HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 05-21A

Applicant: Maui Youth and Family Services, Inc.
P.O. Box 790006
Paia, HI
Phone: 808-579-8414

Project Title: Change in service to include dual diagnosis

Project Address: 1931-C Baldwin Avenue
Makawao, Maui

1. **TYPE OF ORGANIZATION**: (Please check all applicable)

Public	____
Private	__X__
Non-profit	__X__
For-profit	____
Individual	____
Corporation	__X__
Partnership	____
Limited Liability Corporation (LLC)	____
Limited Liability Partnership (LLP)	____
Other: _____	____

2. **PROJECT LOCATION INFORMATION**

A. Primary Service Area(s) of Project: (please check all applicable)

Statewide:	____
O`ahu-wide:	____
Honolulu:	____
Windward O`ahu:	____
West O`ahu:	____
Maui County:	__X__
Kaua`i County:	____
Hawai`i County:	____

3. **DOCUMENTATION** (Please ***attach*** the following to your application form):

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent)
B. A listing of all other permits or approvals from other government bodies (federal, state, county) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.)
C. Your governing body: list by names, titles and address/phone numbers
D. If you have filed a Certificate of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:
   - Articles of Incorporation
   - By-Laws
   - Partnership Agreements
   - Tax Key Number (project's location)

4. **TYPE OF PROJECT.** This section helps our reviewers understand what type of project you are proposing. Please place an "x" in the appropriate box.

	Used Medical Equipment (over $400,000)	New/Upgraded Medical Equip. (over $1 million)	Other Capital Project (over $4 million)	Change in Service	Change in Beds
Inpatient Facility				X	
Outpatient Facility					
Private Practice					

5. **BED CHANGES.** Please complete this chart only if your project deals with a change in your bed count and/or licensed types. Again, this chart is intended to help our reviewers understand at a glance what your project would like to accomplish. Under the heading "Type of Bed," please use only the categories listed in the certificate of need rules.

Type of Bed	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
TOTAL			

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	0
2.	Construction Contract	0
3.	Fixed Equipment	0
4.	Movable Equipment	0
5.	Financing Costs	0
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	0
7.	Other: _____	0
	TOTAL PROJECT COST:	**0**

B. Source of Funds

1.	Cash	0
2.	State Appropriations	0
3.	Other Grants	0
4.	Fund Drive	0
5.	Debt	0
6.	Other: _____	0
	TOTAL SOURCE OF FUNDS:	**0**

7. **CHANGE OF SERVICE:** If you are proposing a change in service, then please briefly list what services will be added/modified. Be sure to include the establishment of a new service or the addition of a new location of an existing service. Please reference the Certificate of Need Rules Section 11-186-5 for the categories of services. If you are unable to determine which category best describes your project, please consult with agency staff.

We were granted a certificate of need for 15 beds serving substance abuse youth. This application is for a certificate of need approval to provide STF services to youth with behavioral health as well as substance abuse diagnoses.

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8. **IMPLEMENTATION SCHEDULE:** Please present a projected time schedule for the completion of this project from start to finish. Include all of the following items that are applicable to your project:

a) Date of site control for the proposed project,
Site control date: 1983
b) Dates by which other government approvals/permits will be applied for and received, ***Permits received on 1/17/01***
c) Dates by which financing is assured for the project,
Financing was approved on 7/1/01
d) Date construction will commence,
e) Length of construction period.
f) Date of completion of the project,
g) Date of commencement of operation

Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementation of a project as described in your application may result in a fine and/or withdrawal of the certificate of need.

9. **EXECUTIVE SUMMARY:** Please present a brief summary of your project. In addition, provide a description of how your project meets each of the certificate of need criteria listed below. If a new location is proposed, please attach an easy to read map that shows your project site.

a) Relationship to the Hawai`i Health Performance Plan (H2P2), also known as the State of Hawai`i Health Services and Facilities Plan.
b) Need and Accessibility
c) Quality of Service/Care
d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
e) Relationship to the existing health care system
f) Availability of Resources.

10. **Eligibility to file for Administrative Review.** This project is eligible to file for Administrative review because: (Check all applicable)

_____ It involves bed changes, which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

__X__ It involves service changes which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It is an acquisition of a health care facility or service, which will result in lower annual operating expenses for that facility, or service.

_____ It is a change of ownership, where the change is from one entity to another substantially related entity.

_____ It is an additional location of an existing service or facility.

__X___ The applicant believes it will not have a significant impact on the health care system.

EXECUTIVE SUMMARY

Introduction

Maui Youth and Family Services (MYFS) request a certificate of need to serve dual diagnosed clients.

Ho'omaka Hou program for substance abuse treatment offered by MYFS is designed to coordinate professional services to support youth in attainment of substance free lifestyles. It is intended for adolescents, ages 12-17. The primary purpose is to provide youth with the skills and knowledge they need to live without the use, abuse and dependency on substance and address/treat any co-occurring disorders the youth present. The program provides a structured family setting with trained, awake supervision twenty-four hours a day, seven days a week. Master's level counselors are available five to six days a week and are on-call for emergencies. The youth for which the program is designed are substance abusing youth, 12-17 years of age who may also have secondary or even tertiary behavioral health diagnoses.

Program Services include:

a) **Individual Counseling** sessions allow participants to explore the causes and effects of their substance dependency and identify methods to maintain clean and sober lifestyles. Treatment also addresses any co-occurring disorders.

b) **Group Counseling** provides the opportunity for participants to improve interpersonal skills by developing effective communication and conflict resolution skills, problem solving, self-advocacy, and assertiveness techniques. This allows for the group support for sobriety that is so important to maintenance of a new skill.

c) **Family Counseling** sessions are designed to resolve family conflicts and improve communication within the family. It is required before a client returns to his family of origin. These sessions help to repair the very strained relationships that occur and rebuild the trust that is lost when a family member is substance dependent.

d) **Case Management** services are provided in the coordination of community services, transportation, concurrent services and to ensure coordination of the treatment plan with all members of the treatment team. Detailed aftercare plans to support gains made in treatment are a part of this service.

e) **Education services** provide a foundation for understanding the mechanics and effects of substances. There is also an emphasis on life skills knowledge as appropriate to the age of the resident.

f) **Academic education** services provide an on-site academic program to remediate missing skills and build upon acquired skills so that the resident will be able to reenter the school system with success.

g) **AA/NA** groups are supported both in-house and in-community to expose residents to the community support available to sustain sobriety on discharge.

a) **REGARDING THE RELATIONSHIP OF THE PROPOSED SERVICE TO THE HEALTH SERVICES AND FACILITIES PLAN – H2P2)**

The facility has been granted a certificate of need for the location and has meant the criteria in the previous application. The facility need has been previously established in certificate of need #0202A. MYFS will continue to meet the criteria in H2P2. Our project is also consisted with Chapter 11 of H2P2.

b) **REGARDING THE NEED AND ACCESSIBILITY OF THE PROPOSED SERVICE.**

We find that at least 95% of all youth presenting with substance abuse diagnoses have additional behavioral health diagnoses. Thus, the need for providing services to the dually diagnosed population is the same as 95% of the substance abusing population.

MYFS accepts clients, regardless of ethnicity or economic status, from throughout the state.

c) **REGARDING THE QUALITY OF THE PROPOSED SERVICE**

The quality criterion was met in certificate of need #0202A and MYFS will continue to maintain a high level of quality. No additional staff qualifications are necessary.

Maui Youth and Family Services maintain the highest standards of care; it has a well-developed and implemented quality assurance and improvement plan in place to maintain quality management. It meets all the requirement of licensing and contracting agencies.

It has been accredited by Council on Accreditation (COA) and meets nationally recognized standards, and standards defined by the Department of Health, Alcohol and Drug Abuse and Child Adolescent Mental Health Divisions. Staff meets clinical and professional standards and credentials are verified by primary source documentation. This MYFS service has received continuous STF licensing from the Department of Health Office of Healthcare Assurance since 1993. Staffing is provided by substance abuse technicians at the ratio of 1:4 with a minimum of two technician staff on duty at all times. This is supplemented by Master's level counselors, preferably with license and CSAC, per eight (8) youth, a site Manager, Case Manager, Assistant Program Director, Teachers, and Program Director. Additional services are provided by consulting psychologist, psychiatrist, registered dietician and other specialized persons as required by client need. Substance abuse technicians receive substantial training in therapeutic interactions with troubled youth and all staff receives forty hours of training per year and supervision.

d) **REGARDING THE COST AND FINANCES OF THE PROPOSED SERVICE**

No new capitol is required for the project.

e) **REGARDING THE RELATIONSHIP OF THE PROPOSED SERVICE TO THE EXISTING HEALTH CARE SYSTEM**

This application will enhance services in the existing health system as we will be able to meet the need for treatment of dually diagnosed youth.

Youth will not need to be sent to separate facilities to treat each aspect of their behavioral/substance abuse disorder.

f) **REGARDING THE AVAILABILITY OF RESOURCES FOR THE PROPOSED SERVICE**

No new staff are required for this proposal. No new capitol is required for this proposal.