workflow changes, and training to ensure that CAMHD's electronic health record and health information technology systems and use conforms to national standards for functional certification and interoperability.

Objective 5.2 Support the development of standards and processes for electronically capturing clinical quality measures for CAMHD to assess quality of care, health disparities, and patient outcomes.

Objective 5.3 Support development, training, and utilization of evidence-based clinical decision support tools.

Objective 5.4 Further the development of an efficient and comprehensive automated billing system and billing process that is fully compliant, transports appropriate claims, provides metrics, and maximizes revenues.

APPENDIX A
PROVIDERS OF MENTAL HEALTH SERVICES

Alakai Na Keiki

Intensive Independent Living Skills	Hawaii East	13-001
Intensive Independent Living Skills	Hawaii West	13-002
Intensive In-Home Therapy	Oahu Leeward	13-003
Intensive In-Home Therapy	Oahu Central	13-004
Intensive In-Home Therapy	Oahu Honolulu	13-005
Intensive In-Home Therapy	Maui	13-006
Intensive In-Home Therapy	Hawaii East	13-007
Intensive In-Home Therapy	Hawaii West	13-008

Aloha House

Crisis Mobile Outreach	Maui	13-009
Evaluation	Maui	13-010
Intensive In-Home Therapy	Maui	13-011

Benchmark Behavioral Health

Community Based Residential I	Statewide	13-012
Psycho-sexual	Statewide	13-013

Bobby Benson Center

Community Based Residential III	Statewide	13-014
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CARE Hawaii

Crisis Mobile Outreach	Oahu	13-015
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Catholic Charities Hawaii

Community Based Residential II	Statewide	13-016
Intensive Independent Living Skills	Oahu Leeward	13-017
Intensive Independent Living Skills	Oahu Central	13-018
Intensive Independent Living Skills	Oahu Honolulu	13-019
Intensive In-Home Therapy	Oahu Leeward	13-020
Intensive In-Home Therapy	Oahu Central	13-021
Intensive In-Home Therapy	Oahu Honolulu	13-022
Transitional Family Home/ Respite Home	Oahu	13-023
Transitional Family Home/ Respite Home	Hawaii	13-024
Homeless Support	Honolulu	15-041

Child and Family Service

Community Based Residential III	Statewide	13-025
Crisis Mobile Outreach	Kauai	13-026
Therapeutic Crisis Home	Hawaii East	13-027
Therapeutic Crisis Home	Hawaii West	13-028
Transitional Family Home/ Respite Home	Hawaii	13-030
Crisis Mobile Outreach	Hawaii	09-018

Hale Kipa

Intensive In-Home Therapy	Oahu Leeward	13-031
Intensive In-Home Therapy	Oahu Central	13-032
Intensive In-Home Therapy	Oahu Honolulu	13-033
Intensive In-Home Therapy	Kauai	13-034
Intensive In-Home Therapy	Hawaii East	13-035
Intensive In-Home Therapy	Hawaii West	13-036
Transitional Family Home/ Respite Home	Oahu,	13-037
Transitional Family Home/ Respite Home	Hawaii	13-038
Homeless Outreach	Honolulu	15-040

Hale Opio

Therapeutic Crisis Home	Kauai	13-039
Transitional Family Home/ Respite Home	Kauai	13-040
Intensive Independent Living Skills	Kauai	13-041

Hawaii Behavioral Health

Intensive Independent Living Skills	Maui	13-042
Intensive Independent Living Skills	Kauai	13-043
Intensive Independent Living Skills	Hawaii East	13-044
Intensive Independent Living Skills	Hawaii West	13-045
Intensive In-Home Therapy	Oahu Leeward	13-046
Intensive In-Home Therapy	Oahu Central	13-047
Intensive In-Home Therapy	Oahu Honolulu	13-048
Intensive In-Home Therapy	Maui	13-049
Intensive In-Home Therapy	Kauai	13-050
Intensive In-Home Therapy	Hawaii East	13-051
Intensive In-Home Therapy	Hawaii West	13-052
Transitional Family Home/ Respite Home	Oahu	13-053
Transitional Family Home/ Respite Home	Maui	13-054
Transitional Family Home/ Respite Home	Kauai	13-055
Transitional Family Home/ Respite Home	Hawaii	13-056

Hawaii Families As Allies

Parent Support	Statewide	11-003
Parent Support	Oahu	12-004

Kahi Mohala

Hospital Based Residential	Statewide	13-057
Partial Hospitalization	Oahu	13-058

Marimed Foundation

Community Based Residential III	Statewide	13-059
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Maui Youth and Family Services

Intensive Independent Living Skills	Maui	13-060
Therapeutic Crisis Home	Maui	13-061
Transitional Family Home/ Respite Home	Maui	13-062

Parent and Children Together

Functional Family Therapy	Oahu	13-063
Functional Family Therapy	Kauai	13-064
MultiSystemic Therapy	Oahu East	09-012
MultiSystemic Therapy	Oahu West	09-013
MultiSystemic Therapy	Kauai	09-014
MultiSystemic Therapy	Maui	09-015

The Institute For Family Enrichment

Functional Family Therapy	Hawaii	13-065
Evaluation	Oahu	13-066
Evaluation	Hawaii	13-067
Intensive Independent Living Skills	Oahu Leeward	13-068
Intensive Independent Living Skills	Oahu Central	13-069
Intensive Independent Living Skills	Oahu Honolulu	13-070
Intensive In-Home Therapy	Oahu Leeward	13-071
Intensive In-Home Therapy	Oahu Central	13-072
Intensive In-Home Therapy	Oahu Honolulu	13-073
Intensive In-Home Therapy	Hawaii East	13-074
Intensive In-Home Therapy	Hawaii West	13-075
MultiSystemic Therapy	Hawaii East	09-016
MultiSystemic Therapy	Hawaii West	09-017

The Queen's Medical Center

Hospital Based Residential	Statewide	13-076
Partial Hospitalization	Oahu	13-077

Waianae Coast Community Mental Health Center

Transitional Family Home/ Respite Home	Oahu	13-078
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