

REPORT TO THE TWENTY-NINTH LEGISLATURE
STATE OF HAWAII
2017

PURSUANT TO SECTION 321-176, HAWAII REVISED STATUTES, BIENNIAL
REVIEW OF PROGRESS MADE ON THE CHILD AND ADOLESCENT MENTAL
HEALTH DIVISION'S FOUR-YEAR STRATEGIC PLAN

PREPARED BY:

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
NOVEMBER 2016

**Child and Adolescent Mental Health Division
Biennial Strategic Plan Progress Report
2015-2016**



Hawaii Department of Health
November 2016

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Biennial Strategic Plan Progress Report
2015-2016**

Pursuant to Section 321-176, Hawaii Revised Statutes, the Child and Adolescent Mental Health Division of the Department of Health submits a biennial review of progress made in 2015-2016 on the Child and Adolescent Mental Health Division's Strategic Plan 2015-2018.

The Child and Adolescent Mental Health Division provides the following report on its five goals:

**GOAL 1 PROMOTE ACCESS TO CLINICALLY DRIVEN MENTAL HEALTH SERVICES AND
REDUCE DISPARITIES**

While the CAMHD continues with its ongoing efforts to increase access to mental health services, new efforts are mentioned below.

Family Engagement

In the summer of 2016 CAMHD sponsored a conference hosting nationally renowned speaker Patricia Miles on strength-based care coordination, family engagement and peer support services. It was attended by all CAMHD direct service workers including psychiatry, psychology, care coordinators, supervisors, family guidance center chiefs as well as contracted providers. The information on peer support services was timely as CAMHD has redefined the scope of the peer support (parent partner) role to align with national standards and enable future billing with Medicaid. With these new expectations CAMHD has seen an increase in utilization and effectiveness of this service.

This conference complimented CAMHD's 2015 summer conference that emphasized uniform care coordination workflows and interfacing with the Comprehensive Community Services program to better assist families with transition age youth.

Finally, CAMHD's ad hoc Family Engagement Committee, composed of staff, providers and parents finalized a Family Engagement policy that has subsequently resulted in the revision of forms and processes for the ease of families receiving mental health services. This is covered in greater detail under Goal 4.

Youth with Multiagency Involvement

CAMHD has been a leader in the development of the Hawaii Interagency State Youth Network of Care (HI-SYNC)—an interagency collaborative forum that brings together state-level leaders from child-serving agencies on a monthly basis. The consortium has developed a Memorandum of Agreement (MOA) articulating the interagency collaboration. In addition to the founding

members—Children’s Community Council (Dept. of Education), CAMHD and Early Intervention, new partners include Developmental Disabilities Division, Office of Youth Services, Judiciary, Child Welfare Services and the Alcohol and Drug Abuse Division. The Memorandum of Agreement is currently in the legal review stage of development. Each participating agency has committed to funding a meeting and project facilitator for the consortium.

Thus far, HI-SYNC has developed two deliverables. An interagency consent form was authored empowering parents to allow agencies to share pertinent information about their child on a single form. The second is the Hawaii Youth Interagency Performance Report (HYIPR), a collation of data from participating agencies on population, utilization, cost, and performance outcomes. For CAMHD specific data, see page 5 for number of registered youth, page 14 for services procured, page 22 for cost per level of care, and page 30 for discharge status. The full report is attached, and can also be found at:

<http://health.hawaii.gov/camhd/files/2015/06/HYIPR-Fiscal-Year-2015.pdf>

Project Laulima, CAMHD’s federally-funded program focused on better serving youth with co-occurring mental health needs and intellectual/developmental disabilities, developed and implemented a Multi-disciplinary Evaluation Team (“MET”) in 2016. The MET is a group of local highly-qualified professionals focused on providing comprehensive evaluation and consultation to children/youth with co-occurring MH/IDD and/or complex needs. MET members include professionals from multiple domains, representing several state agencies and community organizations such as the Department of Education, the Developmental Disabilities Division, the Child and Adolescent Mental Health Division, University of Hawaii - Psychology and Special Education Departments and Shriner’s Hospital. The specific disciplines include educational/behavioral psychology, child/adolescent psychiatry, developmental pediatrics, social work and pediatric neurology. HI-SYNC’s MOU supports the participation of state workers from child-serving agencies on the MET. The MET recently ‘teamed’ around a multi-agency youth with complex needs. The team conducted a comprehensive record review, home and school visits and developed a list of suggestions and recommendations for the youth’s treatment team. Project Laulima is currently receiving additional referrals for this pilot service.

Lastly, CAMHD is a key participant in the Child Welfare Service programs Safety, Permanency and Wellbeing (SPA) and Wraparound. These multiagency collaborations are aimed at establishing permanency for children where permanency has been a significant challenge.

Evidence-Based Specialty Programs

In 2015, CAMHD added a new, specialized service to its existing array. The service is called Comprehensive Behavioral Intervention (CBI) and is focused on serving youth with co-occurring mental health needs and intellectual/developmental disabilities. CBI is based on evidence-informed, therapeutic approaches to serving youth with intellectual/developmental disabilities. CAMHD initiated the contract for this statewide service through the procurement process. Almost sixty youth have been enrolled to date. Outcome data, coupled with qualitative data gathered from families, indicate that youth are benefitting from this specialized service.

Another new service, Parent Child Interaction Therapy (PCIT), now being provided at the Leeward Family Guidance Center, is a manualized evidence-based treatment for young children. In this innovative model, the therapist directs a parent, in real time via an ear piece, while the parent plays with their child. When indicated, Intensive In-Home therapists observe these sessions and continue coaching the parents in their homes.

CAMHD recently completed a federally funded project that developed specialized programming to meet the needs of girls exposed to significant trauma. Project Kealahou (PK) served more than 200 girls on Oahu over a six-year period, using evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TFCBT), youth peer supportive services and community integration efforts through cultural and recreational activities. The relationship-oriented practice used by PK support workers is a gender specific approach for girls with internalizing disorders, such as depression and anxiety. PK incorporated an extensive outcomes evaluation system which found robust positive results for the girls and their families in the program. CAMHD is sustaining this program, now as Kealahou Services, for girls on Oahu ages 11-18 years of age through their local Family Guidance Centers.

Finally, the use of data as clinical feedback has been well established as an evidence-based approach in treatment. While using feedback data for years, CAMHD has recently added the Ohio Scale to its repertoire. This scale, measures various domains of life (for example problem severity, hopefulness, restrictiveness of living) monthly from the youth's and parents' perspectives. The scale is graphed and can be used both clinically with the specific youth or aggregated for a statewide system perspective.

Transition-Age Youth With Mental Health Challenges

Several years ago, a law was passed allowing young people to stay in foster care up to 21 years of age. The Department of Human Services program, "Imua Kakou", provides foster payments beyond 18 years of age and additional funding for rent. This provision allows CAMHD to retain youth in our Transition Family Homes after age 18, increasing our capacity to serve the young adults. CAMHD has been working with MedQUEST Division and Quest Integration plans to further improve access to services for this transition age group.

Furthermore, CAMHD initiated the lowering of the age of consent for mental health services to 14 years of age for the rare instance when obtaining a parental consent poses a barrier to healthcare.

CAMHD System of Care

Due to changes in the youth serving system, CAMHD has seen an increase in the use of out-of-state residential treatment programs over the past 5 years from less than 1% to just above 1% of the total CAMHD enrolled youth. Such treatment pose a considerable disruption to the youth's life. In late 2016, CAMHD was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) grant targeting this population in an effort to keep youth near their families and communities. Other utilization review processes have been implemented which have already reduced the number of youth placed out-of-state.

As mentioned above, CAMHD has sustained the once SAMHSA funded Project Kealahou, with its new iteration, Kealahou Services. These services will continue to provide gender specific activities, evidence-based trauma treatment and promote a trauma-informed youth serving system as it has done in previous years.

In addition to providing specialized services, CAMHD's Project Laulima has coordinated and implemented several training programs and initiatives for the state's child-serving workforce. One such initiative has been the development of a multi-agency professional learning community ("PLC") comprised of fifty professionals from across the state who serve youth with co-occurring mental health needs and intellectual disabilities. The development of a PLC is an effort to increase the knowledge base of those who serve youth with developmental disabilities/mental health challenges, and develop a cross-system network of service providers. Participants in the PLC include CAMHD contracted providers including the Comprehensive Behavioral Intervention (CBI) providers, Hawaii Youth Correctional Facility Social Workers, UH Faculty, Developmental Disabilities Division staff, including Case Managers, Social Workers and Psychologists, and CAMHD Family Guidance Center staff.

Project Laulima has also contracted with the Center for START Services, national experts on co-occurring disorders, to provide web-based training resources to the PLC. Those in the "Mentorship" group of the PLC--twenty out of the fifty PLC participants--watch specific webinars each month and participate in group discussions, conducted via Zoom, with START facilitators. The other thirty participants of the PLC independently access all the training materials and meet quarterly to share information. The PLC's quarterly events include training sessions conducted by PLC participants/local experts. In May of 2017, two staff members from the Center for START Services will come to Hawaii to provide in-person training.

In addition, Project Laulima has also conducted cross-system training events, focused on cross-system collaboration, across the state. Dr. Jenny Wells, a professor within the Special Education Department of University of Hawaii, Manoa, facilitates the training and provides a training session on effective communication and collaboration strategies. During the training event, participants identify challenges to effective cross-system collaboration and problem-solve around system improvements.

The last point on system of care improvements is increasing access to CAMHD services through redesigned workflows, documentation and admission criteria. With the ongoing development of the electronic health record, processes are conducted more efficiently with greater level of oversight. Improved technology has and will result in greater uniformity across the state, greater data collection, further identification of systemic barriers and more effective implementation of improvements. By adjusting admission criteria for younger children, CAMHD has seen the average age of admission decrease resulting in an earlier mental health intervention in the child's life.

Youth at the Detention Facility

CAMHD's Family Court Liaison Branch (FCLB) staffs the detention facility with a full time psychologist and social worker, a weekly psychiatrist and psychology interns. All youth that enter the facility are screened for mental health needs and may receive further services when indicated. The FCLB regularly communicates with the community-based Family Guidance Centers to ensure continuity of care once the youth are released.

GOAL 2 PROMOTE BEHAVIORAL HEALTH INTEGRATION INTO PRIMARY HEALTH CARE

Major Accomplishments of the Past 2 Years

CAMHD continued its primary care integration pilot project in collaboration with the Hawaii Primary Care Association (HPCA) and John A. Burns School of Medicine (JABSOM) Department of Psychiatry (UH DOP). After an initial two years which were focused on planning and experimenting with different integration approaches and models, CAMHD recognized the various strengths and identified barriers and obstacles to behavioral health integration.

The project has now moved to a second phase, with a more clearly defined integration model developed from lessons learned in the more experimental initial developmental phase of the project. The initiative has now combined the once separate projects into a combined integration, leveraging the particular strengths and competencies of each organization-- emphasizing HPCA's administrative and managerial strengths and relationships with Federally Qualified Health Centers (FQHC) in terms of partnering, coordination, planning, and leveraging, and JABSOM Department of Psychiatry's strengths in clinical practice, training and education.

As part of this process, all parties contributed to a revamped project charter to clearly define roles, responsibilities and expectations for Phase 2. The primary project goal is to increase pediatrician capacity to care for mild to moderate behavioral health concerns effectively in the FQHC setting. To accomplish this goal, the integration project has worked to define standardized approaches to screening children for social/emotional and behavioral health needs during clinic visits. To assist FQHC's in the treatment and management of children who screen positive for behavioral health concerns, the project provides scheduled educational sessions on a variety of child behavioral health topics and direct phone access to child psychiatric consultants. In addition, new relationships have been forged between local FQHCS and CAMHD Family Guidance Centers (FGCs) facilitating improved referral and acceptance into CAMHD services for children with more significant behavioral health needs.

After an initial 2 years which were focused on planning and experimenting with different integration approaches and models, we recognized the various strengths and identified barriers and obstacles to integration.

One of the most prominent successes of the project has been linking the FGCs with the FQHCS within their catchment, and increasing the FQHC's understanding of CAMHD's role, the array of services we provide, our eligibility requirements, and the type of clients CAMHD serves. FQHCS

participating in the project report much greater understanding of CAMHD services and are better able to identify clients who meet CAMHD criteria. In addition, the FQHCs have increased their capacity to effectively refer and co-manage shared clients with CAMHD. Routine meetings between the FGCs with the FQHCs within the project have been very successful. The data also show an increase in number of shared clients.

However, there have also been areas of specific challenges, for example, setting up the psychiatric-pediatrician/physician-to-physician consultation line has been achieved with some ups and downs. Similar to other integration efforts across the country, there has not been high utilization of physician-to-physician consultation and it is an area CAMHD wants to explore and improve upon. However, if we take a broader view of touchpoints involving children with social/emotional and behavioral health needs, including communication and consultation around connecting children with treatment and support resources, the project has demonstrated success. A key outcome of the interactions between the FGCS and FQHCs has been an increase in connections with community resources such as Dept. of Education School-Based Behavioral Health and other community treatment resources for the moderate-to-low end, as well as high-end children. CAMHD will need to conceptualize and capture that data and its impact which is a potentially under-recognized benefit of this program.

Overall, the initiative has reached the quarterly goals of child behavioral health-focused education services customized to the FQHCs on topics of their interest. We're now attempting to integrate a case review platform—the Extension for Community Healthcare Outcomes (ECHO) project. There is potential for significant enhancement in the project's educational and training component.

Moving Forward

As for expanding the program, at this time we need to better define the model and work with the FQHCs to achieve more comprehensive and consistent screenings across the multiple sites. We also need to work with each FQHC to get participation from clinical leadership, the entire behavioral health department staff, and the child-providing providers—particularly pediatricians and family medicine practitioners, to be vested and involved.

After all three sites are consistently screening and accessing consultation, the next goal will be to better define the model beyond the FQHC calling a child psychiatrist, but also calling on the CAMHD FGCs as a systems resource and support.

Future project development consideration include getting leadership buy-in, advocacy in other areas, such as healthcare billing and payer reform to prioritize appropriate compensation for this type of screening and referral process. Additionally, it will be important to insure that the FQHCs have the space, time and margin for providers to perform this more complex work and do it comprehensively in spite of current barriers and limitations. The key barrier as to why the doctor peer-to-peer consultation hasn't happened with the success we envisioned is because there is literally no time in their schedules to do this. Primary Care Physicians are challenged even to find time to pick up the phone for 5 minutes in between clients. PCPs have a lot of

other competing interests and priorities – history to gather, physical health conditions to screen and assess for, that, fundamentally, there’s just no time. This lack of time permeates the entire clinic, with the other staff with just as many priorities and demands for their time.

Perhaps CAMHD could look for opportunities of ongoing childhood health initiatives and add in the social-emotional behavioral health component, rather than a stand-alone behavioral health project. We could see if that would lead to any differences in treatment fidelity, outcomes, and success. In the pediatric population, children with obesity and asthma/allergies would be at highest risk for socio-emotional factors contributing to their propensity to overeat and not exercise.

In the future, CAMHD might look at high-risk, high-yield conditions that EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) could identify at particular developmental and age ranges.

GOAL 3 PROMOTE MENTAL HEALTH CAPACITY AND SYSTEMS CHANGE IN THE JUVENILE JUSTICE SYSTEM

Early Diversion from the Juvenile Justice System

The Memorandum of Agreement (MOA) with the Office of Youth Services (OYS) funds CAMHD services for youth who would otherwise be ineligible for CAMHD services. For example, when a youth is not Medicaid eligible and Probation identifies a need that CAMHD deems medically necessary, the MOA allows for OYS to purchase the CAMHD service. The MOA diverts youth from an ineffective correctional system to an evidence-based therapeutic alternative.

While the state has been benefiting from Multisystemic Therapy (MST) for over a decade, the Big Island is now piloting a new workflow that reduces unnecessary care coordination, offers an alternative to correctional involvement and maximizes the utility of MST.

In conclusion, Hawaii is reducing the number of incarcerated youth, increasing interagency problem solving and increasing access of families to an ever growing array of services.

Therapeutic Environment at the Correctional Facility

The Hawaii Youth Correctional Facility (HYCF) started a Training Academy which trains its staff in best practices regarding juvenile justice involved youth. CAMHD provides the mental health component to this curriculum, teaching Motivational Interviewing, suicide prevention, adolescent development, traumatic stress and trauma-informed care. The clinical leadership at CAMHD’s Family Court Liaison Branch (FCLB) meets regularly with HYCF on matters of best practices and juvenile justice reform.

Youth at the Detention Facility

CAMHD’s FCLB staffs the detention facility with a full time psychologist and social worker and a weekly psychiatrist. Additionally, CAMHD’s internship in collaboration with the Western

Interstate Commission for Higher Education (WICHE) provides interns that provide therapeutic services and conduct psychological evaluations augmenting CAMHD's standard service array. Access has increased from serving referred youth only, to screening all youth that enter the facility, with subsequent services when indicated. The FCLB staff regularly communicate with the community-based Family Guidance Centers to ensure continuity of care once the youth are released.

Youth Transitioning from Youth Detention or Correctional Centers

CAMHD has long seen youth at the Judiciary's Home Maluhia shelter. Now CAMHD is piloting a brief intensive in-home therapeutic service, staffed through CAMHD's psychology internship program. The service extends from the shelter back to the home once the youth is released. The reparation of the familial relationship aims to reduce future displacement and stabilize the home environment.

Similarly, CAMHD has developed an aftercare service for youth discharged from Benchmark (treatment for adjudicated youth for a sexual offense) to support their transition back to their homes and communities.

Likewise for the Hawaii Youth Correctional Facility, CAMHD is partnering with the OYS's Wraparound program aimed at successfully transitioning youth back to their homes and communities upon release.

Finally, CAMHD meets every quarter with Family Court judges to discuss the intersection between mental health and the juvenile justice system to address and resolve system issues. CAMHD also participates in the Judiciary's cluster meetings to problem solve child specific matters.

Youth Impacted by Sex Assault and Human Trafficking

CAMHD participated in the Commercially Sexually Exploited Children (CSEC) Workgroup that established a protocol for responding to this population. Every agency--FBI, HPD, Judiciary, Child Welfare Services (CWS), Office of Youth Services (OYS) had their own protocols for sexually exploited youth. The protocols were then collated into a master protocol that guides how the agencies work together. Some agencies work on the front end of the protocol identifying victimized youth, while others, such as CAMHD, are then referred to for the treatment side of the protocol. Law enforcement may work on both identifying youth as well as pursuing those that exploit them. Additionally, CAMHD has offered statewide training to its Crisis Mobile Outreach providers on identifying exploited youth, continues to provide training on trauma-informed care and has developed a statewide provider system certified in Trauma-Focused Cognitive Behavior Therapy (CFCBT).

CAMHD has engaged in ongoing dialogue with the Office of Youth Services and Child Welfare on the further development of a therapeutic response for this special needs population including the option for a short term out-of-home placement and longer term family-based therapeutic homes.

GOAL 4 PROMOTE FAMILY SUPPORT FOR INDIVIDUALS WITH BEHAVIORAL HEALTH ISSUES AND THEIR FAMILIES

After several years of work within a committee that included CAMHD staff, Providers and Parents, CAMHD finalized a new Family Engagement policy that establishes a strengths-based approach to working with families. The purpose of the policy is to ensure that procedures are in place to facilitate family members' participation in the mental health care of their child and in the broader system of care.

The new policy states: "It is the policy of CAMHD to engage, welcome, support, inform and empower family members so that they can participate effectively in the mental health treatment of their child. CAMHD will provide families with information about evidence-based services and best practice guidelines to support decision-making about the treatment options available for their child. CAMHD seeks to include the family perspective in decision-making at all levels of its operations." The policy also re-affirms CAMHD's commitment to the Hawaii Child and Adolescent Service System Program (CASSP) Principles¹.

In order to assure the availability of robust peer support for families, and ensure parent input into CAMHD programs and policies, CAMHD developed a new Request for Proposals (RFP) for a Family Support Organization to provide Peer Support services to caregivers statewide in the Fall of 2015. The contract defines the new role of the Parent Partners as active members of the treatment teams. When cases arise that are more difficult and complex, the Parent Partners can be directed to work on those family situations. The provider of this new contract is Child & Family Service of Hawaii. Their Ohana Program provides Parent Partners in each of CAMHD's Family Guidance Centers and works to ensure that they are all certified by the National Federation of Families to provide Peer Support Services. CAMHD is working with MedQUEST Division to make it possible to obtain Medicaid reimbursement for these services. This should help assure the sustainability of these family supports.

GOAL 5 PROMOTE TECHNOLOGICAL ADVANCEMENT AND ADOPTION

Support Development, Workflow Changes, and Training

Over the past year, CAMHD's Healthcare System Management Office and Clinical Services Office have been developing new workflows, forms, and system operations processes. The essential foundations of this initiative are complete, and CAMHD is now coordinating details surrounding the gradual roll-out of these new processes and forms across the Family Guidance Centers, with the anticipated full release near the start of 2017. As part of this comprehensive CAMHD-wide business process reengineering (BPR) initiative, new versions of forms are now under revision for release and full implementation. Central to this is ending the use of old and

¹ Developed by the Hawaii Task Force, 1993. (Adapted from Stroul, Beth A. and Robert M. Friedman, R.M. (1986) A System of Care for Children & Youth with Severe Emotional Disturbances. (Revised Edition) Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.)

duplicative paper forms, and moving to electronic form versions in line with the Governor's paperless initiative. This streamlines care system operations and business processes. CAMHD has expended great efforts in unifying and standardizing the incoming information from all the Family Guidance Centers. There is now an ongoing campaign to train all Family Guidance Center and provider staff on the new simplified processes and forms.

In alignment with the CAMHD BPR initiative, CAMHD is now in the middle of planning the design, development and implementation of a new electronic health record and case management Information Technology (IT) system. This IT project is in close coordination with Dept. of Health (DOH) Developmental Disabilities Division and Dept. of Human Services (DHS) MedQUEST Division, to serve the needs of customers in both DOH Divisions, and provide information to DOH leadership and MedQUEST. The project's enterprise goals are to improve youth outcomes and care system effectiveness through secure information sharing on shared cases and through time-sensitive reporting feedback on service trends. The IT systems planning work is underway with a planning consultant, to develop the system design, requirements, and federal matching funds specifications. The new streamlined CAMHD business processes and forms are to be incorporated into one IT system handling all youth and family case management, therapeutic services, quality management, and clinical and administrative oversight functions.

Central among the system implementation goals is the core planning aspect of managing and sharing information to tightly link CAMHD youth cases with matching records in the systems of other state programs. This is focused first on DOH programs and DHS MedQUEST, with others such as DHS Child Welfare, DHS Office of Youth Services, Judiciary, and Dept. of Education potentially envisioned to follow. This is to ensure access to care and effective state health and social services, by securely communicating cross-program information for those treating youth and families. These additional linkages to services are anticipated to require significant additional effort and collaboration across programs and agencies over future years.

Electronic Clinical Quality Measurement & Evidence-Based Decision Support Tools

As a program goal, CAMHD seeks to empower team members at all levels to engage in care management and review of treatment progress, via rapid-cycles of information feedback and reporting. In alignment with the development of new workflows, forms, and their implementation in a new IT system, CAMHD is identifying metrics across multiple program areas for feedback on youth progress, services, billing and auditing, program monitoring, and clinical oversight functions. CAMHD's overarching goal, planned in the reorganization, is to ensure the capture of the right information, at the right time, to track care progress and outcomes, for clinical decision support.

This aims to produce more expedient care for each and every served youth in rapid cycles of Continuous Quality Improvement (CQI) across multiple sections of CAMHD. Through the CQI process, CAMHD will have the ability to regularly review, make decisions, and update metrics on all aspects of services. In doing so, this builds an evidence base of data for program changes targeted at more effective and efficient care. This is a shift from CAMHD monitoring data for all

youth based on the aggregate, to a future look at how one specific youth compared last week to their peer in a service. For example this may include: how long a youth remains in a level of care (“length of stay”), the time it takes to get access to care services, metrics on care coordination and the “warm hand-off” to QUEST health plans when ending CAMHD care, and monthly quality metrics on the performance of CAMHD providers.

The new quality operational model and IT system is designed to assist staff and providers through multiple dashboards and reports for clinical and administrative decision-making. The tailored dashboards are to be accessible by CAMHD Care Coordinators, Quality Assurance Specialists, Mental Health Supervisors, Clinical Leads, Family Guidance Center Chiefs, Billers, Management, and Providers. CAMHD Providers are to see their own scorecards, and care teams will be empowered to track how individual clients progress over time. The core theme is assembling different pieces of disparate information from different sources into one picture for more effective care decisions.

Comprehensive Automated Billing & Review System

CAMHD is committed to maximizing Medicaid reimbursement, through billing reviews and intensive regular coordination with MedQUEST on rate planning details. CAMHD’s IT system plan is to produce combined billing and services data reports for recent months, instead of the limited 6 to 12 month delayed trend data available to staff now. Our goal is to ensure people see the data sooner, and gain insights into ongoing services faster, ensuring claims metrics track therapies provided, and youth, in turn, get the greatest value for every appropriate service delivered.

Hawai`i Youth Interagency Performance Report



Produced by the State of Hawai`i:

Department of Health

Child and Adolescent Mental Health Division
Family Health Services Division (Early Intervention)
Developmental Disabilities Division

Department of Education

School Based Behavioral Health
Special Education

Department of Human Services

Child Welfare Services

Hawai`i State Judiciary

Family Court

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Introduction

The Hawai'i Interagency State Youth Network of Care (HI-SYNC) is happy to present the third annual Hawai'i Youth Interagency Performance Report (HYIPR) as part of the collaborative efforts of Hawai'i's child-serving state agencies.

This report was assembled with information from the Department of Health's, Child and Adolescent Mental Health Division (CAMHD), Family Health Services Division, Early Intervention Section (EI) & Developmental Disabilities Division (DDD), the Department of Education's School Based Behavioral Health (SBBH) and Special Education (SpEd) Services, the Department of Human Services' (DHS) Child Welfare Services (CWS) and the Hawai'i State Judiciary's Family Court. The HYIPR presents data reflecting each Department/Division/Section population, utilization, cost, and performance outcomes for Fiscal Year 2015.

Report Structure

For each of the departments/divisions/sections participating in this report, the following questions are addressed:

1. What does this measure/indicator describe?
2. What does the included graph/table tell us about this measure/indicator?
3. In 'dashboard' terminology, is this measure/indicator in "On Track," "Warrants Monitoring," or "Needs Work" mode?
4. If the measure/indicator "Warrants Monitoring" or "Needs Work," what will be done to move it toward being "On Track"?

Performance Indicator Key:

- = On Track
- ▼ = Warrants Monitoring
- = Needs Work

Each department/division participating in the HYIPR used the most recent data they have available (e.g., tables, charts, and graphs) including a brief narrative explanation of the figure included.

To conclude the report, each division/department included a brief summary that addresses efforts underway to increase interagency collaboration and address issues presented in the data. The HYIPR is meant to evolve as new data sets become available or are identified as useful. All contributors to this report will work to develop data sets that are more in-tune with the readers' feedback.

Data Utilization

The data contained in this report are meant to prompt interagency discussions about system barriers and future system improvements. Information gained from the review of the data will be presented to the public in order to provide transparency and allow for input from the community.

Who Are We?

HAWAII DEPARTMENT OF HEALTH

The Child and Adolescent Mental Health Division (CAMHD) provides mental health services to eligible youth ages three (3) through twenty (20) who have a qualifying diagnosis and severe functional impairment. The CAMHD provides an array of culturally sensitive, child and family centered services including assessment, case management, intensive home and community based therapeutic supports, and temporary out-of-home therapeutic programs.

For more information about the CAMHD, visit www.health.hawaii.gov/camhd or call 733-9333.

The Family Health Services Division, Early Intervention Section (EIS) provides services for children from birth to three years of age with special needs. Early Interventionists assist children in the following five developmental areas: Communication (talking, understanding), Cognitive (paying attention, solving problems), Physical (sitting, walking, picking up small objects), Social or Emotional (playing with others, having confidence), Adaptive (eating, dressing self).

For more information about EIS, visit www.health.hawaii.gov/eis or call 594-0000.

The Developmental Disabilities Division (DDD) provides supports and services for persons with intellectual and/or developmental disabilities, which includes principles of self-determination and incorporates individualized funding, person-centered planning, and services provided in homes and in the community. DDD services are provided primarily through the Medicaid 1915(c) Home and Community Based Services Waiver.

For more information about DDD, visit www.health.hawaii.gov/ddd or call 586-5842.

DEPARTMENT OF EDUCATION

School Based Behavioral Health (SBBH) provides evidence-based mental and behavioral health interventions to students with the most challenging mental and behavioral health concerns when it impacts their learning or the learning of others.

For more information about SBBH services, visit <http://www.hawaiipublicschools.org/> or call 808-305-9787.

Special Education (SpEd) is specially designed instruction and related services to meet the unique needs of eligible students with disabilities under the IDEA/Chapter 60. Services include academic services, speech-language services, psychological services, physical and occupational therapy, and counseling services. The Department provides these services at no cost to families to students aged 3 to 22 who demonstrate a need for specially designed instruction.

For more information about Special Education, visit <http://www.hawaiipublicschools.org/> or call 808-305-9806.

DEPARTMENT OF HUMAN SERVICES

The Child Welfare Services Branch (CWSB) provides services to children and their families when the children are reported to have been abused and/or neglected, or to be at risk for abuse and/or neglect. These services include child protection, family support, foster care, adoption, independent living, and licensing of resource family homes, group homes, and child placement organizations.

For more information about CWSB, visit <http://humanservices.hawaii.gov/ssd/home/child-welfare-services/> or call 855-643-1643.

HAWAII STATE JUDICIARY

Family Court (FC) "The Family Courts were established by statute in 1965 to hear all legal matters involving children, such as delinquency, waiver, status offenses, abuse and neglect, termination of parental rights, adoption, guardianship and detention. The Family Court also hears traditional domestic relations cases, including divorce, nonsupport, paternity, uniform child custody jurisdiction cases, and miscellaneous custody matters." (The Judiciary, State of Hawai'i, 2015 Annual Report).

For more information about Family Court, visit <http://www.courts.state.hi.us/> or call (808)954-8000.

Population

Who Do We Serve?

Registered/Served/Enrolled Children and Youth

Who Do We Serve? Registered/Served/Enrolled Children and Youth

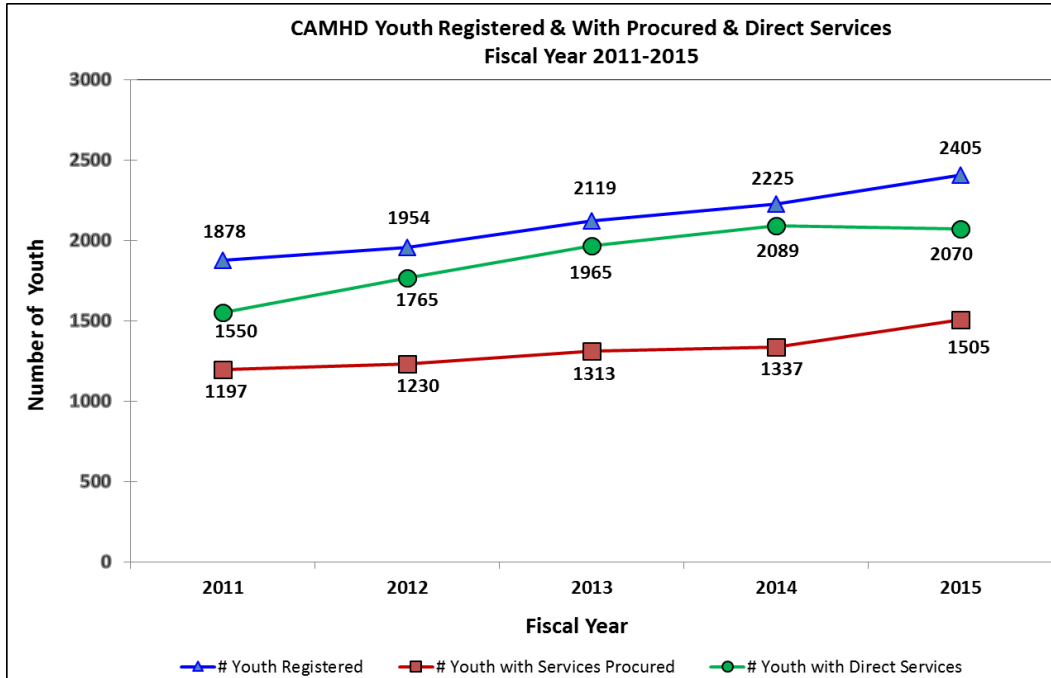
Child and Adolescent Mental Health Division (CAMHD)

What does this measure/indicator describe?

Number of Youth with Services Procured: The chart below shows the number of youth who were: a) registered and b) youth who received direct or c) contracted services at least one day during the reporting period over the past five (5) fiscal years. These are unduplicated counts within each category, but registered youth may receive both direct and contracted services.

Performance Indicator

● = On Track



What does the included graph/table tell us about this measure/indicator?

In FY2015, the CAMHD had 2,405 youth registered and 2,070 (86.1%) of these youth were provided services through CAMHD staff (case management, assessments, etc.). Also, 1,505 youth received services through the various providers (services procured) with which the CAMHD contracts. The number of youth registered and the number of youth receiving procured services has been increasing steadily since 2011 (28.6% increase from FY2011 to FY2015).

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

The CAMHD is “On Track” according to this measure because the number of youth registered to CAMHD and receiving services continues to increase and to better meet mental health needs in the state. CAMHD also continues to increase the number of youth who receive procured services, despite a slight ‘leveling off’ over the past year.

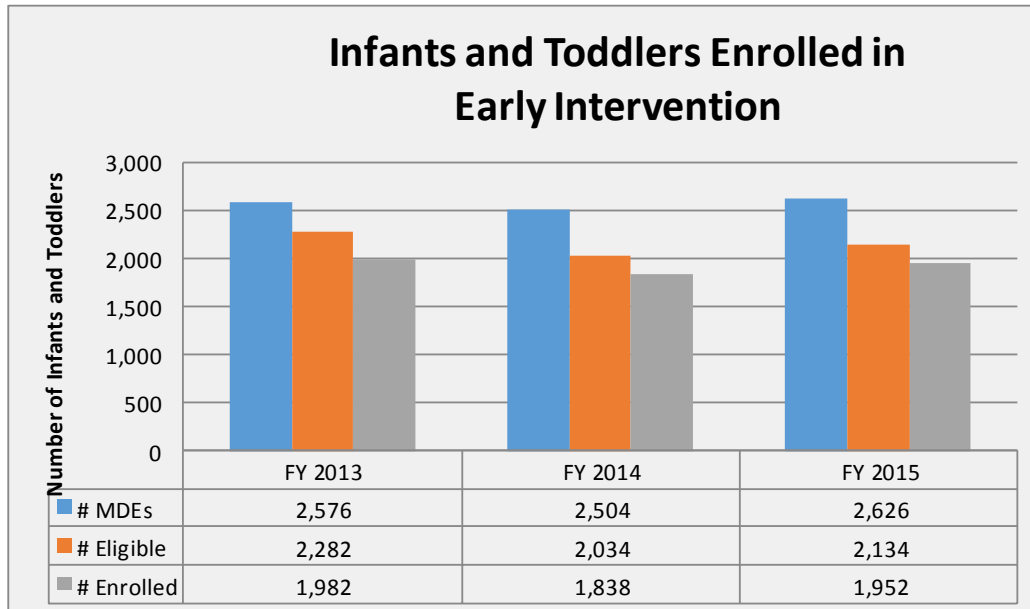
Early Intervention (EI)

What does this measure/indicator describe?

Number of Infants and Toddlers enrolled in Early Intervention (EI): This measure looks at the number of children referred to an Early Intervention Program who had an initial Multidisciplinary Developmental Evaluation (MDE) during the specified year and an Initial Individualized Family Support Plan (IFSP) developed during the specified year.

Performance Indicator

▼ = Warrants Monitoring



***NOTE:** previous numbers revised based on corrected reports generated from database

What does the included graph/table tell us about this measure/indicator?

In FY 2015, the Early Intervention Programs completed 2,626 initial multidisciplinary developmental evaluations (MDEs) and of those evaluated, 2,134 (81%) infants and toddlers met the Hawai'i Part C Early Intervention eligibility criteria. Of those determined eligible, 1,952 (91%) infants and toddlers were enrolled.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

Although the number of infants and toddlers enrolled increased, the percentage of children determined to be eligible (81%) remained the same for FY 2013 and FY 2014. However, the number of children enrolled (91%) in FY 2015 increased slightly from FY 2014 (90%).

**Developmental
Disabilities
Division
(DDD)**

What does this measure/indicator describe?

Background: Hawai`i was the first state to include concepts of self-determination and a planning process that focuses on the individual with an intellectual or developmental disability (I/DD) in its statutes. In just over a decade, Hawai`i moved from laying a foundation for deinstitutionalization to clearly mandating a system of services in the community that is person-centered and ensures self-determination. In 1999, Hawai`i became the ninth state to completely shut down its publicly-operated institutions for individuals with an I/DD. DDD maximizes its funds for community services as state matching funds through the Medicaid 1915(c) Home and Community Based Services (HCBS) Waiver. DDD now provides the majority of its services through the HCBS Waiver through an array of services provided statewide and case-managed by State employees. Besides services provided by community providers, DOH is also mandated to identify funds to “allow consumers to direct the expenditure of the identified funds” to provide for consumer-directed services.

Number of Youth (age 0 to 21): Figure 1 below shows the unduplicated number of youth by age groups registered in the HCBS Waiver over the past five fiscal years (FY 2011- 2015). (Data Source: Waiver Client Listing)

Performance

Indicator

▼ = Warrants
Monitoring

Figure 1.

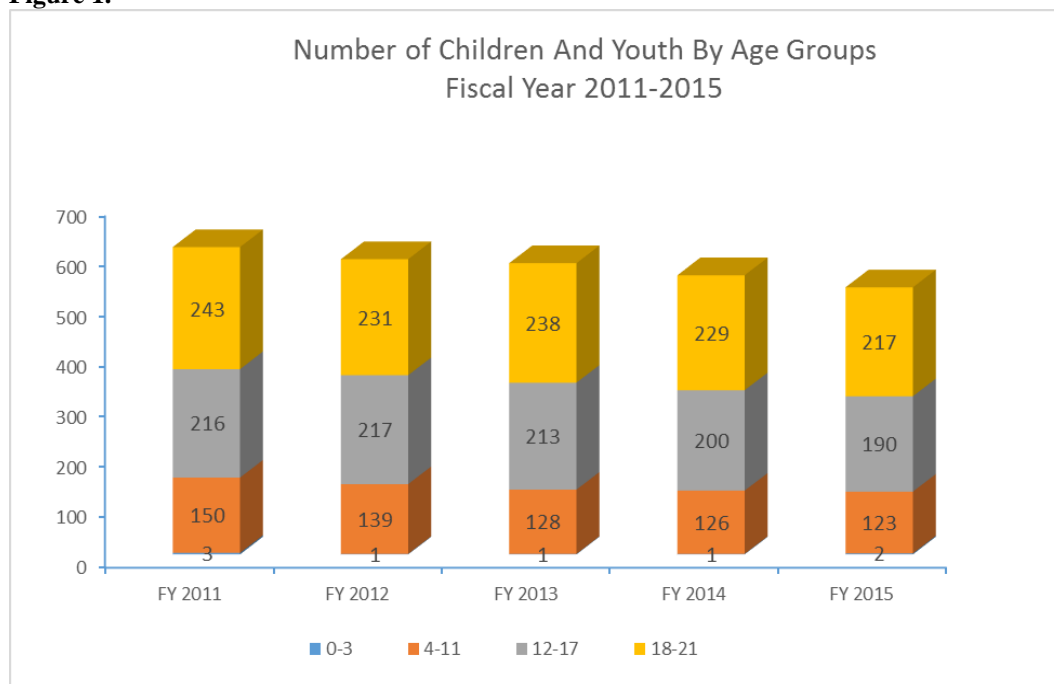
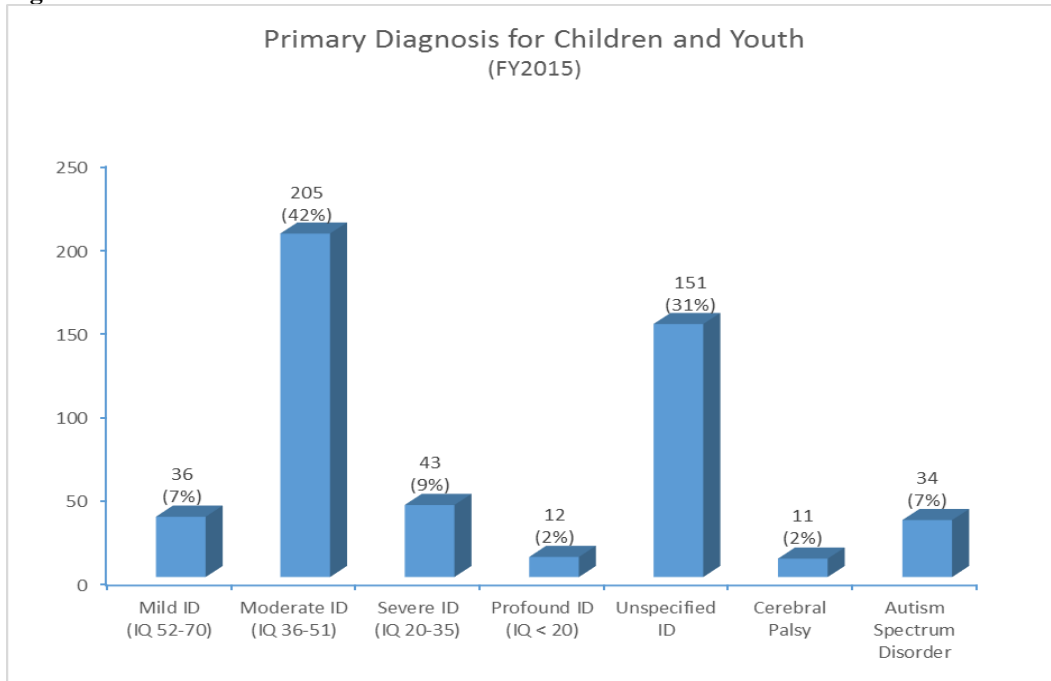


Figure 2 presents the primary diagnosis for children and youth receiving HCBS Waiver services during Fiscal Year 2015.

Figure 2.



What does the included graph/table tell us about this measure/indicator?

There is decreasing trend in the numbers of children served across all age groups.

About 42% of children and youth had a primary diagnosis of moderate Intellectual Disability (ID) as the primary diagnosis. Overall, 92% of children had a diagnosis of intellectual disability. Children with moderate to profound intellectual disabilities typically need considerable supports in school and at home. They often develop cognitively and learn at a significantly slower rate and to a lower level than other children their age. These children have significant deficits in their cognitive skills, their ability to think and reason, as well as their skills of independence, socialization and language, compared with other children their age.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

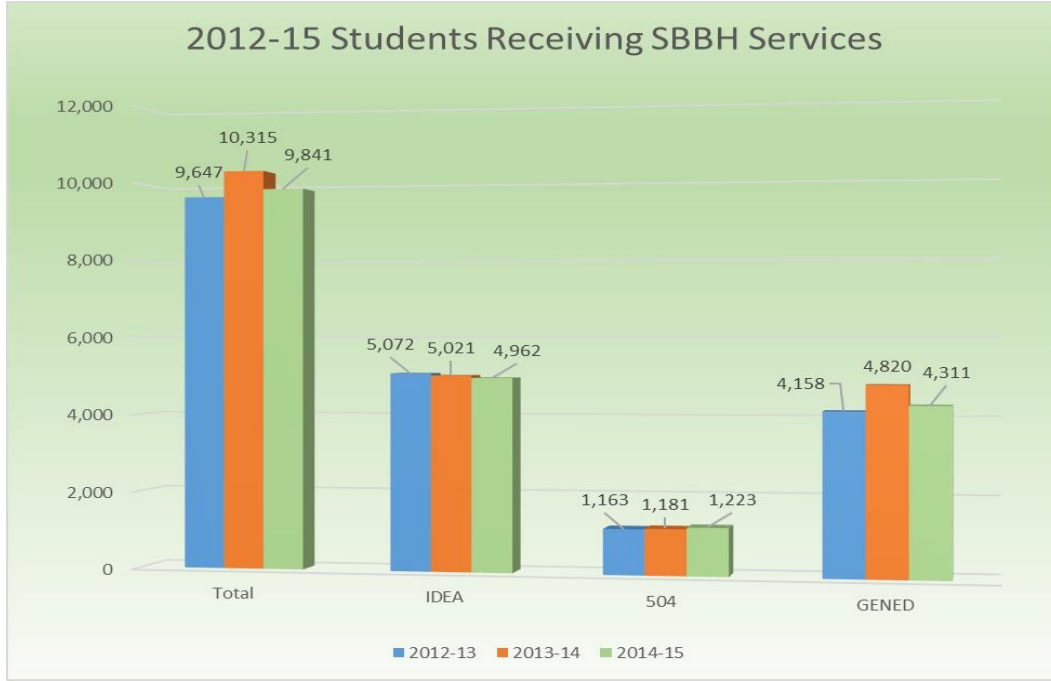
These data are largely descriptive, however the trend of fewer children being served across age groups needs to be monitored in order to ensure access to services for eligible children.

What does this measure/indicator describe?

This indicator describes the number of DOE enrolled students receiving School-Based Behavioral Health (SBBH) services between the school years 2012-2015. Each student name is counted one time, though some receive more than one type of SBBH service in the school setting.

**Performance
Indicator**

▼ = Warrants
Monitoring



What does the included graph/table tell us about this measure/indicator?

Data for School Years (SY) 2012-13, 2013-14, and 2014-15 are presented related to the provision of counseling and all other SBBH services. SBBH provides services to students identified as having needs under the Individuals with Disabilities Education Act (IDEA), under Section 504, as well as those selected members of the General Education (GENED) student population for assistance with less intense needs. The data provides the number of students receiving services at any time during the respective school years for those criteria. During 2014-15, 9,841 different students received Counseling or other SBBH services within the DOE. “Total” refers to all students identified under IDEA, Section 504, or as a GENED student.

IDEA is a federal law that ensures that students who require specially designed instruction to meet their unique learning needs due to a qualifying disability (e.g., Specific Learning Disability, Emotional Disability, etc.) are given an Individualized Education Program (IEP) and related service, if needed, to benefit from special education as appropriate. SBBH counseling can be considered one of those related services. During 2014-15, a total of 4,962 students identified as IDEA received Counseling or other SBBH services within the DOE.

Section 504 of the Rehabilitation act of 1973 is a federal civil rights law that protects students with a disability from discrimination, as well as ensures the same equal opportunity and access to educational opportunities to qualified students as are provided to students without disabilities; identified needs must substantially limit a major life activity and impact a student’s education. Section 504 requires

that students with disabilities are provided appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met; SBBH counseling could be considered a supplementary service and may be listed on their Modification Plan (MP). During 2014-15, a total of 1,223 students identified as IDEA received Counseling or other SBBH services within the DOE.

SBBH services may also be provided to GENED students that are neither identified under IDEA or Section 504. Services may be provided to GENED students to reduce barriers to learning and therefore enhance their educational effectiveness. During 2014-15, a total of 4,311 students identified as IDEA received Counseling or other SBBH services within the DOE.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

The SBBH goal to serve 10,000 students annually was approached in 2014-15. SBBH services to 9,841 unique students involves 5.4% of the total student enrollment.

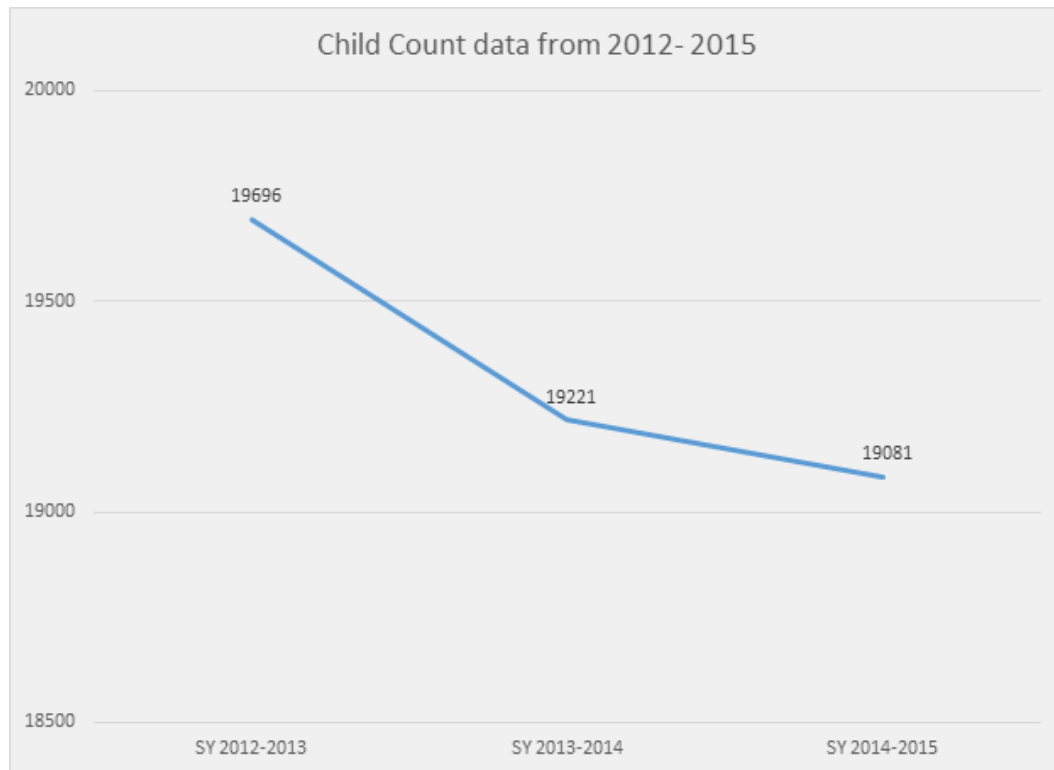
*Department of
Education-
Special
Education
(SpEd)*

What does this measure/indicator describe?

This measure provides the number of students, ages 3 through 21, found eligible to receive special education services based on the requirements in the Individuals with Disabilities Education Act (IDEA). The source of the data is the annual official Child Count taken on December 1 of each year.

**Performance
Indicator**

● = On Track



What does the included graph/table tell us about this measure/indicator?

The data indicates that the total number of students with disabilities in the HIDOE has decreased over the last two years.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

Data for School Years (SY) 2012-13, 2013-14 and 2014-15 are presented. The decrease in the total number of students with disabilities could be attributed to the decline of the total population of students within the HIDOE as well as improved screening methods, interventions, and supports in the general education classroom.

*Department of
Human
Services
(DHS-CWSB)*

What does this measure/indicator describe?

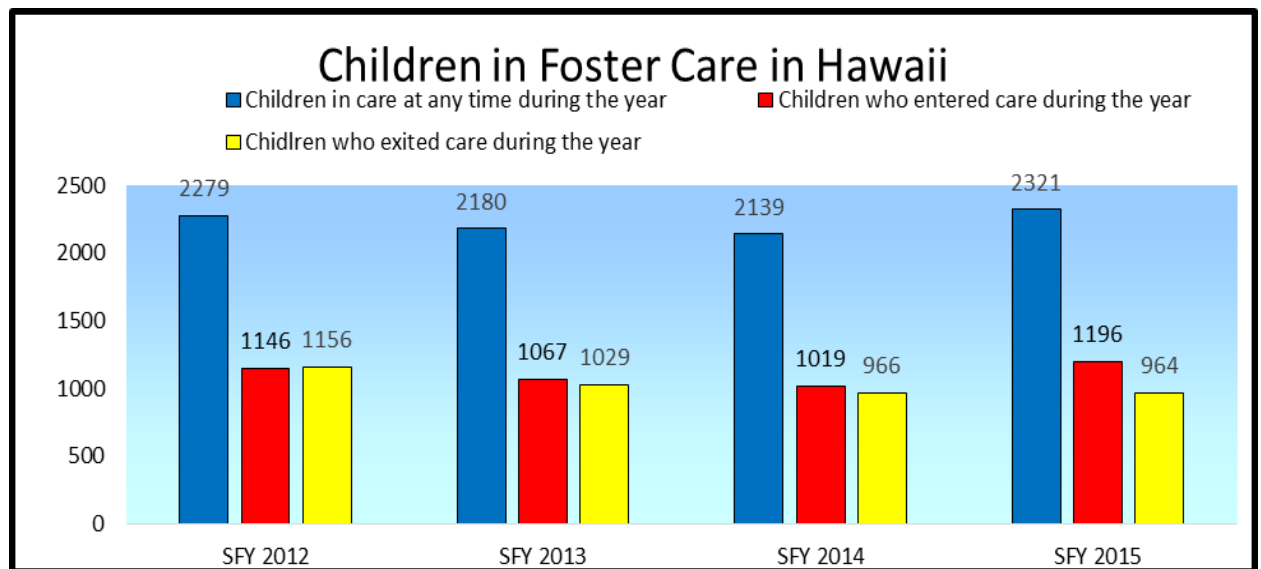
Number of Children in Foster Care. This chart shows the numbers of youth in foster care from State Fiscal Year (SFY) 2012 through SFY 2015.

Data source: DHS, Management Services Office; Annual Progress and Services Report (APSR) 2016

*Please note: The numbers here are unduplicated (each child is only counted once per year).

**Performance
Indicator**

▼ = Warrants
Monitoring



What does the included graph/table tell us about this measure/indicator?

This graph shows a slight increase in the number of children in foster care from SFY 2012 to SFY 2015. Given the 40% reduction in the number of children in foster care in Hawai'i over the past decade, the DHS realized that without significant innovation, it would be unlikely that foster care numbers would continue to decline. In collaboration with Casey Family Programs, the Child Welfare Services Branch (CWSB) Administrative staff examined its practice and has recently begun implementation of a Title IV-E Waiver Demonstration Project.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

CWSB is in the first year of implementing four Title IV-E Waiver Demonstration Project initiatives on Oahu and Hawai'i Island to further safely reduce the number of children in foster care as well as time spent in foster care.

Children who are likely to be in foster care for 30 days or less are the focus of two of the Title IV-E Waiver Demonstration innovations: Crisis Response Team (CRT) and Intensive Home-Based Services (IHBS). Hawai'i is optimistic that the number of children in foster care in Hawai'i will be further reduced when the CWSB is better able to: (1) assess children at the time of potential police booking (CRT), and (2) provide immediate intensive services in the home (IHBS). The belief is that a high percentage of children who are in foster care for one month or less would not need to come into care with the proper upfront services.

Safety, Permanency, and Wellbeing meeting (SPAW) and Family Wrap Hawai'i are two strategies that the CWSB expects to decrease time in foster care, and increase permanency for children in foster care 9 months or longer.

Service Utilization

How Are Children/Youth Using Services?

Utilization of Services

How Are Children/Youth Using Services? *Utilization of Services*

*Child and
Adolescent
Mental Health
Division
(CAMHD)*

What does this measure/indicator describe?

Utilization of Services by Level of Care: The table below shows the number of youth with procured services within each of the five broad categories of care in the most recently completed fiscal year (FY15). It is unduplicated within levels of care but can be duplicated across levels of care. For example, some youth may have received two different types of ‘Intensive Home & Community’ services during the reporting period but were only counted once within ‘Intensive Home & Community.’ However, they could be counted again in another category such as ‘Out-of-Home.’

**Performance
Indicator**

● = On Track

Services Procured	Total N	% of Youth with Procured Services
Out-of-Home (Includes Out-of-State, Hospital-Based Residential, Community-Based Residential, & Transitional Family Home)	360	23.9%
Intensive Home & Community (Includes Partial Hospitalization, Multi-Systemic Therapy, & Intensive In-Home Therapy)	1,156	76.8%
Outpatient (Includes Functional Family Therapy, Outpatient Therapy, & Assessments)	339	22.5%
Supportive Services (Includes Respite Home & Ancillary Services)	182	12.1%
Crisis Stabilization (Therapeutic Crisis Home)	37	2.5%

What does the included graph/table tell us about this measure/indicator?

This table shows the number of youth who received services in each category and the proportions by types of services procured (levels of care) in the past fiscal year (FY15). The CAMHD has served over three-quarters of its youth using the ‘Intensive Home & Community’ level of care and more than one-fifth using ‘Outpatient’ services. Approximately one quarter of the youth were served in therapeutic out-of-home placements at some time during the fiscal year. These percentages are similar to the proportions of youth served in the various settings in the past.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

Since efforts are made to serve youth while still in their homes and with their families, this proportion aligns well with the CAMHD philosophy of using “least restrictive services” whenever appropriate. The lower proportion (23.9%) of cases of youth using out-of-home services also aligns appropriately with the CAMHD philosophy. The most restrictive treatment alternative should be the treatment option reserved for those youth who, for various reasons, cannot be served in the home.

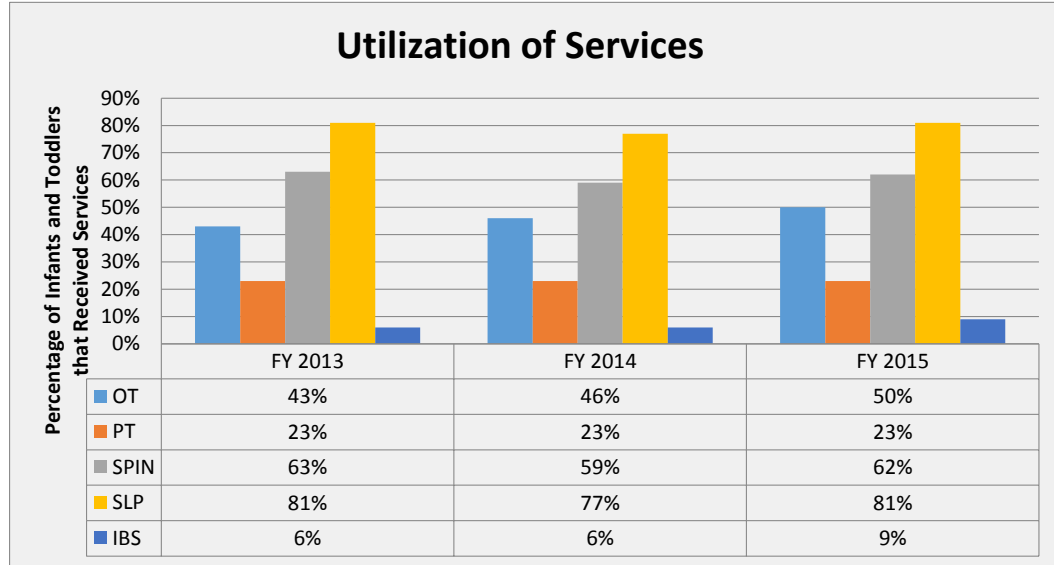
Early Intervention (EI)

What does this measure/indicator describe?

Utilization of Services: This measure indicates the percentage of eligible infants and toddlers that received core services provided by EI Programs as well as Intensive Behavioral Support (IBS) services. It is an unduplicated count within each service and does not include multidisciplinary developmental evaluations.

Performance Indicator

▼ = Warrants Monitoring



OT = Occupational Therapy
PT = Physical Therapy
SPIN = Special Instruction
SLP = Speech Language Pathology
IBS = Intensive Behavioral Services

Services	# of Infants and Toddlers that Received Service in FY 2015	# of Infants and Toddlers with Active IFSP in FY 2015	Percentage
OT	1,803	3,587	50%
PT	808	3,587	23%
SPIN	2,218	3,587	62%
SLP	2,891	3,587	81%
IBS	307	3,587	9%

What does the included graph/table tell us about this measure/indicator?

Eligible infants and toddlers received an array of services. The majority of eligible infants and toddlers received SLP services. All services increased with the exception of PT services that remained the same.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

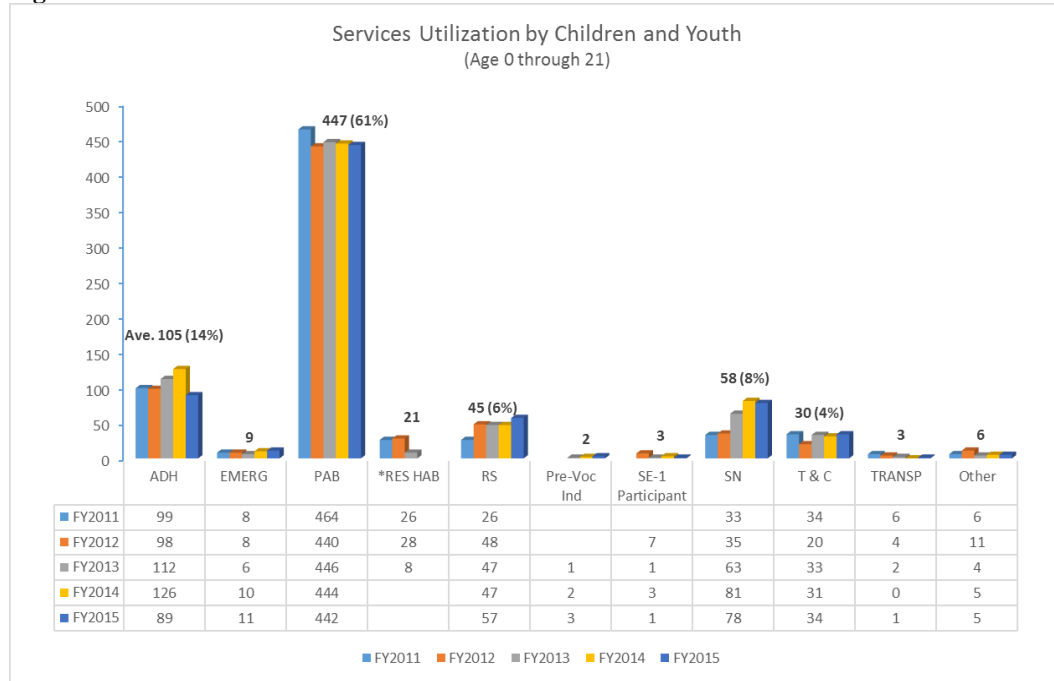
Services received will continue to be tracked so further analysis can be completed.

What does this measure/indicator describe?

Utilization of Services by youth: The figure below indicates the number of Children and Youth through the age of 21 who received various community provider services in fiscal year 2011 to 2015.

**Performance
Indicator**
▼ = Warrants
Monitoring

Figure 2.



*RES HEB was discontinued in the Waiver in FY2012 and services converted to PAB at that point. DDD is proposing to bring back RES HAB through the new Waiver application being submitted to CMS in March 2016.

PAB = Personal Assistance/Habilitation - supports a person to be active in their community or to live in their home.

ADH = Adult Day Health - allows the individual to learn skills, socialize with others and participate in community activities.

RES HEB = Residential Habilitation – individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community.

SN = Skilled Nursing

RS = Respite - provides personnel to care for or provide supervision over an individual with an intellectual or developmental disability for short periods of time, which permits family members caring for a person with I/DD to get needed rest and recreation as to not get “burnt out”.

T and C = Training and Consultation

EMERG = Emergency Outreach and Emergency Shelter

Pre-Voc = Pre-Vocational Activities - prepares a participant for paid employment.

SE = Supported Employments – are targeted toward working with employers to design and develop jobs as well as working with them to train participants for competitive employment in an integrated setting.

What does the included graph/table tell us about this measure/indicator?

Personal Assistance/Habilitation (PAB) was the most utilized service for children and youth, accounting for about 61% of services used. PAB supports a person to be active in their community or to live in their home. ADH was the second highest utilized service, accounting for about 14% of service utilization by children and youth. ADH is selected only if a person is out of school. The utilization of each of the remaining services was minimal, each accounting for 8% or less of services utilized.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

Over the five years, the trend was very stable. PAB was the most utilized service, followed by ADH. As the system moves more into ensuring community integration, we would like to see less use of ADH for youth transitioning out of school, and more use of employment supports and services that promote a full life in the community. Youth used very little pre-vocational and supported employment, which indicates a need for improvement. DDD is actively working on improving employment outcomes.

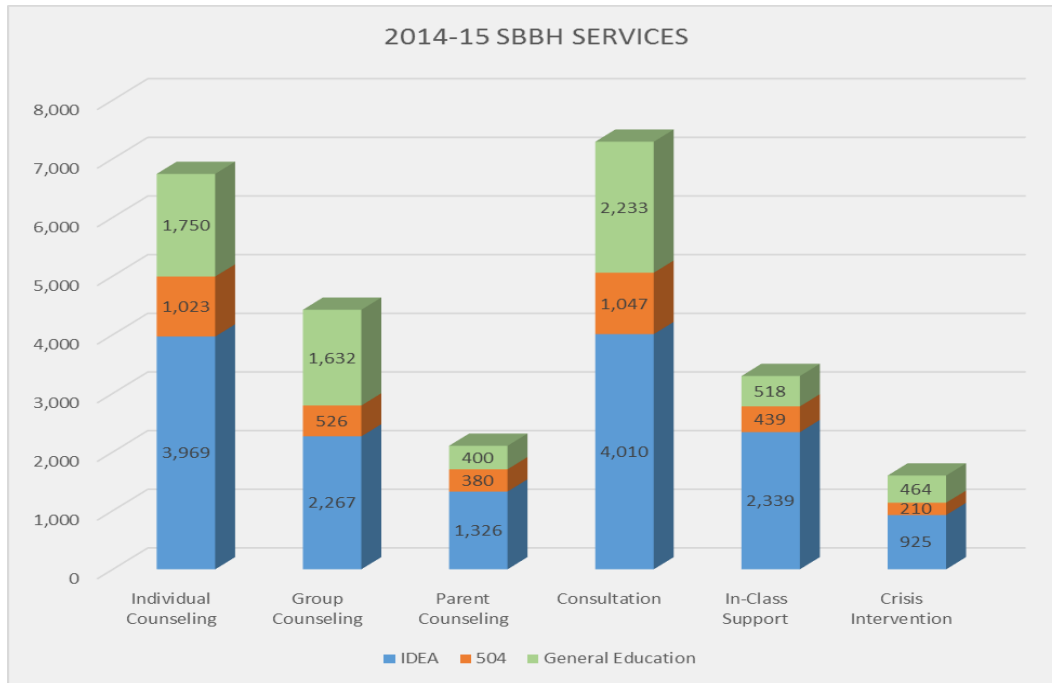
Department of Education (DOE-SBBH)

What does this measure/indicator describe?

The graph below presents a breakdown of the main types of School-Based Behavioral Health (SBBH) services received by students in School Year (SY) 2014-15. This includes types of counseling, consultation, in-class supports, and crisis intervention.

Performance Indicator

● = On Track



What does the included graph/table tell us about this measure/indicator?

SBBH services respond to a variety of needs as manifested in the individual student, and may be delivered through Individual, Group, or Parent Counseling; Consultation (to Teachers, Administrators, Parents, School Staff, etc.), In-Class support, or Crisis Intervention. The numbers reported represent the total services provided to students by type during the school year of July 2014 through June 2015.

Students are not counted more than once for any such service. Note that the service totals by student are aggregated according to whether their status is an IDEA, 504, or General Education student. This report is expected to serve as a baseline for comparison in future years.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

The distribution of services among IDEA, 504, GENED, and the service types is appropriate.

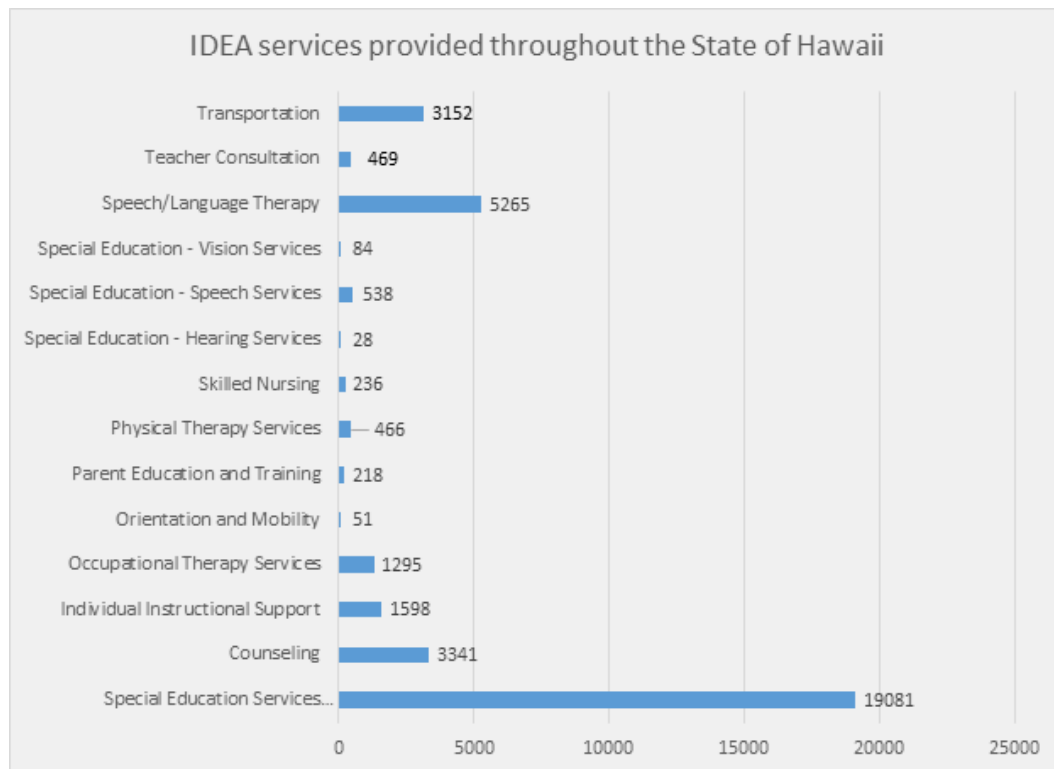
*Department of
Education-
Special
Education
(SpEd)*

What does this measure/indicator describe?

The graph below illustrates the special education and related services offered to special education students within the HIDOE. The total number of special education students receiving services is 19,081 in SY 2014-2015. However, a student could receive multiple services based on needs documented in the Individual Education Program (IEP).

**Performance
Indicator**

● = On Track



What does the included graph/table tell us about this measure/indicator?

Special education and related services are provided by trained HIDOE and contracted personnel, including but not limited to speech/language therapy, physical therapy, occupational therapy, individual instructional support, counseling and specially designed instruction. All students with disabilities under the IDEA receive specially designed instruction. The most common related services provided are transportation, speech/language services and counseling. The least common services provided are vision, hearing and orientation and mobility services.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

Per IDEA, all services are being provided as documented in the Individual Education Program of each student found eligible for special education and related services.

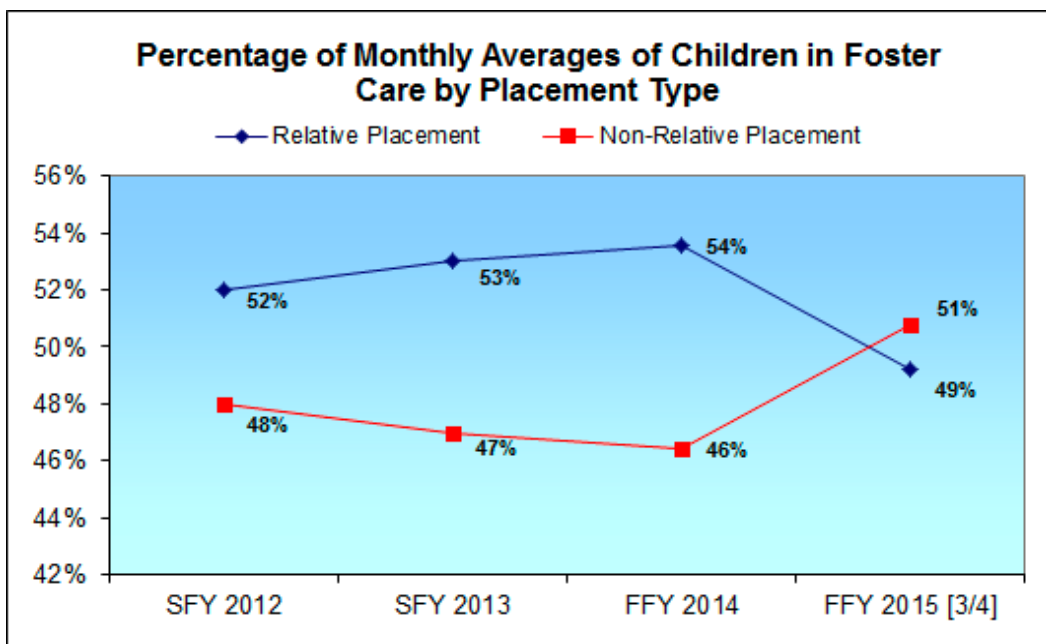
*Department of
Human
Services
(DHS-CWS)*

What does this measure/indicator describe?

This chart represents the monthly average in percentage of foster placement type (either with relatives or with non-relatives). The chart below does not account for all children in foster care, as there are some youth who are in other placements, such as hospitals, emergency shelters, residential drug treatment programs, and residential mental health treatment programs. The youth in placements other than relative and non-relative care account for approximately 5% - 13% of all of the youth in foster care each year. Many of these youth are served by the Child and Adolescent Mental Health Division.

**Performance
Indicator**

● = On Track



What does the included graph/table tell us about this measure/indicator?

The percentage of youth placed with relatives has slightly decreased over the past year.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

Hawai'i has generally done well with relative placements, which can be partially attributed to the cultural values of *'ohana* (family) and *hanai* (similar to fostering, a type of informal adoption). Other factors contributing to this high relative placement rate are the automatic referral for family finding when a child enters foster care, and the State of Hawai'i Revised Statute, Chapter 587A-10 which codifies prioritizing relative placement.

The increase in non-relative placements, surpassing the relative placements, is a new and concerning situation. Internally, Child Welfare Services Branch (CWSB) is working with staff, Quality Assurance/Continuous Quality Improvement (QA/CQI), Office of Information Technology, and the

Research and Statistical Office to look at data trends and correlations to determine if there are some aspects that should be further explored. Once CWSB has reviewed some of the analysis and started to develop some hypotheses next steps will include outreach to community partners and stakeholders during Federal Fiscal Year (FFY) 2016. Some efforts include:

‘Ohana Conferencing is a key means of engagement and case planning, while empowering the family to make safe decisions for the family’s children. This family support system often is a source for possible temporary or permanent placements, facilitators for visitation (‘Ohana Time), or family support at Family Court.

Family Finding is a component of ‘Ohana Conferencing, which involves relative notification during the process of confirming and locating relatives as well as in the process of inviting family members to participate in the ‘Ohana Conference.

“E Makua `Ana” (Becoming and Adult) Youth Circles:

Youth Circles (YC) is one of the services that EPIC ‘Ohana provides under contract with the Department of Human Services. It is a group process, like ‘Ohana Conferencing, for youth who are exiting the foster care system. Youth Circles bring together the youth’s supporters, who can offer support and encouragement and assist the youth with his/her transition plan.

Crisis Response Team (Oahu and Hawai`i Island):

One component of the Crisis Response Team includes identifying and assessing family members to be safety plan participants to maintain the children in the home or as foster care placements if the child must enter foster care.

Cost

**What Is The Cost Of Providing Services
To Children/Youth?**

Cost of Services by Service Type

What Is The Cost Of Providing Services To Children/Youth? *Cost of Services by Service Type*

Child and Adolescent Mental Health Division (CAMHD)

What does this measure/indicator describe?

Cost of Procured Services by Level of Care: This measure shows how much it costs to provide services in each of the broad categories of services ('Out-of-Home,' Intensive Home & Community,' 'Outpatient,' 'Supportive Services' & 'Crisis Stabilization') offered by CAMHD contracted providers in the most recently completed fiscal year (FY15).

Performance Indicator

▼ = Warrants Monitoring

Services Procured	Cost per LOC	Cost per LOC Per Youth	% of Total Cost per LOC
Out-of-Home	\$20,066,591	\$55,741	62.5%
Intensive Home & Community	\$8,869,219	\$7,672	27.6%
Outpatient	\$929,187	\$2,741	2.9%
Supportive Services	\$550,775	\$3,026	1.7%
Crisis Stabilization	\$1,698,555	\$45,907	5.3%
Unduplicated Total	\$32,114,327		

What does the included graph/table tell us about this measure/indicator?

The most costly level of care per youth was 'Out-of-Home.' It accounted for almost two-thirds of the CAMHD total service budget. Although relatively low in cost per youth as compared to 'Out-of-Home,' 'Intensive Home & Community' services accounted for over a quarter of the total expenditures for CAMHD in FY2015. This is due to the fact that over three-quarters of CAMHD youth (76.8% - see CAMHD table in 'How Are Youth/Children Using Services' section) served are provided services in this level of care. So, just over 60% of the CAMHD budget is spent on about one-quarter of the population of youth served by CAMHD while approximately one-quarter of the CAMHD service budget is spent on over three-quarters of the youth.

Is this measure/indicator in "On Track," "Warrants Monitoring," or "Needs Work" mode?

▼ = Warrants Monitoring

As would be expected, the most restrictive (and most costly per youth) level of care, Out-of-Home, absorbs the greatest proportion of the CAMHD annual budget. However, since CAMHD serves many more youth in the less restrictive settings (Intensive In-Home and Outpatient services), less money is expended on the more expensive services than could have been spent had CAMHD not put an emphasis, when appropriate, on providing services to youth while in their own homes. The reason 'Warrants Monitoring' is indicated is because, compared to last year, a greater proportion of resources are being allocated to in-home and supportive services and a smaller proportion to out-of-home services, consistent with CAMHD principles; however, costs per youth have increased in Out-of-Home care, Supportive Services, and Crisis Stabilization.

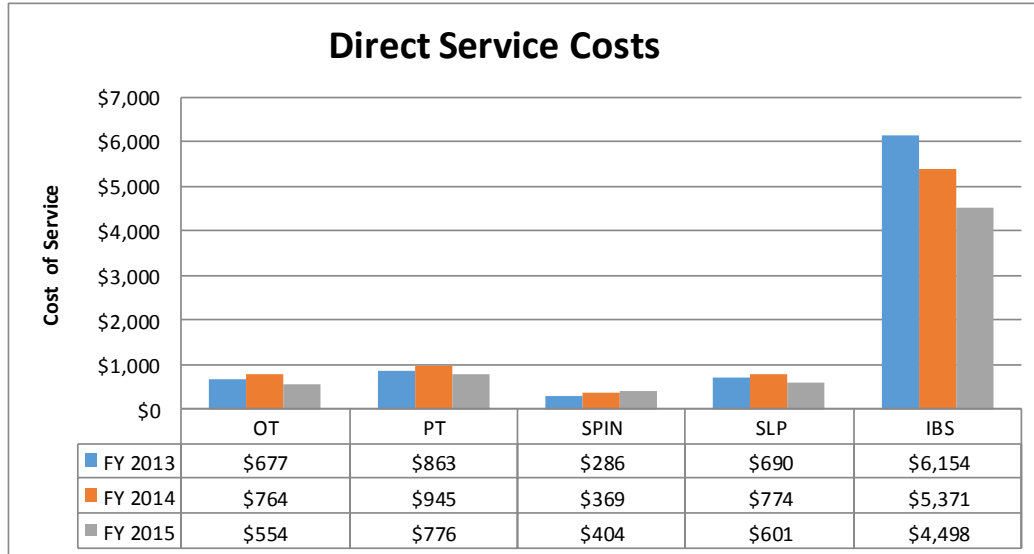
Early Intervention (EI)

What does this measure/indicator describe?

Cost of Providing Services to Infants and Toddlers: This measure indicates the average direct service cost per child of core services provided by the EI Programs as well as cost of Intensive Behavioral Support (IBS) services. It does not include costs for multidisciplinary developmental evaluations.

Performance Indicator

▼ = Warrants Monitoring



FY 2015			
Service	Cost	# of Infants & Toddlers Provided with Service	Average Cost per Child
OT	\$999,168	1,803	\$554
PT	\$626,779	808	\$776
SPIN	\$896,672	2,218	\$404
SLP	\$1,736,134	2,891	\$601
IBS	\$1,380,963	307	\$4,498

OT = Occupational Therapy
PT = Physical Therapy
SPIN = Special Instruction
SLP = Speech Language Pathology
IBS = Intensive Behavioral Services

What does the included graph/table tell us about this measure/indicator?

Intensive Behavioral Support (IBS) services are the most expensive service per child; however, average cost per child has decreased. The frequency and intensity of IBS services is greater to provide the level of support needed by children with autism and/or challenging behaviors and their families.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ = Warrants Monitoring

Costs for services will continue to be tracked so further analysis can be done. Other factors that may be impacting the average costs of services need to be explored.

**Developmental
Disabilities
Division
(DDD)**

What does this measure/indicator describe?

Waiver Expenditures By Service Type. This measure reports on expenditures by the following services for fiscal year 2015:

PAB = Personal Assistance/Habilitation - supports a person to be active in their community or to live in their home.

ADH = Adult Day Health - allows the individual to learn skills, socialize with others and participate in community activities.

RES HEB = Residential Habilitation – individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community.

SN = Skilled Nursing

RS = Respite - provides personnel to care for or provide supervision over an individual with an intellectual or developmental disability for short periods of time, which permits family members caring for a person with I/DD to get needed rest and recreation as to not get “burnt out”.

T and C = Training and Consultation

EMERG = Emergency Outreach and Emergency Shelter

Pre-Voc = Pre-Vocational Activities - prepares a participant for paid employment.

SE = Supported Employments – are targeted toward working with employers to design and develop jobs as well as working with them to train participants for competitive employment in an integrated setting.

**Performance
Indicator**

● = Needs
Work

Figure 1 shows the overall expenditures for children and youth by age group in fiscal year 2011-2015:

Figure 1.

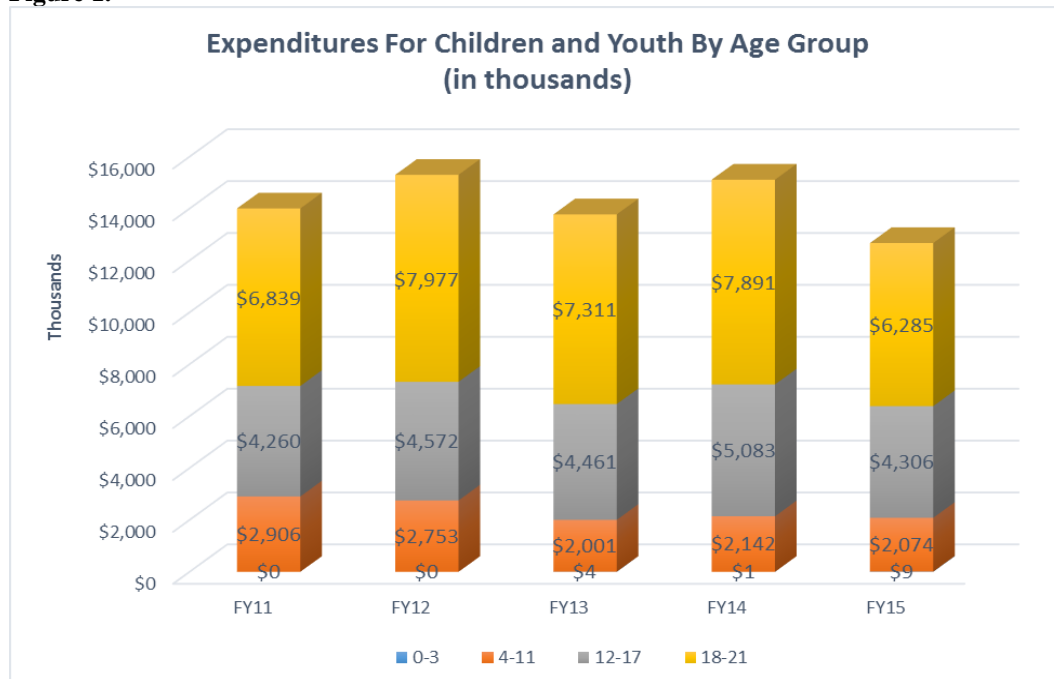


Figure 2 shows the expenditures per person by a child or youth in different age group:

Figure 2.

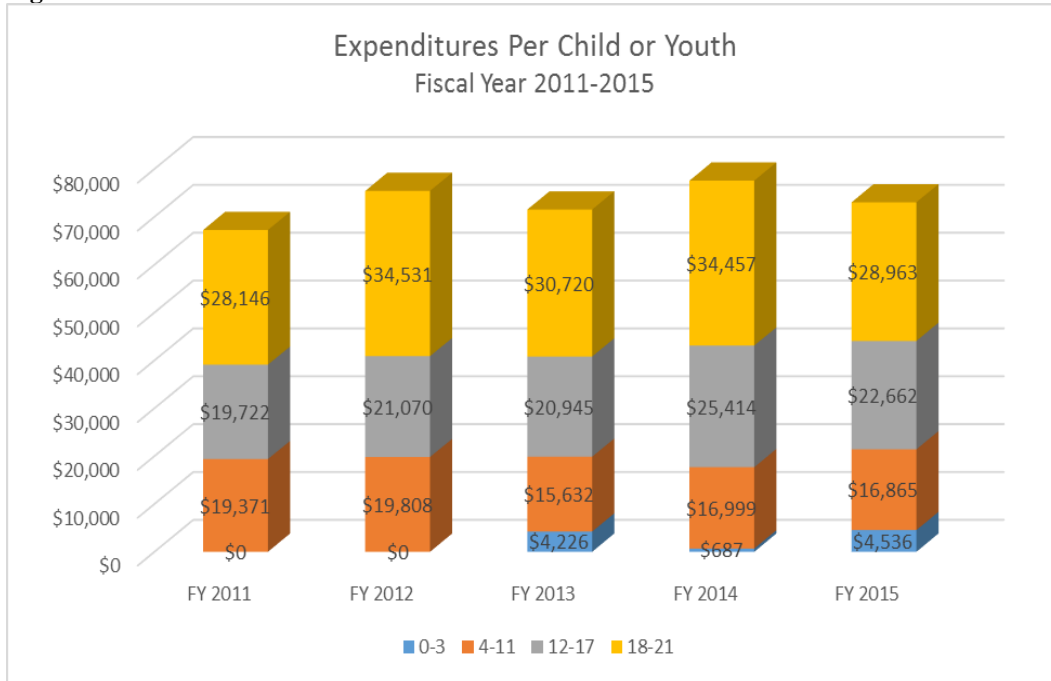
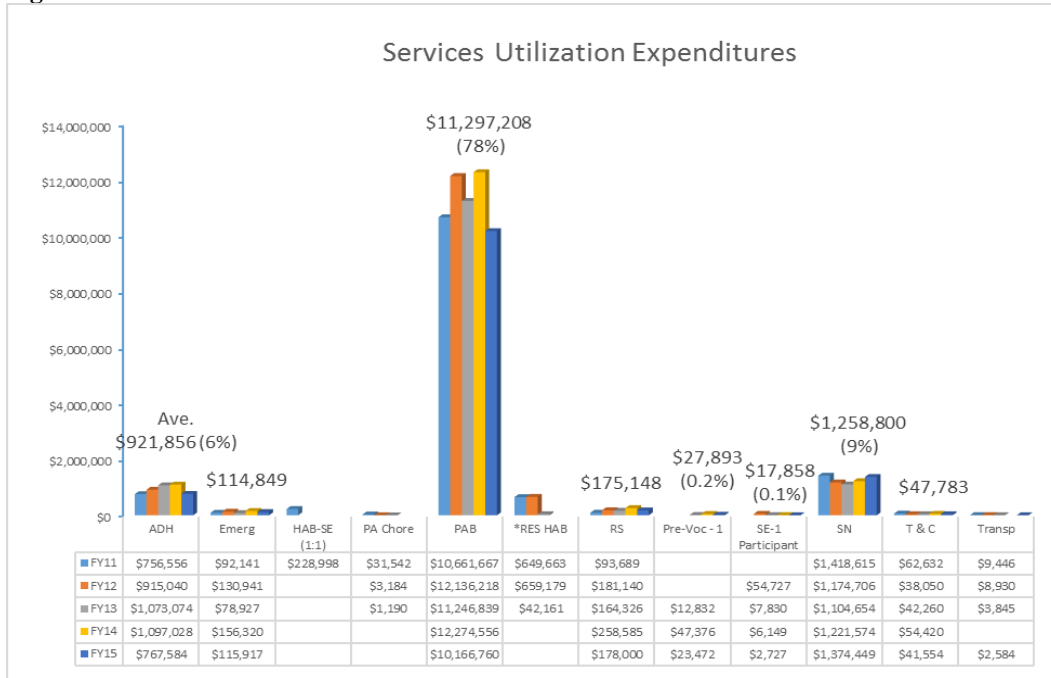


Figure 3 shows the expenditures for children and youth by services:

Figure 3.



*RES HEB was discontinued in the Waiver in FY2012 and services converted to PAB at that point. DDD is proposing to bring back RES HEB through the new Waiver application being submitted to CMS in March 2016.

What does the included graph/table tell us about this measure/indicator?

As described in the “Who Do We Serve” section, most DDD services are provided to adults. Therefore, the total expenditures (Figure 1) as well as expenditures per person (Figure 2) increased as the age increases in this population. And the pattern was relatively stable over the five year period.

Personal Assistance/Habilitation (PAB) was the highest expenditure among all the service types (78%), followed by Skilled Nursing (SN) (9%), and Adult Day Health (ADH) (6%) (Figure 3). The expenditures for the rest of the services - Respite, Training and Consultation, and Emergency Services were minimal. ADH programs are usually selected only if a person is out of school. The expenditures for Pre-Vocational Activities (Pre-Voc) and Supported Employment (SE) were very low, and only accounted for 0.2 and 0.1% of expenditures, respectively.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

These data are descriptive.

As described in the service utilization measure, DDD is working on promoting a system where more money is spent on services that maximize community integration and employment, and less on services that are more isolating in nature.

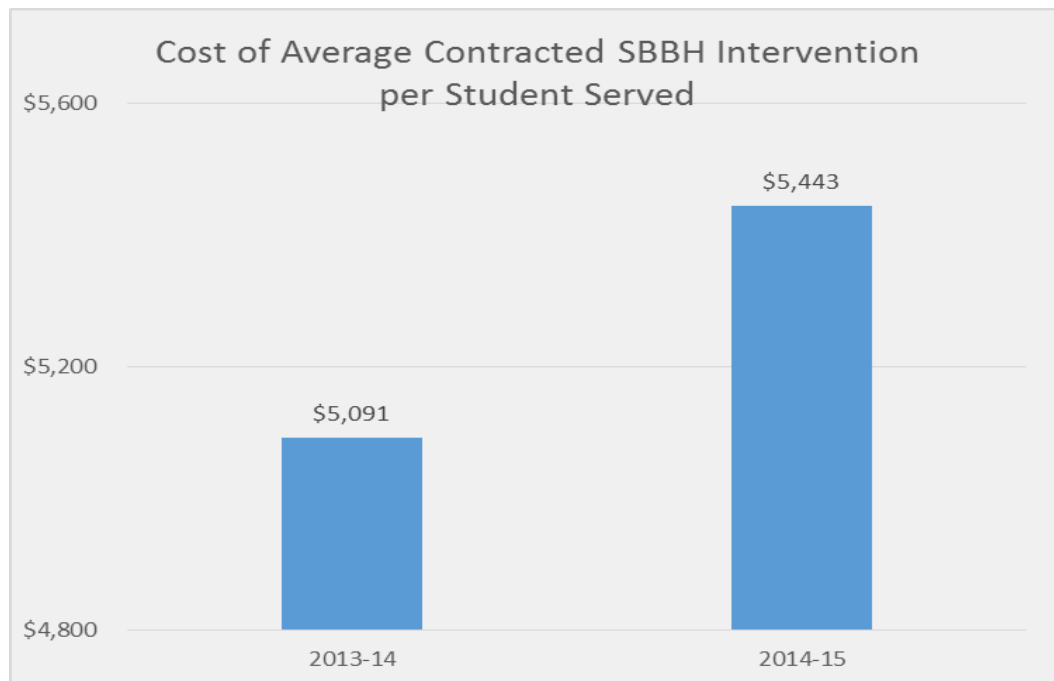
*Department of
Education
(DOE-SBBH)*

What does this measure/indicator describe?

The graph below presents the average cost of contracted School-Based Behavioral Health (SBBH) interventions per student serviced during the school years 2013-14 and 2014-15. SBBH interventions consist of: individual counseling, group counseling, parent counseling, educational team planning, school consultation, and psychiatric medication monitoring.

**Performance
Indicator**

● = On Track



What does the included graph/table tell us about this measure/indicator?

Data for School Year (SY) 2013-14 and 2014-15 provides the average cost of contracted SBBH interventions as provided only for those students that received contracted supports. This report is expected to serve as a baseline for comparison in future years.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

The DOE strives to build capacity within its system to address the needs of all students serviced. However, some specialized populations require a specific specialized skill set that either may be uncommon for DOE SBBH staff to hold, or not readily available for the students when needed to be accessed, and thus necessitating contracting out for additional supports.

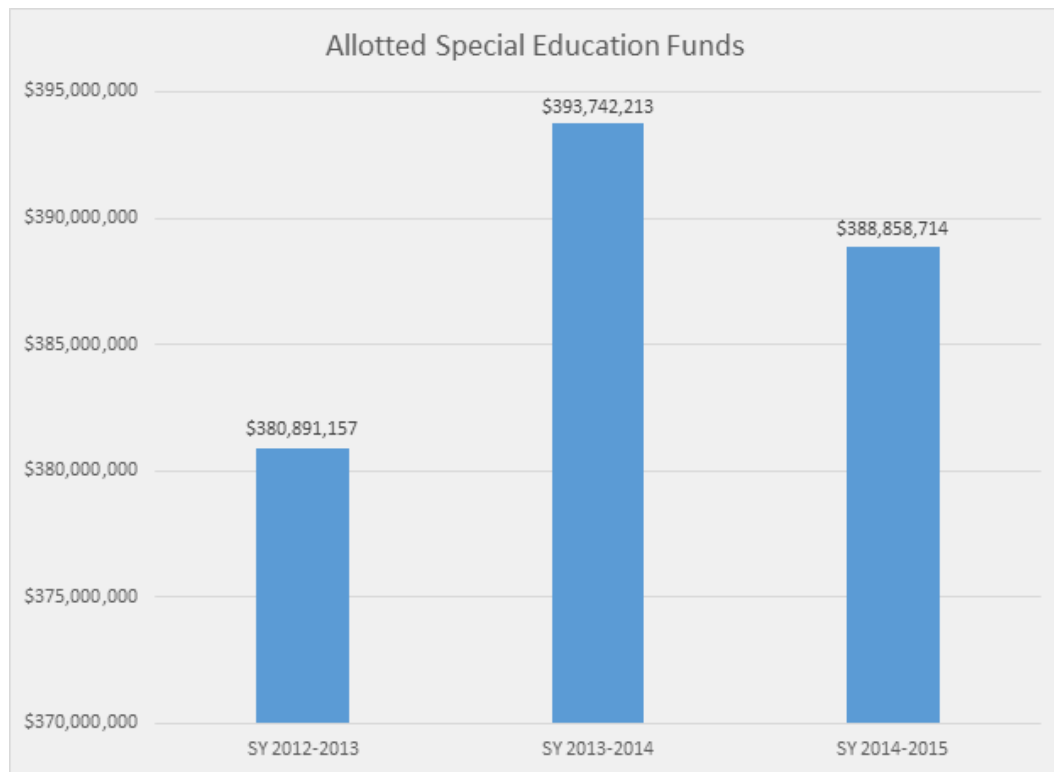
*Department of
Education-
Special
Education
(SpEd)*

What does this measure/indicator describe?

The amount of general and federal funds allotted to HIDOE to provide services to students with disabilities.

**Performance
Indicator**

● = On Track



What does the included graph/table tell us about this measure/indicator?

The graph shows the amount of funds allotted to HIDOE to provide services to students with disabilities for school years (SY) 2012- 2013, 2013-2014, and 2014-2015. There has been a slight increase when comparing SY 2012- 2013 through SY 2014-2015. It is hypothesized that the spike in funds in SY 2013-2014 was due to an increase in personnel costs. The decrease in SY 2014-2015 may be due to the retirement of many senior staff members.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

The overall funding over the past three years has been maintained with a slight increase.

Outcome Measures

**How Well Are We Providing Services
To Children/Youth And Families?**

Outcomes

How Well Are We Providing Services To Children/Youth And Families?

Outcomes

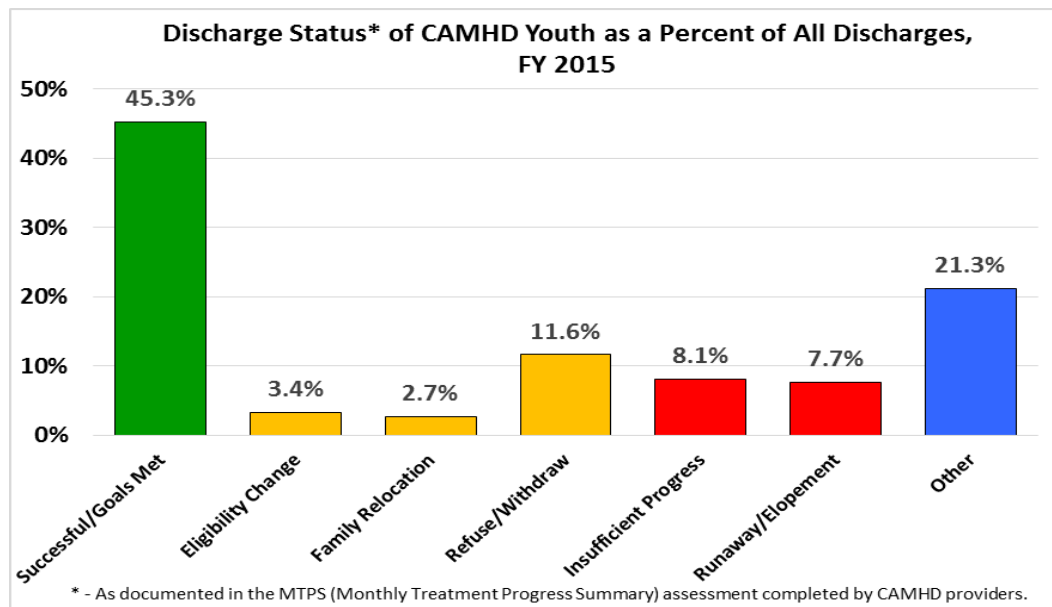
Child and Adolescent Mental Health Division (CAMHD)

What does this measure/indicator describe?

Discharged Youth Status: This graph shows the discharge status for youth in a CAMHD procured service during the past fiscal year (July 1, 2014 to June 30, 2015). The discharge status of ‘Success/Goals Met’ is the goal for the discharge of any youth client from a service. (In past years, CAMHD has presented the CAFAS - Child and Adolescent Functional Assessment Scale - improvement rates over time in the ‘Outcome Measures’ section of the report. At the time of publication of this year’s HYIPR report, no CAFAS data for CAMHD youth had been entered into CAMHD’s MIS and therefore could not be analyzed and presented here at this time. We expect to have CAFAS improvement rate data available for next year’s HYIPR Report for both the FY16 and the previous FY15 period).

Performance Indicator

▼ = Warrants Monitoring



What does the included graph/table tell us about this measure/indicator?

The largest proportion (45.3%) of youth who are discharged after receiving services provided by CAMHD contracted providers are discharged with a status of ‘Successful/Goals Met.’

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

▼ =Warrants Monitoring

We have put ‘Warrants Monitoring’ as a dashboard indicator here because despite having the largest proportion of youth being discharged as ‘Successful/Goals Met,’ there are still a fairly large proportion of youth who are discharged at less than ‘successful’ status and CAMHD would like to see a greater proportion be discharged ‘successfully’ or with all of their treatment ‘goals met.’ The CAMHD Health Systems Office is currently working to improve the data process for youth discharge. This includes adding several new discharge status options based on data currently stored in the ‘Other’ category. The

goal of this effort is to offer a more detailed picture of the status of youth at discharge, giving more meaningful data and reducing the size of the ‘Other’ discharge status category.

**Early
Intervention
(EI)**

What does this measure/indicator describe?

EI Child Outcomes and Family Outcomes: These measures indicate child progress from entry to exit and family satisfaction in the following areas:

EI Child Progress Outcomes measures “Substantially Increased Rate of Growth” and “Functioning Within Age Expectations at Exit” in each of the following areas:

Outcome A: Positive Social and Emotional Skills

Outcome B: Learning and Using Knowledge and Skills

Outcome C: Taking Appropriate Action to Meet Needs

EI Family Satisfaction Outcomes measures their satisfaction in the following areas:

- EI has helped the family know their rights
- EI has helped the family communicate their child needs
- EI has helped the family help their child learn and grow

**Performance
Indicator**

■ = Needs
Work

Statewide Child Outcomes					
	Summary Statement	State Target	FY 2013	FY 2014	FY 2015
Outcome A: Positive social-emotional skills (including social relationships)					
1	Of those children who entered the program below age expectations in Outcome A, the percent that substantially increased their rate of growth in [outcome] by the time they exited.	58.5%	56.3%	53.1%	48.9%
2	Percent of children who were functioning within age expectations in Outcome A, by the time they exited.	82.5%	78.9%	79.3%	73.4%
Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)					
1	Of those children who entered the program below age expectations in Outcome B, the percent that substantially increased their rate of growth in [outcome] by the time they exited.	70.5%	70.5%	70.8%	65.9%
2	Percent of children who were functioning within age expectations in Outcome B, by the time they exited.	77.5%	64.6%	65.2%	58.7%

Outcome C: Use of appropriate behaviors to meet their needs					
1	Of those children who entered the program below age expectations in Outcome C, the percent that substantially increased their rate of growth in [outcome] by the time they exited.	74.5%	64.6%	65.2%	63.7%
2	Percent of children who were functioning within age expectations in Outcome C, by the time they exited.	74.5%	81.2%	80.6%	77.1%

Statewide Family Survey Results				
Family Goal	State Target	FY 2013	FY 2014	FY 2015
Percent of respondent families participating in Part C who report that early intervention services have helped the family know their rights.	92%	87%	87%	88%
Percent of respondent families participating in Part C who report that early intervention services have helped the family effectively communicate their children's needs.	94%	88%	88%	88%
Percent of respondent families participating in Part C who report that early intervention services have helped the family help their children develop and learn.	94%	85%	85%	85%

What does the included graph/table tell us about this measure/indicator?

There has been a decrease in all three child outcome areas in both categories (i.e. percent that made a substantial increase in their rate of growth from entry to time of exit and percent who continue to function within age expectations at exit). The data indicate a decrease in children who were functioning within age expectations, as well as, a decrease in the percentage of children who entered the program below age expectations that substantially increased their rate of growth by the time they exited early intervention.

Regarding family satisfaction, there was a slight increase in the number of families that reported early intervention services helped them know their rights. There was no change in the percentage of families that reported early intervention services helped them effectively communicate their children’s needs and help their children develop and learn.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

■ = Needs Work

The Child Outcomes form has been changed to help the Care Coordinators facilitate the team discussion which includes the family, regarding the three child outcomes ratings. Technical assistance (TA) was provided and continues to be available to programs. The State has also accessed national TA to develop training materials and provide support to programs.

Furthermore, the Child Outcomes is a component of the State Systemic Improvement Plan for Early Intervention. The goal for the plan is to increase capacity of the Early Intervention programs to implement, scale up, and sustain evidence-based practices and improve outcomes for children with special needs and their families.

*Department of
Education
(DOE-SBBH)*

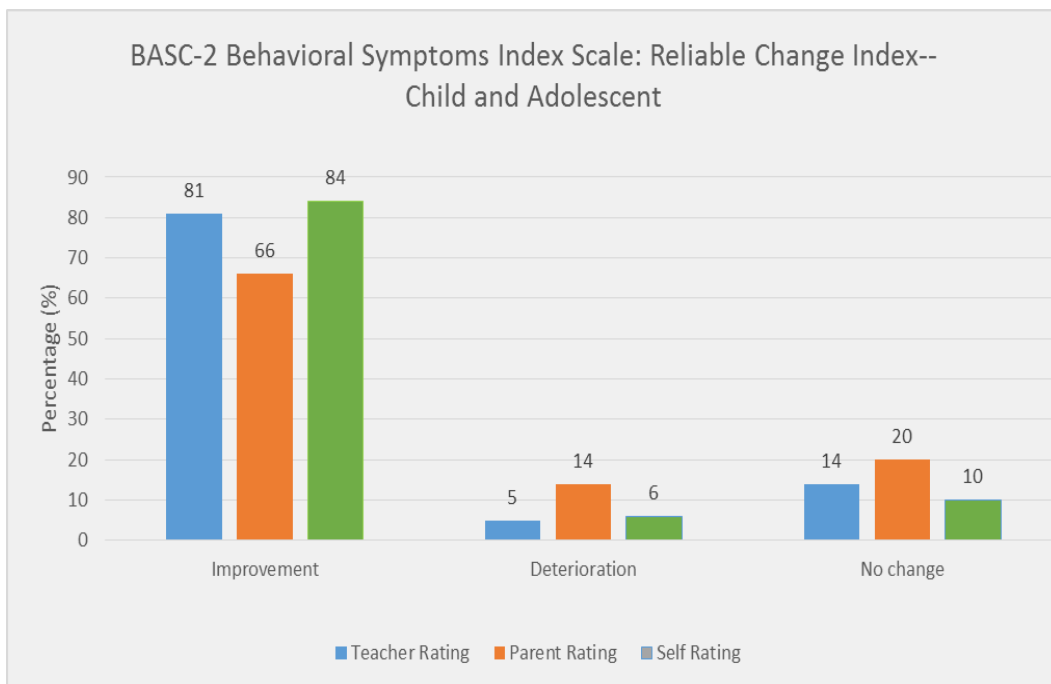
What does this measure/indicator describe?

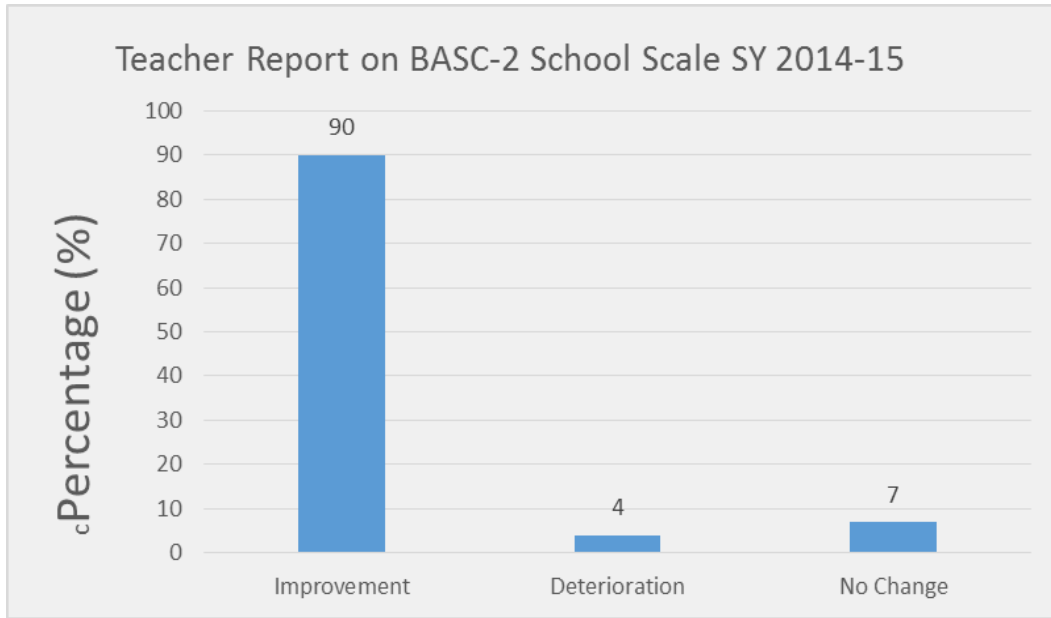
The DOE uses the Behavioral Assessment System for Children-Second Edition (BASC-2) as a measure of program performance so that the SBBH Program can be optimized and to support the overall behavioral support system for students. The BASC-2 is a multimethod system used to evaluate numerous aspects of social, emotional, and behavioral factors of children and young adults.

The first graph below shows the percent of students receiving SBBH counseling, and initially identified as having behaviors within the clinically significant classification range according to the overall global scale, as either showing improvement, deterioration, or no change according to the teacher, parent and self-report scales of the BASC-2. This analysis examines all students who have had at least two BASC-2s administered while also receiving SBBH support since 2004.

The second graph below indicates whether or not students receiving SBBH counseling have shown improvement, deterioration, or no change on the School Scale of the BASC-2. The School Scale is a composite that reflects academic difficulties, including problems of motivation, attention, learning, and cognition. This analysis examines all students who have had at least two BASC-2s administered while also receiving SBBH support since 2004.

Performance Indicator
● = On Track





What does the included graph/table tell us about this measure/indicator?

This measure captures the impact of counseling services for Individuals with Disabilities Education Act (IDEA) and 504 eligible youth who, at baseline, are rated in the clinical range of concern according to teacher, parent, and student self-report.

Overall results indicate that students are improving at a high and consistent rate according to overall global functioning measures of the BASC-2 and across multi-informants (teachers, parents, and students).

Teacher reports indicate that approximately 81% of children and adolescents initially identified as having behaviors within the clinically significant classification range on the overall global scale of the BASC-2 as demonstrating reliable improvement; approximately 5% deteriorated; and the remaining 14% were reported as showing no change. In addition, teachers report 90% of students initially identified as having behaviors within the clinically significant classification range on the School Scale as showing reliable improvement from baseline to follow-up. This suggests that behaviors previously deemed as problematic due to their interfering with academic achievement was significantly reduced by the majority of students receiving SBBH supports.

Parent reports indicate that approximately 66% of children and adolescents initially identified as having behaviors within the clinically significant classification range on the overall global scale of the BASC-2 as demonstrating reliable improvement; approximately 14% deteriorated; and the remaining 20% were reported as showing no change. Of students initially identified as having behaviors within the clinically significant classification range on the overall global scale of the BASC-2, 84% perceive themselves as demonstrating reliable improvement; approximately 6% perceive themselves as deteriorating; and the remaining 10% reported no change.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

The benchmark is for 66% or more of students to show improvement on the BASC-2. Results show student improvement exceeds or is at 66% for all informants. In addition, parents are reporting a significant reduction in behaviors related to academic difficulties for those students receiving SBBH supports.

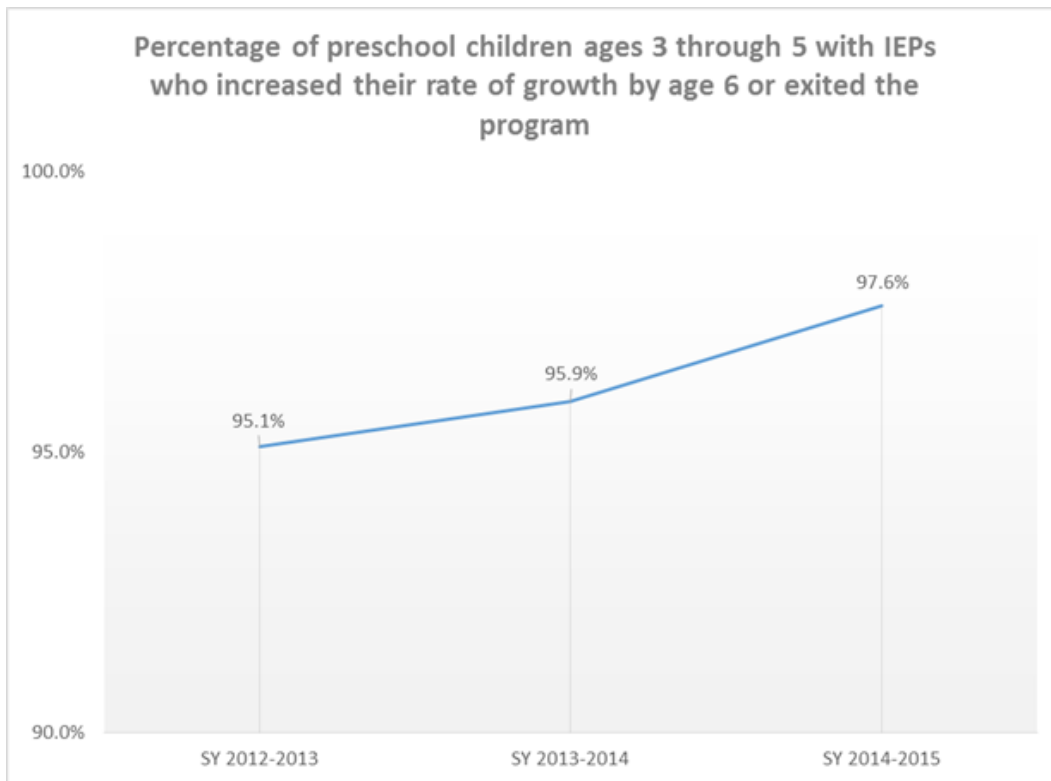
*Department of
Education-
Special
Education
(SpEd)*

What does this measure/indicator describe?

This graph shows percentage of preschool children aged 3 through 5 with Individual Education Programs (IEP)s who entered or exited the early childhood special education program who substantially increased their rate of growth by the time they turned 6 years of age or exited the program. The rate of growth refers to demonstrated student improvement of appropriate behaviors to meet their needs from the time the student entered the program to the time the student exited the program.

**Performance
Indicator**

● = On Track



What does the included graph/table tell us about this measure/indicator?

The graph above indicates that the great majority (95.1%-97.6%) of preschool children ages 3 through 5 with IEPs who entered the program below age expectation substantially increased their rate of growth by the time they turned 6 years of age or exited the program.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

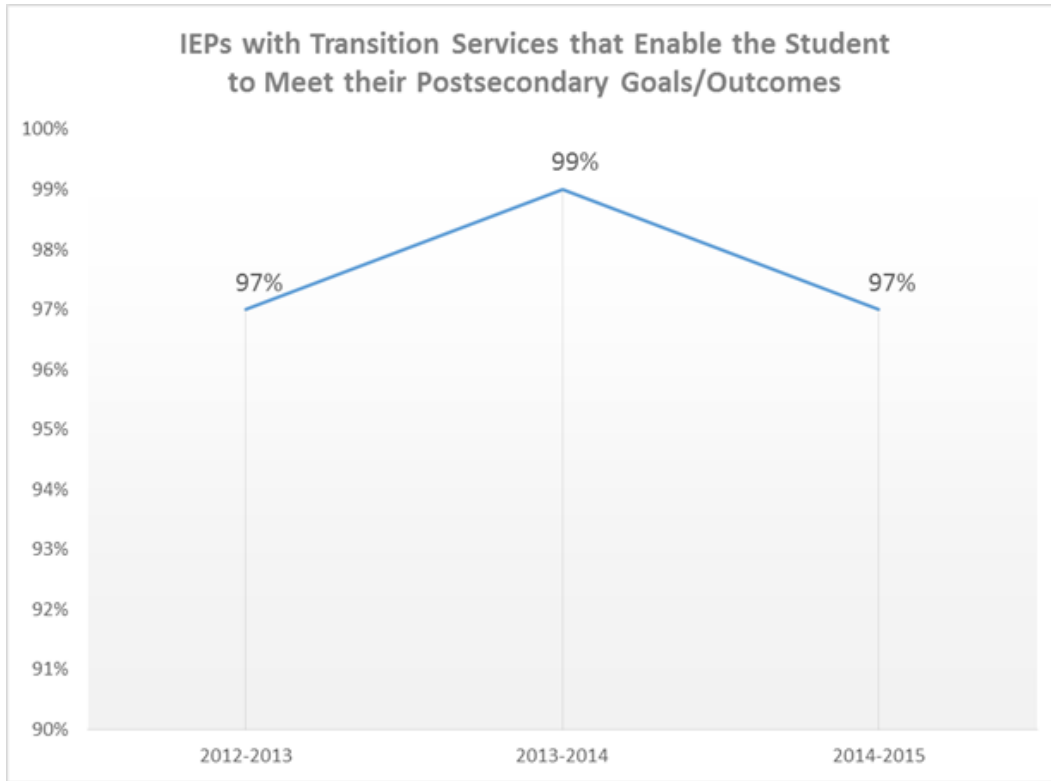
● = On Track, however, the HIDOE is always striving for improvement in this area.

What does this measure/indicator describe?

Annually, the transition plan in IEPs are reviewed and updated based on students’ expressed interests. A key element in the transition plans are the student-identified post-secondary goals/outcomes in the areas of post-secondary Education and Training, Employment, and, if relevant, Independent Living. This indicator demonstrates that a very high percentage of students have appropriate services in their plans, provided by team members, that will help them toward achieving those expressed goals/outcomes.

Performance Indicator

● = On Track



What does the included graph/table tell us about this measure/indicator?

The graph indicates that transition services are addressed for students to meet their postsecondary goals.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

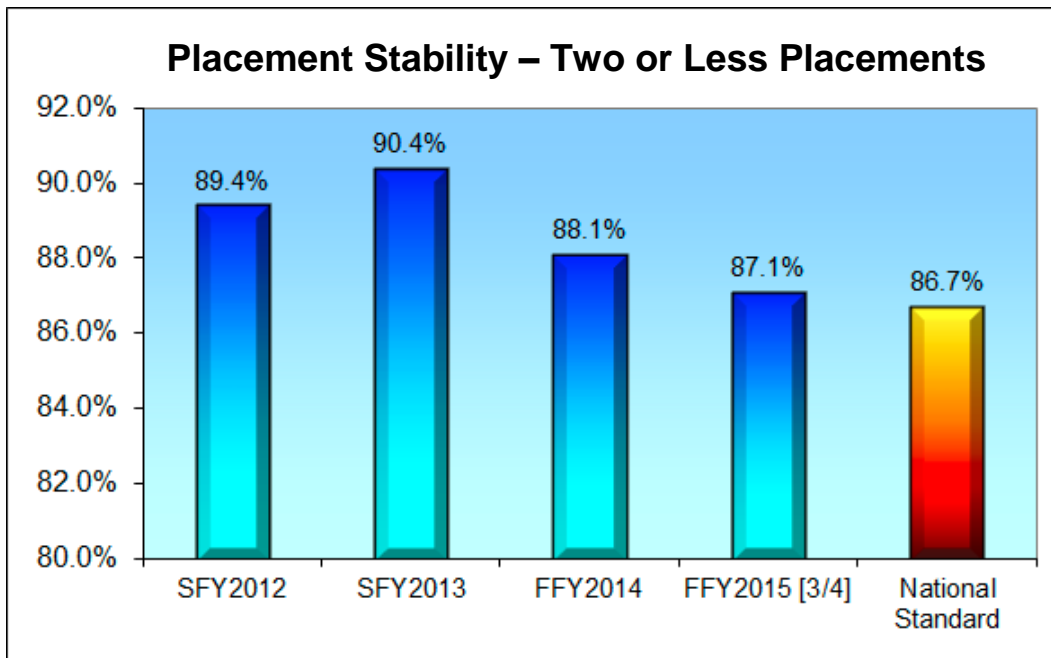
● = On Track, however, the HIDOE is always striving for improvement in this area.

What does this measure/indicator describe?

This chart displays annual aggregate data showing the percentage of children in foster care who lived in two foster homes or fewer during their time in care.

**Performance
Indicator**

● = On Track



Note: Higher percentages are desirable.

What does the included graph/table tell us about this measure/indicator?

Child Welfare Services Branch continues to exceed the national standard. These efforts have been supported over the past few years by new practices of upfront Family Finding activities and ‘Ohana Conferences being held for every child entering foster care. Identifying family resources early and having the family come together to create a plan to support the child are both crucial for minimizing placement disruptions.

Is this measure/indicator in “On Track,” “Warrants Monitoring,” or “Needs Work” mode?

● = On Track

Child Welfare Services Branch (CWSB) continues to improve practice through the Title IV-E Waiver Workgroups, ‘Aha (community gatherings), and various collaborations with other departments, stakeholders, and partners strengthen overall efforts to prevent removals, support reunification or other permanency options, and maintain connections.

Progress Summary

The HYIPR report has grown out of the monthly dialog of the Hawai'i Interagency State Youth Network of Care (HI-SYNC) Committee that is comprised of various agencies.¹ All of these various agencies all agree on at least one thing: in order for agencies serving youth to become more transparent, there is a great need to have consistent data and outcomes reported to the public by the participating agencies. Over the past year, the following initiatives have been taken on by the agencies participating in HI-SYNC to meet this overall goal:

- All agencies worked to supply and share data that should prove to be useful to stakeholders, be they in government or in the private sector. It is important to know that the agencies participating in HI-SYNC have differing capacities regarding their data systems. It should also be recognized that all agencies are in the process of updating their data systems so the data contributed by agencies will be modified as data collection improves. Also, those measures may change from time to time as specific concerns also change.
- HI-SYNC is in the last stages of finalizing a new Memorandum of Understanding (MOU) that describes the three major activities of HI-SYNC, specifically:
 - Assemble and analyze data from all participants and sharing data across agencies.
 - Develop joint policies and design ways for the agencies to work as partners when they hold similar clients or issues.
 - Establish a forum for the discussion and management of particularly complex or troublesome cases. The goal is to develop joint treatment and support plans for individuals who have multiple agency involvement.
- HI-SYNC members, as a group, are committed to going to the next level in establishing a system where HI-SYNC discusses particular youth cases. Because the logistics of getting various decision makers together and documenting the consensus findings and plan can be very difficult, an independent person who is not associated with any one agency participating in HI-SYNC is needed. Several of the agencies have contributed funding to help hire such a person. CAMHD has agreed to pool the funding and publish a small Request for Proposal (RFP) to find a person to take this new position. The person in this new position would deal with facilitating and moving the process along. This person could also be responsible for shepherding joint policy drafts through to final versions.

¹ The various agencies that participate in HYSINC are: Community Children's Council Office, Child and Adolescent Mental Health Division, Family Health Services Division, Family Court, Developmental Disabilities Division, Department of Education, Office of Youth Services, Child and Family Services, Child Welfare Services, and Project Laulima.