"Happy & Healthy
Children & Families,
Living in Caring Communities"

A Strategic Plan for Strengthening Child & Adolescent Mental Health Services 2007-2010

Child & Adolescent Mental Health Division
Hawaii Department of Health
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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
STRATEGIC PLAN 2007-2010

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PREFACE

Over the past, the children's mental health system has had to adjust and improve according to legal oversight, public accountability and changing needs. Reflecting back over the changes, the Child and Adolescent Mental Health Division (CAMHD) and its stakeholders are pleased with the many improvements made to the children's mental health service system. CAMHD has been successful in identifying and implementing evidence-based services so that mental health services are effective and that youth receive the quantity and quality of care that will effect improvements in their life functioning. CAMHD has been successful in developing a system of measures and controls to ensure that services provided meet performance outcomes in terms of quality, timeliness, and appropriateness. CAMHD has also successfully undertaken the task of transforming itself into a managed care organization so that federal Medicaid revenues can be maximized and brought into the state.

Moving forward, CAMHD commits to engaging youth and families in guiding CAMHD's evolution toward higher performance and excellence. Through the strategic planning process over the past year, CAMHD has engaged youth, families, staff, partners, community groups, fellow agency staff, legislators, and others to discuss and prioritize CAMHD's path for the future. Through community input, seven broad priority areas were identified. The Management Work Plan in Section VII outlines the goals, activities, resources and timeline for the priority areas. The Management Work Plan is a working document that will be revised over time in response to progress, setbacks and changes in the environment. Over the next four years, CAMHD will commit time, energy and resources to increasing access to services so that there are no longer gap groups who must go without needed mental health services; to developing ways to better manage limited resources so that needs can be met when and where they occur; to maintaining a publicly accountable performance management system; to recruiting and retaining a qualified mental health work force; to improving the quality of clinical care and practice; to developing a strategic financial plan; and implementing a strategic information technology program. These are big goals, ones that cannot be achieved by CAMHD alone. CAMHD looks to our many partners to help us achieve these goals.

With hope for the future, we proudly present the Child and Adolescent Mental Health Division's Strategic Plan 2007-2010.

Me ke aloha,

Sandra M. Pak

Sandra M. Pak, M.P.H.

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SECTION I.

EXECUTIVE SUMMARY

Over the past decade, the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii State Department of Health has matured into an integrated network of services and supports, consisting of contracted community-based agencies and state managed, community-based Family Guidance Centers with administrative and performance oversight functions at the state office. Since 1995, the system of care has developed a comprehensive array of evidence-based services and supports for children and youth with the most challenging emotional and behavioral needs, and their families.

During the past year, CAMHD, together with youth, families, advocacy groups, policy-makers, staff and other community stakeholders, examined the progress and attainments of the children's mental health system over the last four years, and looked ahead to envision a new future. CAMHD's existing vision, mission, and values were re-visited, while gaps and priorities were discussed and debated. Based on community input, a new vision was crafted and the mission statement was expanded. There was overwhelming consensus to keep CAMHD's guiding principles, the Child and Adolescent Service System Program (CASSP). Issues and trends at the local and national levels were reviewed and discussed. At the national level, mental health systems are trying to transform themselves into a more consumer-focused, community-based system. CAMHD has already institutionalized many of the transformation goals and is committed to maintaining them. Gaps for CAMHD, however, include the smaller-than expected service population, attracting and maintaining a highly-skilled workforce, effectively managing with limited resources, and financially maintaining the system and all its improvements.

Specifically, over the next four years, CAMHD and its partners will focus its attention and efforts on seven broad priorities. The priorities are:

Priority Area 1.	Decrease Stigma and Increase Access to Care

CAMHD's first priority is to increase access to mental health services and decrease the stigma attached to seeking help. The strategic plan calls for strengthening ties and connections with youth, families, primary care practitioners, child welfare, education and juvenile justice, as well as identifying other avenues that the general community and others can access CAMHD's services. Special attention will be given to outreaching to youth in crisis, including youth who are homeless, those with sexual-identity issues, and youth at risk for suicide.

Priority Area 2.	Implement and Monitor Effectiveness of a Comprehensive Resource Management Program

CAMHD must be able to adjust its limited resources and capacities based on projected needs. As a managed care provider CAMHD must be able to provide the appropriate volume of any needed service in a timely manner. The Strategic Plan calls for CAMHD to improve the quality of utilization management data reporting and adjust resources in a timely and effective manner based upon identified needs.

Priority Area 3.	Implement a Publicly Accountable Performance Management Program

The performance management system is key to maintaining the service and system improvements made during the Felix Consent Decree. CAMHD re-commits resources to

maintaining performance management system as well as commits to making ongoing improvements to the system.

Priority Area 4.	Implement and Monitor a Comprehensive Practice Development Program

To assure that mental health services to youth and their families are of high quality, CAMHD will prioritize the implementation of a comprehensive practice development program. This priority area will seek to strengthen the core competencies and practices of clinicians, as well as increase competencies in evidence based practice elements.

Priority Area 5.	Implement and Monitor a Strategic Personnel Management Plan

This priority area will address the need to increase the number of culturally competent mental health professionals in all communities of the state, with particular attention to rural and remote areas.

Priority Area 6.	Implement and Monitor a Strategic Financial Plan

CAMHD will continue the commitment to diversify funding beyond the state general fund. CAMHD will pursue federal funding, and look to expand opportunities to blend and braid funding with community and state partners.

Priority Area 7.	Implement and Monitor a Strategic Information Technology Program

During the next four years, CAMHD will evaluate the performance of its Management Information System (MIS) system, including hardware and software. MIS allows treatment teams to conduct real time reviews of youth's services, to measure and evaluate the performance of multiple facets of mental health service delivery, and to electronically manage billing and payment transfers. Efforts will focus on developing an electronic clinical record system, and integrating electronic forms and electronic submission of data. This information technology priority will also seek to develop telehealth and tele-psychiatry initiatives.

SECTION II

BACKGROUND

A. STATUTORY AUTHORITY

Chapter 334 of the Hawaii Revised Statutes mandates the department of health to "foster and coordinate a comprehensive mental health system utilizing public and private resources to reduce the incidence of mental or emotional disorders and substance abuse and to treat and rehabilitate the victims in the least restrictive and most therapeutic environment possible." The statutes further direct the department of health to "promote and provide for the establishment and operation of a community-based mental health system responsive to the needs of persons of all ages, ethnic groups, and geographical areas of the State, reflective of an appropriate distribution of resources and services, and monitored and evaluated in terms of standards, goal attainment, and outcomes."

In 1974, the Hawaii State Legislature enacted legislation that established the responsibility for children's mental health services with the department of health. Hawaii Revised Statutes §321-171, et seq. require the department of health to develop and implement effective and efficient mental health services for children and youth, including highly specialized programs, and preventative, early identification, screening, diagnostic, treatment and rehabilitative services for emotionally disturbed children and youth. All eligible children between the ages of birth and seventeen are to be provided necessary mental health services in their communities to insure their proper and full development. The department of health is also charged with coordinating the activities of local public and private agencies servicing children in their geographic areas, and coordinating the identification and referral of youth with the department of education

Hawaii Revised Statutes §321-175 requires the department of health to develop a statewide children's mental health services plan every four years. This document serves to present the statewide children's mental health services plan for the years 2007-2010.

H.R.S. §321-176 requires the department to submit a report of its progress to the legislature and the governor every two years. Section VI of this document summarizes the progress made during the last two years of the current strategic plan, Child & Adolescent Mental Health Services Strategic Plan 2003-2006. The first two years of this plan were summarized and provided to the legislature in January 2005. This report is currently available on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/webs/camhdplan/camhdplan.html

B. NATIONAL MENTAL HEALTH TRENDS

Surgeon General's National Action Agenda for Children's Mental Health

In September 2000, the Surgeon General focused national attention on children's mental health. Three hundred stakeholders were invited to participate in the Surgeon General's Conference on *Children's Mental Health: Developing a National Action Agenda*. The participants represented a broad cross-section of mental health stakeholders, including youth and family members, professional organizations and associations, advocacy groups, faith-based practitioners, clinicians, educators, healthcare providers, and members of the scientific community and the healthcare industry. The purpose of the conference was to develop specific recommendations for a National Action Agenda on Children's Mental Health. The Surgeon General's Conference was landmark. The results of the conference were compiled in the **Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.** Available at: www.surgeongeneral.gov/topics/cmh/childreport. The goals of the national action agenda for children's mental health are:

1. Promote ***public awareness*** of children's mental health issues and ***reduce stigma*** associated with mental illness.
2. Continue to develop, ***disseminate, and implement scientifically-proven*** prevention and treatment services in the field of children's mental health.
3. Improve the assessment of and ***recognition of mental health needs*** in children.
4. ***Eliminate*** racial/ethnic and socioeconomic ***disparities*** in access to mental healthcare services.
5. ***Improve the infrastructure*** for children's mental health services, including support for scientifically-proven interventions across professions.
6. ***Increase access*** to and coordination of quality mental healthcare services.
7. ***Train*** frontline providers to recognize and manage mental health issues, and educate mental healthcare providers about scientifically-proven prevention and treatment services.
8. ***Monitor*** the access to and coordination of quality mental healthcare services.

New Freedom Commission on Mental Health

In February 2001, President Bush launched the *New Freedom* initiative to promote full access to community life for people with mental health disabilities, including access to employment and educational opportunities and to assistive and universally designed technologies. In April 2002, the President signed Executive Order 13263 establishing the New Freedom Commission on Mental Health and charged the group with conducting a comprehensive study of the problems and gaps in the mental health service system and to make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, can implement. The Commission framed its work around the five principles set forth in the Executive Order that established its responsibilities. These principles seek to improve the outcomes of mental health care; promote collaborative, community-level models of care; maximize existing resources and reduce regulatory barriers; use mental health research findings to influence service delivery; and promote innovation, flexibility, and accountability at the Federal, State, and local levels.

The Goals of a Transformed Mental Health System are:

1. Americans ***understand that mental health is essential*** to overall health.
2. Mental health care is ***consumer and family driven***.
3. ***Disparities*** in mental health services ***are eliminated.***
4. ***Early mental health screening***, assessment, and referral to services are common practice.
5. ***Excellent mental health care*** is delivered and research is accelerated.
6. ***Technology*** is used to access mental health care and information.

The full Commission report is available at http://www.mentalhealthcommission.gov/

Substance Abuse And Mental Health Services Administration Cross-Cutting Principles and Priority Programs: "SAMHSA Matrix of Priorities"

After the New Freedom Commission on Mental Health submitted its final report to the President in July 2003, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) was tasked to review the Commission's report and to develop an action agenda to achieve the goals for transformation outlined by the Commission. In response, SAMHSA developed a matrix of priorities and principles to serve as an agency roadmap. This roadmap, called the "SAMHSA Matrix" visually depicts SAMHSA's priority programs and cross-cutting principles that is used to guide program, policy and resource allocation for SAMHSA. The matrix is based on an underlying principle that people of all ages, with or at risk for mental or substance use disorders, should have the opportunity for a fulfilling life that includes an education, a job, a home, and meaningful relationships with family and friends. It is also founded on SAMHSA's vision of "a life in the community for everyone." (See appendix for the SAMHSA Matrix of Priorities) More information is available at: www.samhsa.gov/Matrix/Matrix_Brochure_2006.pdf.

Substance Abuse and Mental Health Services Administration, Child, Adolescent and Family Branch (CAFB) "Transforming Children's Mental Health Care in America"
In response to the SAMHSA matrix of priorities and President's New Freedom Commission Report, the CAFB developed a logic model for serving children and young people with mental health needs. The CAFB defined core system values as being family driven, youth guided, evidence based, with a commitment toward clinical excellence, and cultural and linguistic competence. More information about the CAFB Transformational Plan, visit the website at: www.systemsofcare.samhsa.gov

C. HISTORICAL BACKGROUND OF HAWAII STATE CHILDREN'S MENTAL HEALTH SYSTEM

Felix Consent Decree
In 1993, the Governor, the Superintendent of Education and the Director of Health were sued in Hawaii federal court for failure to provide the needed mental health services to children and adolescents in order to benefit from their educational programs. In 1994, the case was settled based upon the Felix Consent Decree which sets forth the terms and conditions of the settlement. The Consent Decree provided that members of the plaintiff class shall receive free and appropriate public education as required under IDEA and Section 504 of the Rehabilitation Act. Additionally, the State was to create a system of services, programs, and placements for the plaintiff class following the principles of the Child and Adolescent Service System Program (CASSP) (adapted from Stroul, Beth A. and Friedman, Robert M. 1986, *A System of Care for Children & Youth with Severe Emotional Disturbances*, Washington, D.C, Georgetown University Child Development Center.)

On May 31, 2005, after 12 years of system improvements, the federal court found the State of Hawaii in full compliance with federal law and the Felix Consent Decree ended. This determination was based on statewide improvements in services, practices, and outcomes for youth with emotional and behavioral health needs enrolled in public school.

System of Care Implementation
In 1993, the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health was awarded a six-year federal grant to develop a community-based system of care for children, youth and their families on the Leeward Project (*Ohana Project*). This federal grant brought technical assistance and consultation resources to the Leeward district, which was then shared with all communities across the state. The federal support received helped introduce the CASSP system of care values and guiding principles to all communities. Given the convergence of this grant and the Felix Consent Decree requirements that a system of care be established statewide, all communities were immersed in the CASSP principles.

In 2005, the CAMHD received another SAMHSA-sponsored six-year system of care cooperative agreement to develop and strengthen the system of care for youth transitioning to adulthood residing in the Kalihi-Palama community (titled *Project Ho'omohala*). This current cooperative agreement is building upon the strong foundation of CASSP principles to specifically focus on the specific needs and unique challenges facing youth 15-21 years as they enter their young adulthood. As with the *Ohana Project*, technical assistance and consultation resources received as part of this federal funding is being shared with all communities statewide, so that they may also strengthen the transition supports and services for all young people

Based upon the historical factors of the Felix Consent Decree and these SAMHSA federal funding opportunities, CAMHD continues to administer and manage the statewide child and adolescent mental health system from a system of care framework based upon the guiding CASSP principles. The system of care model encompasses a coordinated network of community-based services and supports that are specifically crafted to meet the unique challenges of children and youth with serious mental health needs and their families. Families

and youth are considered equal partners with public and private providers, with all parties working in a team-based framework to identify, implement and evaluate the services and supports.

National data support the effectiveness of the system of care model.

- Emotional and behavioral problems of youth served by systems of care were reduced or remained stable for 89 percent of children and youth after 6 months.
- Almost 91% of children and youth with a history of suicide attempts or ideation improved or remained stable in their emotional and behavioral problems when served within a system of care.
- School performance improved or remained the same for 75% of children and youth after 6 months if served by a system of care.
- Children and youth with co-occurring disorders improved after 6 months.
- Families and Caregivers report being satisfied with the cultural competence of service providers.

(Substance Abuse and Mental Health Services Administration. (n.d.) *Helping Children and Youth with Serious Mental Health Needs: System of Care*. [brochure])

Therefore, CAMHD has established the CASSP principles as the guiding principles for the statewide child and adolescent mental health system. CAMHD implements initiatives and monitors performance to assure that all services and supports are individualized, youth-guided and family driven.

<u>CAMHD'S Guiding Principles (Hawaii CASSP)</u>

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

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

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

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

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

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

Community-based Service Delivery
Service availability management and decision-making rest at the community levels.

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

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

Medicaid Child & Adolescent Behavioral Health Carve Out

In 2002, CAMHD entered into a Memorandum of Agreement with the State's Medicaid Agency, the Med QUEST Division (MQD) of the Department of Human Services (DHS) to provide intensive mental health services to Medicaid and Quest eligible youth within a no-risk carve-out capitation arrangement. This designation enables the state to appropriately benefit from the federal Medicaid dollars, while continuing to serve children and youth within the system of care that had been established. In accordance with this agreement, CAMHD meets all requirements of the Balanced Budget Act of 1997 as a Prepaid Inpatient Healthplan (PIHP). Compliance requires administrative and programmatic compliance, including the development and implementation of a Quality Assurance and Improvement Program (QAIP), as well as quality and infrastructure changes. Thus, functions such as credentialing, delegation, risk management, utilization management and quality assurance, have been integrated into the CAMHD business and management operations. CAMHD is monitored annually by an External Quality Review Organization (EQRO) for compliance with required standards of quality and oversight. Operating as a PIHP has strengthened the overall performance of CAMHD's business and management operations and the performance of provider agencies, while sustaining and improving child and family outcomes. This behavioral health carve-out, the Support for the Emotional & Behavioral Development of Youth or *SEBD Program*, allows Medicaid or Quest eligible youth with intensive mental health needs to access comprehensive community-based health care.

Functioning as a behavioral health plan has allowed CAMHD to realize over $25 million dollars of non-general fund revenue since fiscal year 2003, and $18,540,931 of federal funding in just the last two years of completed billing.

Cross Agency Coordination & Integration

In the fall of 2000, the Hawaii Department of Education (DOE) implemented school-based behavioral health services statewide. Each school provides the prevention services, support services, mental health assessments and school-based individual, family and group treatment services that students need to benefit from their education. If the school team (inclusive of teachers, parents and student) identifies that more intensive mental health services are needed to help the youth meet their educational goals, the school contacts the Family Guidance Center in their community to gain full access to the CAMHD intensive mental health services. At that time, a CAMHD Mental Health Care Coordinator works with the school and family to facilitate appropriate services. This coordinated relationship between the school system and the mental health system is defined by an interagency memorandum of agreement between the Departments of Health and Education, and provides an integrated system of care that has the school as a central access point for mental health services for educationally disabled youth.

Sustained Performance Monitoring

When the federal court revised the Felix Consent Decree in 2000, it required that the state continually examine its ability to provide appropriate services to youth and their families and maintain a certain level of system performance. The court defined the elements of a sustainable system as:

> "The system must be able to continue to purchase the necessary services to provide for the treatment of children appropriate to the individual needs of the child.

> "The system must be able to monitor itself through a continuous quality management process. The process must detect performance problems at local schools, family guidance centers, and local service provider agencies. Management must demonstrate that it is able to synthesize the information regarding system performance and results achieved for students that are derived from the process and use the findings to make ongoing improvements and, when necessary, hold individuals accountable for poor performance.
>
> "The system must be able to ensure teachers, therapists, and other support staff to continue their professional development and improve their skills and knowledge of effective educational and therapeutic methods and techniques."
> (Revised Felix Consent Decree, July 31, 2000, page 20).

CAMHD is committed to ongoing evaluation of performance and the use of data to continue the development and management of the system. CAMHD's performance management practices involve an extensive system for examining performance and using findings to make informed decisions about services and needed adjustments to program implementation. Performance data in CAMHD are tracked and analyzed across all aspects of service delivery and care. This information allows CAMHD to determine how well the system is performing for youth, and how well youth are progressing. It is sensitive enough to determine if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring. Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services. CAMHD, in collaboration with the Department of Education and Early Intervention Services of DOH, produces a quarterly performance report identifying trends and making policy and practice recommendations. This quarterly report may be accessed from the CAMHD website at http://www.state.hi.us/health/mental-health/camhd/index.html

Evidence-Based Services (EBS) Dissemination

In 1999, CAMHD formed the Empirical Basis to Services (EBS) Task Force made up of University of Hawaii experts, CAMHD leadership, provider agency representatives, and families to review the research literature for evidence-based services and programs. The EBS Task Force later became a formalized integral part of the CAMHD system, with the name change to Evidence-Based Services Committee. The committee has continued to meet monthly for the past 7 years, and continues to review and code the research to identify the practices and services that have undergone evaluation to show evidence of effectiveness for youth with behavioral and emotional needs. Over the past 7 years, the EBS committee has screened over 2533 research articles, read over 249 papers in full detail and coded more than 350 treatment protocols.

Based upon the findings of the EBS Committee, the CAMHD staff provide training and support on evidence-based practices for CAMHD staff, contracted providers, staff of other state agencies, and families of special needs children and youth.

Clinical practice support is made available through the Interagency Performance Standards and Practice Guidelines, a.k.a. "Purple Book", which includes information about the standards of services provided by CAMHD providers, as well as practice guidelines. The "Blue Menu" (a matrix summarizing the findings of the EBS committee), the EBS "Practice Tip of the Week", and EBS full Biennial Report (and past reports) is available at:
http://www.hawaii.gov/health/mentalhealth/camhd/library/webs/ebs/ebs-index.html

CAMHD contracts for evidence-based treatment programs across the state. Multisystemic Therapy, Multidimensional Treatment Foster Care, Functional Family Therapy (in implementation phase), and Common Sense Parenting programs are available. In addition, CAMHD supports and encourages each team to review the results of the services provided to each child and family. CAMHD does not require teams to implement any particular evidence based treatment. Rather,

CAMHD expects each team to use the research findings as data to guide them as they develop individualized plans. The teams are then expected to routinely monitor the outcomes of the services they have provided. CAMHD supports the use of practices and approaches that achieve the goals as established, not any particular treatment approach.

Federal Grants

In September 2004, Hawaii was one of eight states awarded a three-year Substance Abuse and Mental Health Services Administration (SAMHSA) State Infrastructure Grant (SIG) aimed at the reduction/elimination of seclusions and restraints (S/R) in hospital and residential care. The Hawaii Cultures of Engagement in Residential Care (CERC) project is part of CAMHD's ongoing practice development initiative to continue refining best practices and promote the use of evidence-based services for children, adolescents and families. CERC is also designed to improve residential care practices in settings that use these techniques seldom, in order to address other difficulties such as frequent violence, running away, etc.

Also in September 2004, Hawaii was awarded a 3-year federal grant from the Substance Abuse and Mental Health Services Administration for the Hawaii's State Mental Health **D**ata **I**nfrastructure **G**rant for Quality Improvement (DIG). The project is designed to evolve the CAMHD data collection and information system to meet the reporting requirements of the federal Uniform Reporting System (URS), to improve integration of the URS information with the state Community Mental Health Services Block Grant, to increase dissemination of system information to stakeholder groups, and to expand Hawaii's participation in the national Data Infrastructure Grant network.

In October 2005, CAMHD was awarded a SAMHSA system of care cooperative agreement. The goal of Project Ho'omohala is to implement a system of care encompassing the Transition to Independence Process for youth with emotional or behavioral challenges between the ages of 15-21 living in the Kalihi-Palama Community on the island of Oahu. With the lessons learned from this project, it is anticipated that the successful components will guide the development of a statewide system for young people.

In September 2006, the Department of Health was notified that it was awarded 5-year $14.2 million Mental Health Transformation State Incentive Grant from the Substance Abuse and Mental Health Services Administration. The prestigious award will allow Hawaii to develop policy initiatives across state departments and the community to transform the entire mental health services delivery system. Although Hawaii has made great strides over the last decade, much work remains to assure that every individual with mental health issues can have "a life in the community."

SECTION III

CURRENT STATUS OF SYSTEM

A. DESCRIPTION OF THE CHILD AND ADOLESCENT MENTAL HEALTH DIVISION (CAMHD), HAWAII DEPARTMENT OF HEALTH

The CAMHD Vision

Happy and Healthy…Children and Families…Living in Caring Communities

The CAMHD Mission

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

The CAMHD Organization

In the Department of Health, three divisions comprise the Behavioral Health Administration (BHA): Adult Mental Health Division (AMHD), Alcohol and Drug Abuse Division (ADAD), and the Child and Adolescent Mental Health Division (CAMHD). The Deputy Director for Behavioral Health oversees the Behavioral Health Administration and reports to the Director of Health. The Director of Health is an appointed cabinet level position and reports to the Governor.

CAMHD is headed by a Division Chief and consists of both line and staff offices. The staff offices are maintained at the state level and consist of approximately 75 positions. The line offices are organized into eight (8) CAMHD branches consisting of seven (7) Family Guidance Centers (FGCs) and one (1) Family Court Liaison Branch (FCLB), and include approximately 164 positions. A network of approximately 18 contracted provider agencies located throughout the State provides an array of home and community-based and residential treatment services. The Division's FY 2007 state allocation is approximately $50.9 million, which is fairly stable from the previous year's funding. CAMHD augments this general fund allocation with federal reimbursements.

The CAMHD state office includes the Research & Evaluation Office, Administrative Operations Office, Clinical Services Office and the Performance Management Office. The Research & Evaluation Office is responsible for designing and overseeing a comprehensive, statewide evaluation and reporting system for the purpose of improving effectiveness and efficiency, improving clinical practice and client outcomes. Administrative Operations Office is responsible for budgeting, accounting, personnel resource management, information management and contracting. The section is also responsible for maximizing alternative funding sources, such as Title XIX, Title IV-E and grants. The Clinical Services Office is responsible for clinical practice issues, training, specialty case consultation, utilization review, and resource management. The Performance Management Office (PMO) develops, implements, and monitors a Division-wide, structured system for continuous improvement of mental health services delivery and youth outcomes. CAMHD's Management Information System (CAMHMIS) provides the organizational foundation for CAMHD's outcome tracking, utilization management, and accountability systems, as well as billing and general registration.

The community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGC's are strategically located in geographic areas that correspond with the Dept. of Education school districts. Four FGCs are located on Oahu, where close to 72% of the State's population resides. Also, there is one FGC each on the neighbor island counties--Kauai, Maui, and the Big Island. Several FGCs also have satellite offices. Each FGC is headed by a Branch Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide

intensive case management. Services provided by the centers include facilitating access to care coordination (intensive case management), direct service provision, service procurement, utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

The Family Court Liaison Branch (FCLB) provides screening, assessment, evaluative, diagnostic, treatment and consultative services to youth with mental health challenges in the state juvenile justice system. FCLB provides mental health treatment linkages between the Family Court, Hawaii Youth Correctional Facility, and the State's Detention Home. The FCLB works in partnership with families and the court system to design and implement individualized service and treatment plans suitable to specialized needs of children and youth involved with the Hawaii juvenile justice system. FCLB differs from CAMHD's other FGCs because it does not have a geographical limitation, and provides direct services in collaboration with other state agencies and Family Court. FCLB staff spends considerable time and effort in conducting mental health assessments of youths at the direction of Family Court judges and in advocating for treatment of such youth in less restrictive settings, where appropriate.

CAMHD Administration and Oversight

The Division Chief is the senior executive responsible for directing, maintaining and supporting an effective system for mental health service delivery for eligible youth and their families. The governing body of CAMHD is its Executive Management Team (EMT), which is chaired by the Division Chief, and is represented by the Medical Director, Performance Manager, Executive Director of the Statewide Family Organization, Public Health Administrative Officer, Provider Relations Liaison, and Branch Chiefs of the Family Guidance Centers.

The Performance Improvement Steering Committee (PISC) oversees the activities of the CAMHD Quality Assurance and Improvement Program (QAIP). The activities of the PISC are reported to the EMT. The Performance Manager chairs PISC; and the Medical Director serves as vice-chair. PISC is composed of chairpersons of its standing committees, the Division Chief, a representative of the Branch Chiefs, representatives from agencies in CAMHD's provider network, a representative from an organization representing family members, and a psychiatrist from the community at large.

CAMHD maintains standing committees to implement and manage much of its work. The established committees include the Compliance Committee, Credentialing Committee, Grievance and Appeals Committee, Information Systems Design Committee (ISD), Policy and Procedures Committee (P&P), Evidence Based Services (EBS) Committee, Safety and Risk Management Committee, Training Committee, and Utilization Management Committee (UM).

Workforce Development: Recruitment

CAMHD positions that were created during the years of the Felix Consent Decree were often created as exempt from civil service obligations, in order to more quickly recruit and attract qualified professionals. With the ending of the Felix Decree, CAMHD is no longer authorized by state statute to maintain these exempt positions. Of the 252 allocated positions, 92 are still in this exempt status. Many others have been replaced by civil service positions through attrition and through previous conversion requirements. This conversion to civil service process has created personnel challenges in the form of recruitment and retention due to the lack of permanency offered to incumbents, and often times rigid civil service salary structures. CAMHD is pursuing legislative action to guide this conversion to civil service process, and to allow some positions to remain exempt by statute.

Since moving to the civil service system, CAMHD has experienced an increase in the personnel vacancy rate. The inherent delays in recruitment associated with the required procedures have caused many positions to remain vacant over extended periods of time. CAMHD currently has 73

vacant positions of the 252 approved positions, which is a vacancy rate of approximately 29%. This vacancy rate has been remained at this level for the past year, since undergoing the conversion to civil service. The average time that is taken to successfully recruit into a position is 234 days, with 10 positions unable to be filled for more than 500 days.

Workforce Development: Orientation & Training

All CAMHD staff receive orientation to CAMHD system within 90 days of employment. The administrative services personnel office manages this orientation. In addition, all CAMHD clinical staff working in the Family Guidance Centers receive the following core competency training within ninety (90) days of hire:

a. Engagement Skills
b. Evaluating Stages of Change & Readiness for Care
c. Interagency Collaboration Skills
d. Intensive Case Management Skills (MHCCs and their supervisors only):
e. System of care values, CASSP principles, CAMHD mission and strategic plan
f. Overview of evidence-based services
g. Using evidence-based treatment literature with teams
h. Strengths based Coordinated Service Planning:
i. Child and Adolescent Functional Assessment Scale (CAFAS) certification.
j. Child and Adolescent Service Intensity Instrument (CASII, formerly CALOCUS).
k. Achenbach System of Empirically Based Assessment (ASEBA).
l. Using the Interagency Performance Standards & Practice Guidelines

The Practice Development Section of CAMHD's Clinical Services Office provides ongoing training and mentoring of evidence-based practices for CAMHD staff, staff of contracted providers and other state agencies, as well as families of youth with special health needs.

B. COMPREHENSIVE SERVICE ARRAY

In November 2005, CAMHD issued a Request for Proposals (RFP) to procure a defined array of services for children and youth with mental health needs. Per contract agreement, all services must be provided in accordance with the standards and requirements defined in the Interagency Performance Standards and Practice Guidelines, a.k.a. the "Purple Book." Available at: http://www.hawaii.gov/health/mental-health/camhd/library/pdf/purplebook.pdf. These contracts are executed annually, but may be renewed for the next 6 years. CAMHD specified that the contracted services must meet 5 major goals:

Goal 1. Provide eligible youth and young adults with timely access to a comprehensive array of community-based and evidence-based mental health services provided by credentialed individuals that are knowledgeable and competent in delivering these treatments, and ensure that these treatments and interventions are provided within a system of care embodying the Hawaii CASSP principles.

Goal 2. Promote the use of current knowledge regarding evidence-based services in the development of individualized plans and promote the mental health system in a manner that facilitates the application of these services.

Goal 3. Demonstrate an accountable and efficient child and adolescent behavioral health system through dynamic evaluation of performance data and application of findings to guide management programmatic and service planning decisions.

Goal 4. Demonstrate an effective and efficient publicly managed behavioral health plan for Medicaid eligible youth with the most serious emotional challenges.

Goal 5. Demonstrate an effective integrated cross agency system of services for educationally disabled students identified as requiring mental health services to benefit from their public education.

Children & Youth Eligibility

Array of Emergency Public Mental Health Services
The services defined in this section are available to all children and youth in Hawaii, ages 3-18 years, experiencing an imminent life threatening mental health crisis. No prior authorization process for these emergency public health services are necessary.

Array of Educationally Supportive (ES) Mental Health Services
Students with an educational disability that have been determined to be in need of intensive mental health services to benefit from public education. The criteria for enrolling a youth in the ES program are IDEA eligibility, an Individualized Education Program (IEP) with recommendation for services from CAMHD, and an IEP meeting with CAMHD participation to determine the goals of mental health services to be provided. Access for ES services is done through DOE and the IEP process for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific supports via their IEP.

Support for Emotional and Behavioral Development (SEBD) Program
Medicaid eligible youth or MedQUEST enrolled youth requiring mental health services that exceed the scope or intensity that is able to be provided by their selected QUEST health plan. The criteria for enrolling a youth are QUEST or Medicaid eligibility, a DSM IV[1] diagnosis of at least 6 months, and a CAFAS[2]/PECFAS[3] score of 80 or greater. SEBD eligibility is determined by the CAMHD Medical Director.

Mental Health Only Category
Youth, ages 3 to 18 years, with emotional and/or behavioral challenges that are not eligible through either ES or SEBD, but who are determined to be in need of mental health services by the CAMHD Medical Director.

Array Of Services Provided By Community-Based Providers And Standards For Treatment
CAMHD's system of care provides timely, consistent and responsive mental health services in the following areas. For specific definition of each level of care, please refer to the Interagency Performance Standards and Practice Guidelines, which may be accessed from the CAMHD website at: http://www.hawaii.gov/health/mental-health/camhd/library/pdf/purplebook.pdf

Emergency Public Mental Health Services

The provision of emergency public mental health services are limited to times of crisis that involve a great deal of urgency. These services are available to the general public and are provided as part of the CAMHD commitment to public health service. These services are available 24 hours a day, 365 days per year.

The service of 24 Hour Crisis Telephone Stabilization, traditionally known as the Emergency Hotline, is provided through a memorandum of agreement between CAMHD and AMHD Access Line. This service is available to all youth whose immediate health and safety may be in jeopardy due to a mental health issue.

[1] Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).
[2] Child and Adolescent Functional Assessment Scale (CAFAS)
[3] Preschool and Early Childhood Functional Assessment Scale (PECFAS)

Other services, contracted to provider agencies, include Crisis Mobile Outreach, Crisis Therapeutic Foster Home, and Community-Based Crisis Group Home.

Educationally Supportive (ES) Intensive Mental Health Services

All ES services emanate from the educationally focused team-based plan. The plan may be the Individualized Education Program (IEP) described above, or a CAMHD Coordinated Service Plan (CSP) that is referenced or linked to the IEP. A CSP is a broad, strengths-based plan that incorporates the multi-agency services and informal supports to be provided. Often times, IEP teams will refer to the services referenced in the CSP, and visa versa. Whether services are described in the IEP document, or the CSP document linked to the IEP, ES services are provided with the goal of providing educationally related treatment services that are necessary in order for the youth to meet his/her IEP goals. Services include the following.

- Psychosexual Assessments
- Intensive In-Home Intervention
- Multisystemic Therapy
- Respite Homes
- Community Mental Health Shelter
- Therapeutic Foster Home
- Multidimensional Treatment Foster Care
- Therapeutic Group Homes
- Independent Living Programs 16–18
- Independent Living Programs 18 – 21
- Community-Based Residential Level III
- Community-Based Residential – Level II
- Community-Based Residential – Level I
- Hospital-Based Residential

Support For Emotional And Behavioral Development (SEBD) Program Services

Youth or young adults enrolled in the SEBD program have been evaluated and determined to meet eligibility criteria, which includes being enrolled in a QUEST Healthplan (or Medicaid eligible) with a current mental health assessment showing active mental health diagnosis and functional assessment showing significant life impairment.

The CAMHD Medical Director serves as the Chief Medical Officer and determines individual eligibility. If determined to be eligible for the SEBD program, the following comprehensive array of services are available to each youth and their family. These services are provided in accordance with all requirements of the CAMHD-MQD Memorandum of Agreement (MOA) and the Balanced Budget Act. Services are determined through an individualized Coordinated Service Planning (CSP) process using the IPSPG as guidance in determining appropriate services. Services provided to SEBD youth link with services required in the students IEP, if the student is IDEA eligible.

Youth enrolled in the SEBD Program, may access all of the ES Services listed above, as well as the following:

- Comprehensive and Focused Assessments
- Psychiatric Evaluation
- Medication Management
- Individual Therapy
- Group Therapy
- Family Therapy
- Partial Hospitalization

- Functional Family Therapy
- Peer Support
- Parent Skills Training
- Intensive Outpatient Treatment for Co-Occurring Substance Abuse
- Intensive Outpatient Services For Independent Living Skills

As of the date of this printing, the following community-based providers have been awarded Purchase of Service contracts to provide mental health services to CAMHD youth. Over time, the list may change as new RFP's are issued, funding is increased or decreased, contracts are terminated for nonperformance, or other reasons. For an up-to-date list of providers, contact CAMHD state office at 733-9339.

Alakai Na Keiki, Inc.
Aloha House
Bobby Benson Center
Bountiful Psychiatric Hospital
CARE Hawaii, Inc.
Catholic Charities of Hawaii
Child and Family Service
Hale Kipa, Inc.
Hale Opio Kauai, Inc.
Hawaii Behavioral Health, LLC
Kid's Behavioral Health
Marimed
Maui Youth & Family Services, Inc.
Parents & Children Together
Queen's Medical Center
Sutter Health Pacific, dba Kahi Mohala
The Institute for Family Enrichment
Waianae Coast Community Mental Health Center, Inc.

(See Appendix for CAMHD's Service Array Definitions and a Cross-Tabulation of Behavioral Health Service by Provider, by geographic area.)

Federal Community Mental Health Services Block Grant

Each year the Department of Health administers the Community Mental Health Services Block Grant from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the federal funds is to support comprehensive, coordinated, community-based service systems of care for adults with serious mental illness and children with serious emotional disturbance. In recent years, including this current year, CAMHD has allocated these federal block grant funds to the following initiatives.

Support for Transition to Adulthood Services.

At the national level, as well as in Hawaii, there is a growing focus on assisting youth who "age out of the system" to transition to adulthood and independence. CAMHD has dedicated block grant funds to support the development and implementation of a plan to create a statewide support network for young adults ages 17-21 with emotional and/or behavioral challenges. The plan would identify the skills needed by these youth to succeed in the areas of vocational training or education, housing, health, social and community participation, treatment and mental health service needs and peer support needs.

Suicide Prevention

Hawaii has higher rates for youth reporting attempted suicide. Based on Youth Risk Behavior Surveillance System (YRBSS) data from the U.S. Centers for Disease Control and Prevention, in 2001, while 8.8% of high school youth in the U.S. attempted suicide in

the past 12 months, 13.4% of Hawaii high school youth attempted suicide in the past 12 months.

CAMHD dedicates block grant funds to support youth suicide prevention. Since 2005, CAMHD supported its sister agency in the Department of Health, the Injury Prevention and Control Program, which has identified suicide prevention as one of its priorities in its Strategic Plan and staffs a Suicide Prevention Steering Committee, which includes representatives from CAMHD and Adult Mental Health Division. Based on the recommendations of the Suicide Prevention Steering Committee, the program funds are used to conduct ASIST "Gatekeeper" training.

Collaborations with other Child-Serving Agencies

Youth in the juvenile justice and child welfare systems are not receiving appropriate, timely mental health services. CAMHD is working to improve the integration and coordination of services with other state agencies. In CAMHD's discussions with Family Court and Child Protective Services, both agencies shared their perspectives that getting their youth to qualify for CAMHD services are seen as a barrier. CAMHD dedicates block grant funds to support mental health assessments so that youth in need of mental health services in the child welfare and juvenile justice systems can be identified and referred.

Through an Office of Juvenile Justice and Delinquency Prevention grant, Hawaii Family Court has developed a new initiative, Girls Court. The program seeks to recognize and address the unique needs of girls who end up in the juvenile justice system. Many of the girls have trauma backgrounds, which may include child/domestic/sex abuse and neglect, and undiagnosed mental health problems and needs. The Girls Court Program identified the provision of mental health services as key to identifying and addressing the underlying issues that cause the girls to run away or offend. CAMHD and Family Court will initiate a new partnership to provide for the unique mental health needs of the girls. Block grant funds will be used to support the goals of the program, and provide much-needed mental health services.

Support for Families and Youth Involvement in System Partnerships

CAMHD allocates block grant funds in support of a statewide family organization that offers training, support and guidance to families of children and youth with emotional or behavioral challenges. The statewide family organization provides parent partners throughout the state. These parent partners provide training, outreach, and support to the families. The parent partners are also members of Family Guidance Center management teams. On a statewide level, the Executive Director of the Statewide Family Organization is a member of CAMHD Management Committees, and an appointee to the State Council on Mental Health.

Outreach to Homeless and Gay/Lesbian/Bisexual/Transgender Youth

The CAMHD contracts with a provider to outreach to homeless and runaway youth and develop trusting relationships with youth so that the youth have some place and someone to turn to in times of need, and take advantage of any of the health, education, housing or vocational opportunities the program and can provide or arrange. As the relationship between staff and youth strengthen, the staff will be able to offer information and referrals to mental health services. In 2005, the homeless outreach provider began to outreach to another gap group, gay/lesbian/bisexual/transgender/questioning youth.

Reducing Stigma and Barriers to Service

Stigma against mental illness continues to be a challenge in Hawaii, particularly where there are strong cultural beliefs against disclosing mental illness in the family. Using block grant funds printed public awareness materials were purchased and made available at each of CAMHD's regional Family Guidance Centers.

Hawaii has a sizeable portion of its population that speaks a language other than English at home. For the past several legislative sessions, immigrant-serving agencies have tried, unsuccessfully, to pass legislation that requires state agencies to provide translation services. This year, however, they were successful and the Governor signed Act 290 which requires agencies to take steps to provide oral and written language access services. CAMHD is currently updating its Consumer Handbook which is provided to every child and family. Block grant funds will be used to increase access to the information in the Handbook with multiple language translations, as well as audio and large print versions.

Evidence Based Services

Block grant funds are used to support the work of the broad-based Evidence Based Services Committee in its methodological review of scientific literature to identify, disseminate, and improve practice of evidence-based services in children's mental health. Recently, the Evidence Based Services Committee developed a subcommittee to evaluate prevention programs and identify those with sufficient evidence to support replication.

Community-based Approaches

In a demonstration project to enhance services to youth with trauma backgrounds, CAMHD is supporting a program that provides exposure to art therapy, music therapy, therapeutic horseback riding and outdoor adventure as a mechanism to bring joy back into their childhoods, provide opportunities to find skills and talents and build self-esteem, and provide a supportive, safe environment for youth who have had similar traumatic experiences. Initial evaluation reveal that many youth have found comfort in knowing that they are not alone in their experiences, and have found talents and strengths within themselves, and that the parents and foster parents enjoy the weekly respite away from these high-needs youth while knowing the youth are well-cared for in a safe, nurturing environment.

C. STANDARDS OF TREATMENT

On July 1, 2006, the DOE and CAMHD launched the implementation of the revised *Interagency Performance Standards and Practice Guidelines (aka the Purple Book)*, which defines service content standards and aims to improve the efficiency and effectiveness of school-based behavioral health services and the array of intensive mental health services. It is used by DOE and CAMHD employees and contracted providers in developing individualized plans and providing behavioral/mental health services to students. This guide describes performance standards for nearly sixty (60) distinct services within Hawaii's comprehensive service array. The 584-page reference document is available on CAMHD's webpage at: http://www.hawaii.gov/health/mental-health/camhd/library/pdf/purplebook.pdf

Monitoring Standards of Care & Agency Performance

CAMHD has systemically integrated performance evaluation throughout the children's mental health system to ensure that the CASSP principles and effective services are being implemented at all levels of care. By incorporating performance accountability and data-based decision making throughout the system, the activities involved with routine evaluation are incorporated into personnel and contracted provider expectations.

The comprehensive monitoring system includes not only monitoring of compliance with standards but uses methodologies that allow for the examination of practice. Additionally, the Child and Adolescent Mental Health Management Information System (CAMHMIS) features information, including a clinical module that allows for "real-time" reporting of child-status and service utilization patterns accessed at the line-level by care coordinators.

CAMHD monitors child status through case-based review methodology conducted by the local services system and through contracted service provision, functional status trends (Child and Adolescent Functional Assessment Scale), symptomology trends, school attendance, court involvement, service utilization and days served in home, school and community.

CAMHD monitors system performance through provider agency case-based reviews, child and family satisfaction surveys, complaint review and analysis, sentinel event analysis, comprehensive provider monitoring, and internal Quality Assurance monitoring. CAMHD operates in accordance with its Quality Assurance and Improvement Plan (QAIP) that is reviewed and revised annually. Additionally, each FGC has a center-specific plan. Quarterly performance reports are produced that present current status and trends of CAMHD's performance measures.

D. PERFORMANCE

Population And Demographics

According to the President's New Freedom Commission's report, *Achieving the Promise: Transforming Mental Health Care in America,* about 5% to 9% of children ages 9-17 have a serious emotional disturbance. Primary source: Friedman, R. M., Katz-Levey, J. W., Manderschied, R. W., & Sondheimer, D. L. (1996b). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71–88). Rockville, MD: Center for Mental Health Services.

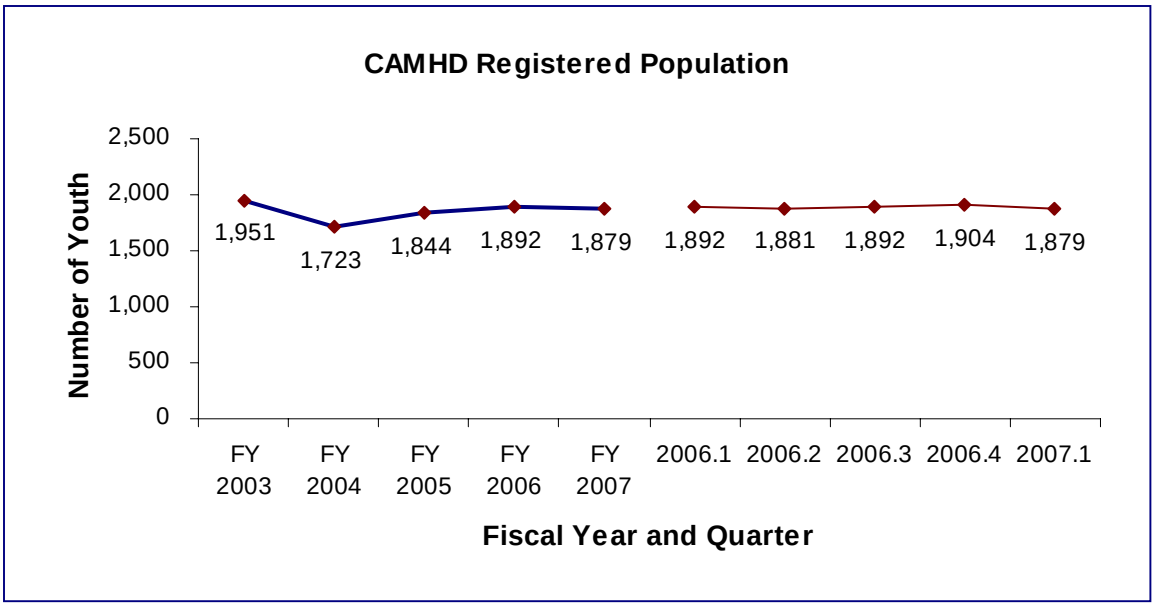
According to data provided by the NASMHPD (National Association of State Mental Health Program Directors) Research Institute (NRI), there were 148,991 youth aged 9-17 in Hawaii in the year 2003. NRI estimated that between 14,899 and 17,879 of these individuals had a serious emotional disturbance (SED). This range represents 10-12% of youth ages 9-17. Using the 2000 census, the prevalence of SED by county for individuals aged 9-17 is shown in the table below, and is observed to be 15,035-18,043 statewide. Extrapolating down to age 3 to age 17, there may be as many as 35,492 children and youth in the state with serious emotional and behavioral disturbances.

Estimated Range of Number of SED Youth Aged 9-17 Years by County, based on 2000 Census			
County	Total Youth	Lower SED Number	Upper SED Number
Hawaii	21,104	2,110	2,532
Honolulu	103,912	10,391	12,469
Kauai	8,359	836	1,003
Maui	16,977	1,698	2,037
STATE	150,352	15,035	18,042

Estimated Range of Number of SED Youth Aged 3-17 Years by County, based on 2000 Census			
County	Total Youth	Lower SED Number	Upper SED Number
Hawaii	33,498	3,350	4,020
Honolulu	174,835	17,483	20,980
Kauai	13,362	1,336	1,603
Maui	27,660	2,766	3,319
STATE	249,355	24,935	29,923

Annually in Hawaii, about 2,400 children and youth are registered for Child and Adolescent Mental Health Division services with distribution showing that 63% typically residing on Oahu, 25% on the Big Island, 7% in Maui County, and 5% on Kauai. Serving 2,400 youth per year and

given the census number of 249,355, it becomes clear that CAMHD is serving approximately 1% of the child population. Given that our state has implemented statewide school based behavioral health services, it is known that DOE is serving approximately 9,000 students per year with SBBH services, and it is known from third party payers and TriCare that some families are accessing mental health services for their children through those means. However, taking all of that into account, as a state, we are probably only serving approximately 3-4% of the children needing services.



The overall size of the CAMHD population has stabilized with a small movement toward growth. A greater number of geographic regions increased in size, but Kauai continued to decrease. The evolution toward decreasing special education involvement and increasing health care (QUEST) involvement continued. Recent growth in juvenile justice involvement appeared to stabilize. The CAMHD population remains mostly male, but the proportion of females continue to increase, with approximately 65% male and 35% female. Similarly, the CAMHD population is largely adolescent and the trend toward decreasing age has settled at an average of 14.2 years, most participants are between the ages of 9-17. Relative to the general population of youth in Hawaii, Asian youth are under-represented in the CAMHD population whereas Hispanic and Multiracial (predominantly White and Native Hawaiian or Other Pacific Islander) youth are over-represented. Youth are increasingly identified with multiple diagnostic problems, the most common being disruptive behavior (50%), attentional disorders (40%), and mood disorders (33%), substance-related (17%), and anxiety problems (20%) increasing. The majority of registered youth (75%) have multiple diagnoses, with an average of 1.9 diagnoses at admission.

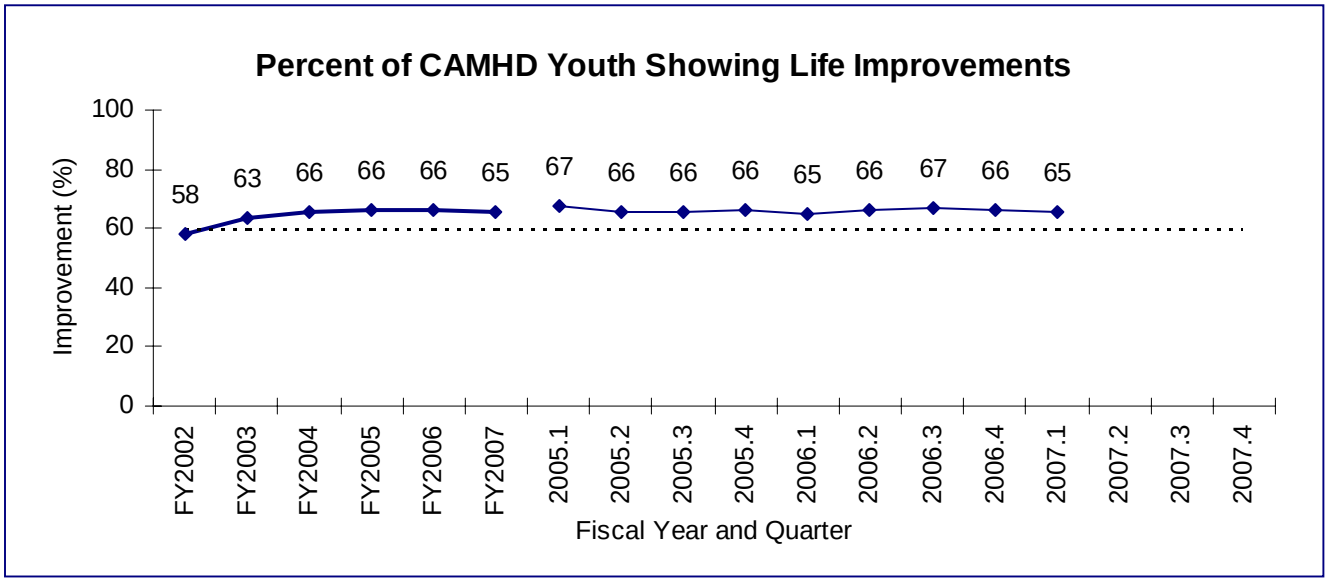
Utilization

With CAMHD's commitment to the CASSP principle of serving the child in the least restrictive environment, CAMHD tracks whether at least 65% of all youth are served strictly in their homes and communities, without needing to place the child in residential services. Since fiscal year 2003, CAMHD has been steadily improving on this goal, with an average of 73% of youth being served in their home communities during the last quarter of FY2006. Similarly, CAMHD is has been successful in achieving the goal that 95% of youth will receive treatment within the state of Hawaii, without needing to send the child out-of-state. Since FY2003, 99% of youth remained in the islands. From FY2002-2005, the average length of services was reduced by 40%-60%, and the average length of service reduced most rapidly from FY2002-2004. For example, youth went from an average length of service from 866 days in 2002 to 434 days in 2004. Average

expenditures were also reduced from FY2002-2005. Costs reduced from $1,083 per point of improvement in the CAFAS during 2002 to $650 in 2005.

Outcomes

CAMHD also tracks whether the youth served by CAMHD have improved in their functioning, competence and behavioral health. CAMHD's goal is that at least 60% of youth sampled show an improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA). In FY2002, only 58% of youth showed an improvement, but beginning the next year, FY2003, CAMHD began to consistently meet its goal of over 60% of youth improving. During the last quarter of FY2006, 66% of youth showed improvements in functioning since entering the CAMHD system. During the period FY2002-2004, youth were admitted with average clinical impairment scores of 110 on the CAFAS; youth were maintained at a moderate level of impairment (85) and discharged with an average CAFAS total score of 60. A rate of change calculation found that youth were getting better faster. Similar rates were found in ASEBA.



E. GAPS/LIMITATIONS

Although the system has been fairly stable and meets many of the established performance targets, there are areas in which concerns persist.

At-Risk Populations: Youth in Juvenile Justice, Chronic Patterns of Running, and Youth with Trauma

Although no national estimates exist, small-scale studies have revealed that the prevalence of mental disorders among children in the juvenile justice system is much larger than that of the general child population. Nearly two-thirds of males and three-quarters of females in the juvenile justice system have at least one psychiatric disorder.

Psychiatric Disorders Among Youth in Juvenile Detention		
	Females	Males
Major Depressive Episode	22%	13%
Psychotic Disorders	1%	1%
Anxiety Disorder	31%	21%
ADHD	21%	17%
Disruptive Behavior Disorder	46%	41%
Substance Abuse Disorder	47%	51%
ANY DISORDER	74%	66%

Source: Teplin, L. A., et al. (2002). Psychiatric Disorders in Youth in Juvenile Detention. *Archives of General Psychiatry, 59*(12), 1136 [as cited in Koppelman, J. (2005, July 12). *Mental Health and Juvenile Justice: Moving Toward More Effective Systems of Care* (Issue Brief No. 805). Washington, DC: National Health Policy Forum. Retrieved November 1, 2006, from: www.nhpf.org/pdfs_ib/IB805_JuvJustice_07-22-05.pdf].

In a study that looked at Hawaii's 2004 Juvenile Justice Information System data and Family Court case files of incarcerated juveniles and juveniles on probation, about 70% of both boys and girls in the juvenile justice system have an Axis I psychological diagnosis. Twenty-eight percent (28%) of girls and 14% of boys case files contained records of depression; 19% of boys and 13% of girls case files had records of conduct disorder; and 23% of boys and 7% of girls case files had records of ADHD[4].

A recent report published by the Hawaii Department of the Attorney General, The Female Juvenile Offender in Hawaii[5], used 2004 Juvenile Justice Information Systems data to compare gender differences, and found that 1,906 boys and 2,808 girls were arrested for being runaways. Among 10,693 total offenses for boys and 6,657 total offenses for girls, runaway was the top offense for both sexes. The youth have a frequency range of runaway offenses of 0-50 for boys and 0-31 for girls; the average number of runaway offenses for boys is 4.5, and 6.9 for girls. In an analysis of the strongest predictors of runaway arrests, the Department of the Attorney General identified the following factors: female gender, Oahu residence, multiple property arrests, frequent drug use and suicide ideation.

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[4] Pasko, L. (2006). Profiles of Female and Serious Juvenile Offenders in Hawaii PowerPoint presentation. Retrieved November 1, 2006, from http://hawaii.gov/ag/cpja/main/rs/sp_reports/0306.

[5] Pasko, L. J. (2006). The Female Juvenile Offender in Hawaii: Understanding Gender Differences in Arrests, Adjudications, and Social Characteristics of Juvenile Offenders. Honolulu, HI: Department of the Attorney General. Retrieved November 1, 2006 from http://hawaii.gov/ag/cpja/main/rs.

In an analysis of the 2004 Juvenile Justice Information System offense data and Family Court cases, the following risk factors were found in the youth's case records:

Hawaii Juvenile Offenders - Abuse and Mental Health		
	Females	Males
Physically abused	50%	41%
Witnessed domestic violence	58%	42%
Sexually abused	38%	8%
Self-injury	28%	5%
At least one prior Suicide attempt	35%	12%

Source: Pasko, L. Profiles of Female and Serious Juvenile Offenders in Hawaii Power Point. Department of the Attorney General. Available at http://hawaii.gov/ag/cpja/main/rs/ under Special Reports 2003-2006.

In its Strategic Plan, CAMHD will prioritize improving access to mental health services for youth in the juvenile justice system. See Strategic Plan Goal 1.7.

CAMHD sentinel event reports show that elopement from programs is the largest significant safety concern at provider agencies. During the year 177 elopements occurred, mostly in the highest levels of care where the highest risk cases are placed. In the fourth quarter of FY2006, elopement accounted for 15% of all sentinel events. The biggest increase in elopements during the quarter was in therapeutic group homes (from 38 to 73), and in therapeutic foster care (from 18 to 43).

In Fiscal year 2005, CAMHD served 69 youth (2.8% of all registered youth) who had an absent living situation; 67 of them runaway, and 3 were homeless[6]. Over the next four years, CAMHD's Strategic Plan Goal 1.11 will focus efforts to reach out to homeless and runaway youth and provide services to meet their unique needs.

Need for Suicide Prevention and Intervention Focus

Based on Youth Risk Behavior Surveillance System (YRBSS) data from the U.S. Centers for Disease Control and Prevention, Hawaii's rate for youth reporting attempted suicide was higher than the U.S. in all years from 1993-2001. In 2001, while 8.8% of high school youth in the U.S. "attempted suicide in the past 12 months", 13.4% of Hawaii high school youth attempted suicide in the past 12 months.

Tragically over the past several months, there have been several completed suicides and suicide attempts among youth and young adults. CAMHD has offered resources to the community, including the services of our clinical staff and an experienced psychiatrist who was instrumental in working with another community on the same issue. CAMHD is also supporting gatekeeper training for people who work closely with youth. Gatekeepers are taught to identify the warning signs of suicide and to intervene before an event can take place. CAMHD is currently exploring ways to deploy its staff of Psychiatrists to educate and train the public on suicide issues.

Suicide is a priority issue and will be addressed in CAMHD's Strategic Plan Goal 1.11. As CAMHD moves toward achieving this goal, CAMHD hopes to identify community partners interested in developing community response plans to respond to suicides and suicide attempts in their communities.

Services for Gay, Lesbian, Bisexual, Transgender (GLBTQ) Youth with Mental Health Needs
According to the National Mental Health Association website, GLBT youth are:

[6] Daleiden, E. L. and Yogi, N. (2006). *Annual Factbook Fiscal Year 2004* . Honolulu, HI: Child and Adolescent Mental Health Division.

- often subjected to such intense bullying that they're unable to receive an adequate education;
- more apt to skip school due to fear, threats, and property vandalism directed at them;
- more than three times more likely to drop out of school than the average heterosexual students; and
- two to three times more likely to attempt suicide than their heterosexual counterparts.

Source: National Mental Health Association at www.nmha.org/pbedu/backtoschool/bullyingGayYouth.cfm.

Youth with mental health needs who also identify themselves as GLBTQ, are at even higher risk of suicide, self-harm, or being victims of threats and aggression. In order to better serve young people who are eligible for services, and who also identify as being GLBTQ, CAMHD has contracted for a specific group home to provide treatment. Youth who are GLBTQ and have been in need of community-based care in our state have experienced challenges while being served in other CAMHD contracted programs. While not all youth would chose to be in this type of program, CAMHD has contracted for this service to better serve this population. In addition, CAMHD will incorporate unique issues faced by GLBTQ youth in its anti-stigma plan in Goal 1.1.

Workforce Development

In an island state, such as Hawaii, it is often a challenge to recruit and retain qualified health and medical professionals. CAMHD addresses the mental health workforce shortage issue in its Strategic Plan Goal 5.5. The goal focuses on promoting distance learning and alternative forms of remote participation in higher education for neighbor island students, investigating adaptations for service provision in rural areas, and developing incentive programs to attract and retain qualified mental health workers in rural communities.

The Health Resources and Services Administration (HRSA) has given several geographic areas on each of the islands the designation of Medically Underserved Populations or Medically Underserved Areas. It has also designated the following areas as Mental Health Professional Shortage Areas: All of Hawaii County except Hilo and Kona, Waimea on the island of Kauai, Hana on the island of Maui, the island of Molokai, and Kalihi-Palama and Kalihi-Valley on the island of Oahu. In the past few years, the lack of mental health professionals, particularly on the islands of Maui and Hawaii have become huge challenges. CAMHD intends to explore the option of telepsychiatry as a means to address the issue. See CAMHD's Strategic Plan Goal 7.9.

SECTION IV.

COMMUNITY INPUT AND STAKEHOLDER CONSULTATION

Strategic Planning is, "a continuous and systematic process where the guiding members of an organization make decisions about its future, develop necessary procedures and operations to achieve that future, and determine how success is to be measured." [7]

CAMHD utilized a standard logic model for the strategic planning process. The process was initiated with re-visiting CAMHD's vision, mission, guiding principles, and statutory obligations. Then, after evaluating past performance, and conducting a needs assessment on current and future issues and a SWOT analysis, strategic priority issues were identified. Then a planned campaign of gathering input from stakeholders from the community level to top state administrators was implemented with communication loops and feedback.

The Strategic Planning Process

The Child and Adolescent Mental Health Division conducted its strategic planning processes throughout calendar year 2006. The year-long process was designed to engage and involve multiple levels of stakeholders in crafting CAMHD's strategic plan. Through ever-widening circles of stakeholders, CAMHD sought input and comment and, when necessary, adjusted its plan based on the input.

Although several preliminary and informal meetings were held, on January 20, 2006, CAMHD convened its first formal strategic planning meeting. At that meeting, CAMHD's senior and mid-level managers, psychiatrists, psychologists, public health administrative officers, and representatives of the statewide family organization, Hawaii Families as Allies, were gathered to begin the planning process. The meeting was used to orient the work group, named the Statewide Management Team, on the tasks ahead. CAMHD's past performance and system improvements were reviewed so all members had a firm understanding of what had been accomplished in the past and could identify what needed to be done in the future.

The same group was convened again in March to define the strategic process and tools. Participants were given an overview of the purpose and tasks of strategic planning, information on CAMHD's statutory and federal obligations, an overview of local and national trends, and a review of the past performance and improvements to the CAMHD system. As a group, participants discussed the issues facing the organization and tentatively identified key priority for inclusion in the strategic plan. As discussion moved on to the process of consulting stakeholders, participants identified state agencies, community organizations and grassroots groups to be engaged. There was agreement that the discussions needed to take place at the state policy level, as well as in local communities. Individual participants were then assigned to gather input by specific geographic areas, making sure that all identified stakeholders were invited to participate. Members were given an array of tools, resources, references, and guiding documents for their use. Additionally, each participant was invited to consult with their own professional membership organizations and discipline groups about CAMHD's intended priority areas.

From January through July CAMHD staff met with youth, families, advocacy groups, CAMHD staff, child serving agencies and provider agency managers across the state. These included representatives from the Department of Education, Department of Human Services, Department of the Attorney General, University of Hawaii, other divisions in Department of Health, Judiciary, Probation Officers, provider agencies, Mental Health Association, State Council on Mental Health, Community Coordinating Councils, and Hawaii Disability Rights Center. Multiple community level

[7] Goodstein, Leonard A., T. M. Nolan, and J. W. Pfeiffer, Applied Strategic Planning: A Comprehensive Guide. New York: McGraw-Hill, 1993.

meetings were held in Hawaii County, Maui County, Central Oahu, Leeward Oahu, Windward Oahu and Honolulu. At the state level, input was solicited from the Youth Council, family agencies, advocacy groups, child serving agency leadership and provider agency leadership. The mechanisms for input included community stakeholder meetings, staff meetings, telephone conversations, surveys, and email comments. To manage the input gathering process as well as the information that would eventually flow back to CAMHD, a common set of questions for all stakeholders were developed. The Statewide Management Team used these common set of questions as a basis for discussions at community forums and meetings. The questions were constructed around several broad themes:

1. Do the vision, mission, and guiding principles of CAMHD reflect where our state's child and adolescent mental health system should focus?
2. Does "CAMHD "House" framework (Guiding Principles, Evidence-Based Services, Performance management and CAMHD Credo) provide the right support for Hawaii's child and adolescent mental health system?
3. What do you think of CAMHD's proposed priority areas:
    a. Implement a comprehensive workforce development program
    b. Promote sustainability of a quality service system
    c. Promote transformation of child and adolescent mental health care
    d. Implement a Strategic Information Technology Program
4. What challenges can CAMHD expect in meeting those goals?

In July, the Statewide Management Team was re-convened to collate and synthesize the input gathered from around the state. Some of the feedback is summarized below:

<u>Mission</u> – Broaden the statement to better reflect the statutory obligations, add language to reflect young adults or young people; qualify the population; include prevention.
<u>Guiding Principles</u> (CASSP) – Groups reaffirmed commitment to CASSP
<u>Business Credo</u> (EMPOWERS) – Groups were impressed with the business credo.
<u>"House" Conceptual Framework</u> – Generally, the concept was well received by most and the comments centered on making the house look more local and needing a door.
<u>Statutes</u> – Regarding the services provided, revise to add "as funds allow or as funds provide"; revise the age of the service population up to age 21 years; regarding coordination with the department of education, revise to add community private providers; remove the term "mental illness"; don't remove "mental illness"; add families.
<u>Priority Areas</u> – Include prevention, and improve EPSDT and prevention programs in elementary schools; increase the number of bilingual mental health providers; provide services for homeless families;
work on getting acute hospitalization on the neighbor islands; bring autism services back to CAMHD;
allow younger aged youth to access CAMHD's Multi-System Therapy; listen more to families; include an abbreviation dictionary; more emphasis on cultural sensitivity; more emphasis on smooth transitions; communicate the outcomes.

Adopt 6 priority areas:

1. Implement a comprehensive workforce development program
2. Develop & monitor a 4-year financial plan
3. Implement a comprehensive resource management program
4. Strengthen performance management practices throughout the system
5. Develop a strategic information technology program
6. Improve access to care

In August, the Statewide Management Team was convened to develop the Strategic Management Plan. Chairpersons were assigned to convene and lead workgroups per priority. Invited to the work groups were persons responsible for implementing all or parts of the priority work plan, as well as any other interested staff. The work groups spent the day developing goals,

activities, measures, responsible parties and timelines for their own priority work plans. The work groups were also expected to begin meeting and working to achieve their goals.

By the beginning of September, the workgroups were expected to have developed their work plans in sufficient detail. The workgroups were convened to share their work plans in a round robin fashion that the other workgroups could comment and add to the work plans, wherever the work plans overlapped other plans. During the continued open dialog of the strategic plan priorities and Management Plan with the public and staff, it was recommended that one of the priority areas could be separated into two. It was decided that the workforce development priority would be separated into 1) the types of skills and competencies needed by CAMHD's and provider's staff to provide services to youth, and 2) the personnel/workload management issues. Thus, the final 7 priority areas are:

1. Decrease stigma and increase access to care
2. Implement and monitor the effectiveness of a comprehensive resource management plan
3. Implement a publicly accountable performance management program
4. Implement and monitor comprehensive practice development program
5. Implement and monitor a strategic personnel management plan
6. Implement and monitor a strategic financial plan
7. Implement and monitor a strategic information technology program

In October, the modified vision, mission, and 7 priority areas were, again, shared with the community for input and comment. Presentations were made to various community groups, including Children's Coordinating Councils, Hawaii Families as Allies, and staff. The strategic management plan was posted on CAMHD's website and the public was invited to provide comment. Public hearing notices were published in local newspapers and hearings were held across the state, with one in each county, except that in Honolulu three public hearings were held.

SECTION V.

STRATEGIC PLAN OVERVIEW

Over the next four years, CAMHD will be focused on seven priority areas. Through the community and stakeholder process described in Section IV these areas were identified as the most important issues to be addressed by CAMHD to meet its statutory obligations, and to continue to provide high quality, effective mental health services for the children and adolescents with mental health issues and their families.

The framework for this strategic plan includes a revised vision, a revised mission, and a commitment to the Child and Adolescent Service System Program (CASSP) Principles.

CAMHD's new vision reflects the community's hope for the future:

Happy and Healthy
Children and Families
Living in Caring Communities

CAMHD's new mission:

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

After gathering input from youth, families, providers, policy makers, staff, child serving partners, and other community stakeholders, CAMHD has identified seven priorities areas to be addressed over the next four years.

Priority Area 1.	Decrease Stigma and Increase Access to Care

Societal and cultural stigma attached to mental illness and help-seeking behaviors create barriers for people to access needed care. An anti-stigma social marketing campaign will be developed to identify and change negative attitudes and perception about mental illness and to change cultural norms so that people will not be afraid to seek help.

Although the national estimate for children with severe emotional disturbances is 5%-9% of the child population, CAMHD is currently serving about 1%-2% of Hawaii's youth population who may be in need of mental health services. Although a considerable number of youth are served by their private insurance and by the DOE School-Based Behavioral Health system, together with CAMHD, there continues to be a service gap. Therefore, CAMHD's first priority is to increase access to mental health services and decrease the stigma attached to seeking help. The strategic plan calls for strengthening ties and connections with youth, families, primary care practitioners, child welfare, education and juvenile justice, as well as identifying other avenues that the general community and others can access CAMHD's services. Specific goals for this priority are as follows:

1.1 Develop and Implement an Anti-Stigma Strategic Plan
1.2 Strengthen the youth voice in the individualized service planning process.
1.3 Strengthen the youth voice in system issues and development.
1.4 Strengthen the family voice across all aspects of the system.
1.5 Improve access to care for the general community
1.6 Improve access to care for the child welfare system
1.7 Improve access to care for the juvenile justice system
1.8 Strengthen access to care for the education system

1.9 Strengthen access to primary care
1.10 Strengthen partnerships with community organizations
1.11 Strengthen outreach to youth in crisis (including homeless and suicidal youth)

Priority Area 2.	Implement and Monitor Effectiveness of a Comprehensive Resource Management Program

To better meet the fluctuating needs of individual youth and the CAMHD population as a whole, CAMHD will prioritize the effective management of its resources. Per the CASSP principles, the services provided to each youth are individualized and customized to meet the specific needs at each point in time. Often the needs of the youth shift among different types of services over time. CAMHD, as a managed care provider, must be able to provide the appropriate volume of any needed service in a timely manner. To do so, CAMHD must be able to accurately measure the filled and stored capacity of each type of care in real time to assure that youth receive their appropriate services as soon as it is available. CAMHD must also be able to adjust its resources and capacities based on projected needs. The Strategic Plan also calls for CAMHD to identify disparate needs of subpopulations and develop system capacity to adequately meet those varied needs. The specific goals for this priority area are listed below.

2.1 Improve the quality of utilization management data reporting
2.2 Develop and adjust resources in a timely and effective manner based upon identified needs

Priority Area 3.	Implement a Publicly Accountable Performance Management Program

During the community input phase of the strategic planning process, many, including parents, community members and staff, endorsed the value and expressed their appreciation for CAMHD's performance management activities. The performance management system is seen as key to maintaining the service and system improvements made during the Felix Consent Decree. CAMHD re-commits to maintaining performance management system as well as commits to improving its system. The goals are below.

3.1 Implement annual local community and state Quality Assurance & Improvement Programs
3.2 Perform annual evaluations with recommendations for system refinements
3.3 Develop and maintain consistent partnerships with Dept. of Education and Child Welfare Services in conducting cross-agency case-based reviews
3.4 Facilitate Interagency Quality Assurance Group meetings at the community and state levels
3.5 Demonstrate compliance with the Balanced Budget Act of 1997, Medicaid Final Rules for Managed Care Organizations
3.6 Develop feedback linkages between performance data and all levels of system management and policy decision-making
3.7 Consistently communicate performance data to communities and stakeholders
3.8 Strengthen Family Guidance Center branch quality assurance practices
3.9 Strengthen CAMHD contracted provider agencies' quality assurance practices
3.10 Strengthen the quality of performance monitoring practices with a focus toward improving provider core competencies and clinical practices

Priority Area 4.	Implement and Monitor a Comprehensive Practice Development Program

To assure that mental health services to youth and their families are of high quality, CAMHD will prioritize the implementation of a comprehensive practice development program. This priority area will seek to strengthen the core competencies and clinical skills and practices of clinicians and their supervisors. Through partnerships with higher education, professional guilds, and other child serving agencies, CAMHD will seek to strengthen the supply and increase the demand for highly trained clinicians with valuable technical skills. Specifically, this priority area has the goals as listed below.

4.1 Strengthen and expand academic liaisons to impact pre-service educational programs
4.2 Strengthen inter-agency agreements regarding workforce and practice development
4.3 Disseminate evidence-based services and monitor the utilization of evidence-based practice elements
4.4 Strengthen the core competencies of the current work force
4.5 Increase collaboration with statewide professional guild around training, professional development, evidence-based services dissemination, and other professional issues.

Priority Area 5.	Implement and Monitor a Strategic Personnel Management Plan

This priority area will address the need to increase the number of culturally competent mental health professionals, and increase access to those professionals in rural and remote areas. Goals and activities in this priority area will address workload and organizational structure to assure reasonable working conditions for licensed clinicians and staff, as well as strategies to address recruitment and retention. CAMHD will continue to lead an ongoing interagency and university collaboration to evaluate and distribute information about evidence-based practices throughout its system, including pre-service training of future mental health professionals.

5.1 Clarify and define workload structure for CAMHD licensed clinicians
5.2 Implement task force recommendations approved by the CAMHD Executive Management Team for workload structure for licensed clinicians
5.3 Implement new policies and procedures related to licensed clinicians workload
5.4 Assure the organizational framework supports effective practices
5.5 Implement rural and neighbor island workforce development
5.6 Implement a recruitment and retention initiative
5.7 Establish “safety net” case management once the average caseload of section exceeds 20 to insure that case coordinator workloads are reasonable

Priority Area 6.	Implement and Monitor a Strategic Financial Plan

As part of the Department of Health’s goal to develop a seamless network of programs and services with funding sources to sustain improvements beyond court involvement, CAMHD will prioritize diversifying its funding beyond the state general fund. CAMHD will pursue increased federal funding and maximize the benefits of Medicaid reimbursement. This initiative will also include efforts to implement a financial reporting system. The goals are as follows:

6.1 Strengthen the Title XIX Medicaid billing practices
6.2 Strengthen the Random Moments Studies billing

6.3 Strengthen the Title IV-E billing
6.4 Strengthen braided and blended funding
6.5 Maximize funding opportunities by pursuing federal and community grants
6.6 Develop third-party billing agreements
6.7 Implement routine financial reporting

Priority Area 7.	Implement and Monitor a Strategic Information Technology Program

CAMHD relies on its Management Information System to allow treatment teams to conduct real time reviews of youth's services, to measure and evaluate the performance of multiple facets of mental health service delivery, and to electronically manage billing and payment transfers. During the next four years, CAMHD will evaluate the performance of its MIS system, including hardware and software. As the nation moves toward a paper-less system, so, too, will CAMHD. Efforts will focus on developing an electronic clinical record system, and integrating electronic forms and electronic submission of data. This information technology priority will also seek to develop telehealth and tele-psychiatry initiatives.

7.1 Implement an electronic clinical record system, including integrated electronic forms and electronic submission of forms
7.2 Evaluate quality performance of the Child and Adolescent Mental Health Management Information System (CAMHMIS) on an ongoing basis
7.3 Identify and gain funding supports for CAMHMIS
7.4 Implement a youth-developed internet website on emotional health
7.5 Strengthen the quality of the CAMHD website
7.6 Stabilize hardware and software
7.7 Strengthen the quality of training on the use of information technology
7.8 Maintain the development of CAMHMIS for CRM, MTPS, dashboards and other tools
7.9 Develop telehealth/telemedicine system and integrate with information technology

SECTION VI.

PROGRESS AND ACHIEVEMENTS ON CAMHD'S 2003-2006 STRATEGIC PLAN

Goal 1: CAMHD will facilitate and support the shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.

1.1 All child-serving entities have an understanding and appreciation of each other's roles and responsibilities in addition to their own.

Specific Achievements	Activities Not Accomplished
▪ Improved CAMHD internal management values and practices through appropriate supervisory infrastructure, regular opportunities for feedback on work environment, and integration of management values into everyday operations. ▪ Provided community presentations on improvements. ▪ Established protocols for DHS, DOE and CAMHD personnel in resolving community level disputes. When communities are unable to resolve, the issues are referred to the State Interagency QA Team for recommendation and action.	▪ Statewide leadership framework unable to be established. The newly awarded Mental Health Transformation State Infrastructure Grant will provide this framework. ▪ Statewide interagency joint outcome measures were not established. The MHT SIG will also provide this opportunity. ▪ Medicaid State Plan Amendment not yet completed ▪ Updates to child serving agency statutes not done

1.2 There will be adequate resources available for all child-serving entities in order to meet their statutory mandates and their obligation to Hawaii's children and youth.

Specific Achievements	Activities Not Accomplished
▪ Data Infrastructure Grant ▪ Alternatives to Seclusion and Restraint Grant ▪ Ho'omohala Transition to Adulthood Grant ▪ Mental Health Transformation State Incentive Grant ▪ Increased Medicaid reimbursements	▪ Updates to CAMHD statutes

1.3 Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care.

Specific Achievements	Activities Not Accomplished
▪ All families receive information on Hawaii Families As Allies ▪ Strengthen MHCC engagement training ▪ Favorable family satisfaction surveys ▪ Clinical Directors regularly meet with families, participate in IEP, and interface with providers around the needs of youth. ▪ Clinical Directors participate in community meetings for families with HFAA	▪ Establish more regular community educational meetings around evidence-based services, CASSP principles, and system of care

1.4 Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and an evaluative manner of thinking.

Specific Achievements	Activities Not Accomplished
▪ Strengthened relationship with UH psychology ▪ Developed UH Research & Evaluation Training (RET) program ▪ Strengthened UH social Work – Hiilei Project ▪ Practicum site for the Argosy Psy.D. Clinical psychology training program. ▪ Clinical Directors hold clinical faculty positions with John A. Burns School of Medicine and participate in residency training ▪ Funding provided to UH to begin a child and adolescent mental health APRN graduate program ▪ UH Center for Disabilities Studies providing leadership for the prevention committee.	▪ Develop mini-modules for different universities to use on various practice areas (will be carried forward to Strategic Plan 2007-2010)

Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles.

2.1 Maintain and improve the community-based, accessible system of care through which families are guided by knowledgeable and experienced veteran staff.

Specific Achievements	Activities Not Accomplished
▪ Mental Health Supervisors developed a more CASSP-focused supervisory practice ▪ Lower staff turnover, resulting in seasoned, knowledgeable staff ▪ New staff receive foundation training ▪ Improved service array in 2006, with more intensive community-based services	▪ Strengthen capacity of HFAA Parent Partner to engage and guide families

2.2 Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children/youth with mental health needs.

Specific Achievements	Activities Not Accomplished
▪ An increase presence of Parent Partners in presentations, trainings, and policy decisions ▪ HFAA developed several public service announcements ▪ Co-training with Family Guidance Center staff and HFAA on destigmatizing children's mental health, CASSP principles, and other related topics.	▪ Improve public awareness of what has been done by sharing of information ▪ Self-assessment of attitudes of FGC staff, partners and community members toward families w/mental health needs ▪ Development and distribution of family/public friendly literature, to include behavioral/functional examples for each CASSP principle.

2.3 Increase broader community involvement and development of resources to support children and youth and their families.

Specific Achievements	Activities Not Accomplished
▪ New services were added: Multi-Systemic Therapy, Functional Family Therapy, Intensive Outpatient, Independent Living Skills, Respite Therapeutic Foster Home, Respite Homes, Community Mental Health Shelter ▪ HFAA Youth Council established ▪ Utilize block grant funds to support services to homeless and gay/lesbian/bisexual/transgender youth ▪ Systematic review of service gaps with particular attention to availability of mental health services in rural communities	• Need to continue efforts to improve collaboration and communication between various agencies in the provision of mental health/social services • Support and promote the voice and choice of youth in developing and implementing their own plan, especially for transition aged youth

Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services.

3.1 Achieve the widespread availability of evidence-based services.

Specific Achievements	Activities Not Accomplished
▪ Family Guidance Center (FGC) Clinical Psychologists received training in a number of specific evidence-based services through participation in a MacArthur Grant-funded therapy research project. ▪ FGC Clinical Psychologists increased involvement in providing direct clinical services, including evidence-based treatment and assessment services. ▪ New evidence-based treatment packages: ▪ Multi-dimensional Treatment Foster Care (MTFC) ▪ Functional Family Therapy ▪ Partnership with HFAA to develop capacity to provide evidence-based parent training ▪ Restraint and Seclusion grant to disseminate best practices in residential care. ▪ Through Restraint and Seclusion grant, CAMHD participates in a national evaluation of effectiveness of a model for reducing restraint and seclusion in inpatient and residential care settings. ▪ Practice Development offers monthly consultation and training groups on evidence-based approaches to sexualized behavior and conduct disorder. ▪ Monthly consultation and training groups on evidence-based approaches to youth with severe emotional dysregulation and self-harming behavior. ▪ Clinical Directors reinforce use of EBS with youth in evaluation, treatment recommendations, IEP, CSP, and MHP meetings and in consultations.	▪ Consistent engaging of providers and network partners to participate in evidence based training events. ▪ Developing the contracts with the purveyors of packaged evidence-based treatment approaches has been a laborious process; we have experienced frequent setbacks in timelines due to these challenges. ▪ Need to increase the amount of evidence based services training offered to providers; this has been limited due to personnel resource challenges ▪ Provide case-based supervision training for EBS with provider agencies with EBS supervisors/end users

3.2 Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.

Specific Achievements	Activities Not Accomplished
▪ Developed strategies for measuring the use of evidence-based approaches, including monitoring protocols ▪ Clinical Directors are increasingly using Rating Scales to evaluate effectiveness of services ▪ Clinical Directors are monitoring use and effectiveness in individual case consultations and group consultations ▪ Provider and Family Satisfaction Surveys conducted annually to assess the impact of current practice	▪ Develop outcome measures at FGC level to compare those with usual care to youth actually receiving EBS ▪ Develop measures at FGC level of fidelity of providers to "stated" EBS that is being provided ▪ Develop measures at FGC level of outcomes for targeted EBS

3.3 Promote the sustained and appropriate application of evidence-based services and principles: Facilitation.

Specific Achievements	Activities Not Accomplished
▪ Ongoing Evidence-Based Services (EBS) Committee which reviews the scientific literature systematically and code all relevant studies. ▪ EBS Biennial Reports ▪ EBS regularly updates The Blue Menu ▪ EBS "Practice Brief"/"fact sheet" subcommittee developing brief informational summaries for therapists in the field and for parents/teachers. ▪ New prevention Subcommittee formed to identify evidence-based prevention and early intervention programs ▪ Written recommendations on EBS approaches routinely incorporated into psychological assessments; "blue menu" attached to reports. ▪ Quarterly "Clinicians' Open House" during 2004-2005, which promoted on-going dialogue with providers around evidence-based services. ▪ FGC Clinical Psychologists have been consulting with care coordinators, reviewing treatment plans and Provider Monthly Summary reports for individual youth. ▪ In-service training at FGCs about EBS approaches ▪ "Purple Book" Standards have been implemented. This work helps to assure that EBS principles are reflected in the revised Interagency Performance Standards and Practice Guidelines.	▪ The EBS "fact sheets" have not been completed due to personnel resource limitations. ▪ Role of FGC psychologists regarding EBS service delivery need clarity. ▪ The quarterly clinicians open house has been only a partial success. It has been challenging to get consistent attendance by providers and it has used up time the psychologist group needs to meet together. The psychologist group is developing alternative strategies for engaging providers and working with them on utilizing evidence-based services appropriately. Strategies the psychologist group wants to use in the future include: making more personal contact with supervisors at local home-based services, therapeutic foster, and out-patient agencies; attending team meetings at local agencies; and offering educational programs on specific EBS approaches locally. ▪ Analysis of data regarding the assessment of EBS fidelity has been limited.

Goal 4: CAMHD and its provider agencies will routinely evaluate performance data and apply the findings to guide management decisions and practice development.

4.1 Expand and improve the existing operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is readily exchanged in collaborative relationships with providers and partner agencies.

Specific Achievements	Activities Not Accomplished
▪ SUBSTANTIAL ACHIEVEMENT ▪ Forms and Reports clinically meaningful for decision-making ▪ Development of CAMHMIS clinical/supervision module ▪ Training and technical assistance on clinical processes and clinical/supervision module	

4.2 A clearly defined, decentralized, streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel with clear direction for practice and policy decisions in the context of a knowledge-based learning organization.

Specific Achievements	Activities Not Accomplished
▪ Designed and implemented a new monitoring tool ▪ Strengthened QA practices at the FGCs- QAIPs at most FGCs have been completed ▪ Developing an MOA that will include interagency monitoring ▪ Conducted a number of special studies ▪ Developed QA operational manual for FGCs	▪ Involve families in evaluation ▪ Consistent core QA practices across all FGCs ▪ Routine use of performance data in all CAMHD staff supervision ▪ Increase number of agencies using internal case-based reviews

4.3 Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative, community, and family groups and incorporates their feedback in measure selection, data interpretation and system design.

Specific Achievements	Activities Not Accomplished
▪ SUBSTANTIAL ACHIEVEMENT ▪ Clinical summary reports available for retrieval ▪ Increased number of published articles and national presentations	▪ Development of a media plan

Goal 5: The business practices implemented throughout CAMHD and its provider agencies will ensure high quality and accountable operations.

5.1 All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.

Specific Achievements	Activities Not Accomplished
▪ Integration of HIPPA requirements ▪ CAMHD employee Handbook revised ▪ Business Plan developed ▪ Three reorganizations completed ▪ Updated most position descriptions	▪ Three more reorganizations must be completed ▪ 100% of CAMHD staff receive appropriate training

5.2 Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.

Specific Achievements	Activities Not Accomplished
▪ Compliance program with comprehensive claims review and post-review analysis completed ▪ Implementation of Utilization Management Plan ▪ Summary of Services protocol developed and implemented ▪ Defined the requirements to automate CAMHD's accounting function to properly interface with DAGS accounting system	

5.3 Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals and objectives.

Specific Achievements	Activities Not Accomplished
▪ SUBSTANTIAL ACHIEVEMENT ▪ Implementation of Med-QUEST required HIPAA modifications ▪ Workstation upgrades for FGCs and Central Office ▪ Website regularly updated	▪ Comprehensive computer training of CAMHD staff

SECTION VI.

PROGRESS AND ACHIEVEMENTS ON CAMHD'S 2003-2006 STRATEGIC PLAN

Goal 1: CAMHD will facilitate and support the shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.

1.1 All child-serving entities have an understanding and appreciation of each other's roles and responsibilities in addition to their own.

Specific Achievements	Activities Not Accomplished
▪ Improved CAMHD internal management values and practices through appropriate supervisory infrastructure, regular opportunities for feedback on work environment, and integration of management values into everyday operations. ▪ Provided community presentations on improvements. ▪ Established protocols for DHS, DOE and CAMHD personnel in resolving community level disputes. When communities are unable to resolve, the issues are referred to the State Interagency QA Team for recommendation and action.	▪ Statewide leadership framework unable to be established. The newly awarded Mental Health Transformation State Infrastructure Grant will provide this framework. ▪ Statewide interagency joint outcome measures were not established. The MHT SIG will also provide this opportunity. ▪ Medicaid State Plan Amendment not yet completed ▪ Updates to child serving agency statutes not done

1.2 There will be adequate resources available for all child-serving entities in order to meet their statutory mandates and their obligation to Hawaii's children and youth.

Specific Achievements	Activities Not Accomplished
▪ Data Infrastructure Grant ▪ Alternatives to Seclusion and Restraint Grant ▪ Ho'omohala Transition to Adulthood Grant ▪ Mental Health Transformation State Incentive Grant ▪ Increased Medicaid reimbursements	▪ Updates to CAMHD statutes

1.3 Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care.

Specific Achievements	Activities Not Accomplished
▪ All families receive information on Hawaii Families As Allies ▪ Strengthen MHCC engagement training ▪ Favorable family satisfaction surveys ▪ Clinical Directors regularly meet with families, participate in IEP, and interface with providers around the needs of youth. ▪ Clinical Directors participate in community meetings for families with HFAA	▪ Establish more regular community educational meetings around evidence-based services, CASSP principles, and system of care

1.4 Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and an evaluative manner of thinking.

Specific Achievements	Activities Not Accomplished
▪ Strengthened relationship with UH psychology ▪ Developed UH Research & Evaluation Training (RET) program ▪ Strengthened UH social Work – Hiilei Project ▪ Practicum site for the Argosy Psy.D. Clinical psychology training program. ▪ Clinical Directors hold clinical faculty positions with John A. Burns School of Medicine and participate in residency training ▪ Funding provided to UH to begin a child and adolescent mental health APRN graduate program ▪ UH Center for Disabilities Studies providing leadership for the prevention committee.	▪ Develop mini-modules for different universities to use on various practice areas (will be carried forward to Strategic Plan 2007-2010)

Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles.

2.1 Maintain and improve the community-based, accessible system of care through which families are guided by knowledgeable and experienced veteran staff.

Specific Achievements	Activities Not Accomplished
▪ Mental Health Supervisors developed a more CASSP-focused supervisory practice ▪ Lower staff turnover, resulting in seasoned, knowledgeable staff ▪ New staff receive foundation training ▪ Improved service array in 2006, with more intensive community-based services	▪ Strengthen capacity of HFAA Parent Partner to engage and guide families

2.2 Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children/youth with mental health needs.

Specific Achievements	Activities Not Accomplished
▪ An increase presence of Parent Partners in presentations, trainings, and policy decisions ▪ HFAA developed several public service announcements ▪ Co-training with Family Guidance Center staff and HFAA on destigmatizing children's mental health, CASSP principles, and other related topics.	▪ Improve public awareness of what has been done by sharing of information ▪ Self-assessment of attitudes of FGC staff, partners and community members toward families w/mental health needs ▪ Development and distribution of family/public friendly literature, to include behavioral/functional examples for each CASSP principle.

2.3 Increase broader community involvement and development of resources to support children and youth and their families.

Specific Achievements	Activities Not Accomplished
▪ New services were added: Multi-Systemic Therapy, Functional Family Therapy, Intensive Outpatient, Independent Living Skills, Respite Therapeutic Foster Home, Respite Homes, Community Mental Health Shelter ▪ HFAA Youth Council established ▪ Utilize block grant funds to support services to homeless and gay/lesbian/bisexual/transgender youth ▪ Systematic review of service gaps with particular attention to availability of mental health services in rural communities	• Need to continue efforts to improve collaboration and communication between various agencies in the provision of mental health/social services • Support and promote the voice and choice of youth in developing and implementing their own plan, especially for transition aged youth

Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services.

3.1 Achieve the widespread availability of evidence-based services.

Specific Achievements	Activities Not Accomplished
▪ Family Guidance Center (FGC) Clinical Psychologists received training in a number of specific evidence-based services through participation in a MacArthur Grant-funded therapy research project. ▪ FGC Clinical Psychologists increased involvement in providing direct clinical services, including evidence-based treatment and assessment services. ▪ New evidence-based treatment packages: ▪ Multi-dimensional Treatment Foster Care (MTFC) ▪ Functional Family Therapy ▪ Partnership with HFAA to develop capacity to provide evidence-based parent training ▪ Restraint and Seclusion grant to disseminate best practices in residential care. ▪ Through Restraint and Seclusion grant, CAMHD participates in a national evaluation of effectiveness of a model for reducing restraint and seclusion in inpatient and residential care settings. ▪ Practice Development offers monthly consultation and training groups on evidence-based approaches to sexualized behavior and conduct disorder. ▪ Monthly consultation and training groups on evidence-based approaches to youth with severe emotional dysregulation and self-harming behavior. ▪ Clinical Directors reinforce use of EBS with youth in evaluation, treatment recommendations, IEP, CSP, and MHP meetings and in consultations.	▪ Consistent engaging of providers and network partners to participate in evidence based training events. ▪ Developing the contracts with the purveyors of packaged evidence-based treatment approaches has been a laborious process; we have experienced frequent setbacks in timelines due to these challenges. ▪ Need to increase the amount of evidence based services training offered to providers; this has been limited due to personnel resource challenges ▪ Provide case-based supervision training for EBS with provider agencies with EBS supervisors/end users

3.2 Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.

Specific Achievements	Activities Not Accomplished
▪ Developed strategies for measuring the use of evidence-based approaches, including monitoring protocols ▪ Clinical Directors are increasingly using Rating Scales to evaluate effectiveness of services ▪ Clinical Directors are monitoring use and effectiveness in individual case consultations and group consultations ▪ Provider and Family Satisfaction Surveys conducted annually to assess the impact of current practice	▪ Develop outcome measures at FGC level to compare those with usual care to youth actually receiving EBS ▪ Develop measures at FGC level of fidelity of providers to "stated" EBS that is being provided ▪ Develop measures at FGC level of outcomes for targeted EBS

3.3 Promote the sustained and appropriate application of evidence-based services and principles: Facilitation.

Specific Achievements	Activities Not Accomplished
▪ Ongoing Evidence-Based Services (EBS) Committee which reviews the scientific literature systematically and code all relevant studies. ▪ EBS Biennial Reports ▪ EBS regularly updates The Blue Menu ▪ EBS "Practice Brief"/"fact sheet" subcommittee developing brief informational summaries for therapists in the field and for parents/teachers. ▪ New prevention Subcommittee formed to identify evidence-based prevention and early intervention programs ▪ Written recommendations on EBS approaches routinely incorporated into psychological assessments; "blue menu" attached to reports. ▪ Quarterly "Clinicians' Open House" during 2004-2005, which promoted on-going dialogue with providers around evidence-based services. ▪ FGC Clinical Psychologists have been consulting with care coordinators, reviewing treatment plans and Provider Monthly Summary reports for individual youth. ▪ In-service training at FGCs about EBS approaches ▪ "Purple Book" Standards have been implemented. This work helps to assure that EBS principles are reflected in the revised Interagency Performance Standards and Practice Guidelines.	▪ The EBS "fact sheets" have not been completed due to personnel resource limitations. ▪ Role of FGC psychologists regarding EBS service delivery need clarity. ▪ The quarterly clinicians open house has been only a partial success. It has been challenging to get consistent attendance by providers and it has used up time the psychologist group needs to meet together. The psychologist group is developing alternative strategies for engaging providers and working with them on utilizing evidence-based services appropriately. Strategies the psychologist group wants to use in the future include: making more personal contact with supervisors at local home-based services, therapeutic foster, and out-patient agencies; attending team meetings at local agencies; and offering educational programs on specific EBS approaches locally. ▪ Analysis of data regarding the assessment of EBS fidelity has been limited.

Goal 4: CAMHD and its provider agencies will routinely evaluate performance data and apply the findings to guide management decisions and practice development.

4.1 Expand and improve the existing operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is readily exchanged in collaborative relationships with providers and partner agencies.

Specific Achievements	Activities Not Accomplished
▪ SUBSTANTIAL ACHIEVEMENT ▪ Forms and Reports clinically meaningful for decision-making ▪ Development of CAMHMIS clinical/supervision module ▪ Training and technical assistance on clinical processes and clinical/supervision module	

4.2 A clearly defined, decentralized, streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel with clear direction for practice and policy decisions in the context of a knowledge-based learning organization.

Specific Achievements	Activities Not Accomplished
▪ Designed and implemented a new monitoring tool ▪ Strengthened QA practices at the FGCs- QAIPs at most FGCs have been completed ▪ Developing an MOA that will include interagency monitoring ▪ Conducted a number of special studies ▪ Developed QA operational manual for FGCs	▪ Involve families in evaluation ▪ Consistent core QA practices across all FGCs ▪ Routine use of performance data in all CAMHD staff supervision ▪ Increase number of agencies using internal case-based reviews

4.3 Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative, community, and family groups and incorporates their feedback in measure selection, data interpretation and system design.

Specific Achievements	Activities Not Accomplished
▪ SUBSTANTIAL ACHIEVEMENT ▪ Clinical summary reports available for retrieval ▪ Increased number of published articles and national presentations	▪ Development of a media plan

Goal 5: The business practices implemented throughout CAMHD and its provider agencies will ensure high quality and accountable operations.

5.1 All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.

Specific Achievements	Activities Not Accomplished
▪ Integration of HIPPA requirements ▪ CAMHD employee Handbook revised ▪ Business Plan developed ▪ Three reorganizations completed ▪ Updated most position descriptions	▪ Three more reorganizations must be completed ▪ 100% of CAMHD staff receive appropriate training

5.2 Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.

Specific Achievements	Activities Not Accomplished
▪ Compliance program with comprehensive claims review and post-review analysis completed ▪ Implementation of Utilization Management Plan ▪ Summary of Services protocol developed and implemented ▪ Defined the requirements to automate CAMHD's accounting function to properly interface with DAGS accounting system	

5.3 Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals and objectives.

Specific Achievements	Activities Not Accomplished
▪ SUBSTANTIAL ACHIEVEMENT ▪ Implementation of Med-QUEST required HIPAA modifications ▪ Workstation upgrades for FGCs and Central Office ▪ Website regularly updated	▪ Comprehensive computer training of CAMHD staff

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

PRIORITY AREA #1: DECREASE STIGMA AND INCREASE ACCESS TO CARE

Overarching 4-year goals: Complete an evaluation of the anti-stigma initiative
Demonstrate evidence of clear and diverse youth voice guiding all aspects of the system
Demonstrate clear diverse family partnerships driving all aspects of the system
Increase statewide penetration rate of children and youth accessing mental health services

MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
1.1	***DEVELOP & IMPLEMENT ANTI-STIGMA STRATEGIC PLAN***	**1.1.1** Create a multi-cultural, public-private work group, to include youth & families, charged with creating and evaluating a public education campaign to improve the overall understanding of child & youth mental health needs and encourage youth and families to seek help for their challenges.	Anti- Stigma Workgroup (ASW) established.	EMT	Feb 2007
		1.1.2 ASW to review the national initiatives	ASW provides a summary of national activities to EMT	Chair, ASW	July 2007
		1.1.3 ASW to develop and make formal recommendations to EMT for CAMHD's adoption of the anti-stigma plan.	ASW submits Anti-Stigma Plan to EMT for approval	Chair, ASW	Oct 2007
		1.1.4 ASW to provide routine updates on progress with plan implementation.	ASW quarterly reports to EMT include updates on national initiatives, implementation of plan, and any formal recommendations	Chair, ASW	Feb 2008 May 2008 Aug 2008 Nov 2008
		1.1.5 The plan will identify and address cultural factors contributing to stigma	Issues of culture and impact on stigma clearly evident in strategic plan	Chair, ASW	Oct 2007
		1.1.6 Provide community education about emotional and behavioral needs of children and youth	1.1.6 a - Run 2 public service announcements per year 1.1.6.b - Address social marketing strategies the anti-stigma strategic plan 1.1.6.c – Include routine public education and outreach in ASC plan	1.1.6.a CAMHD Planner 1.1.3.6 – Chair, ASW 1.1.6.c – Chair, ASW	Dec 2007 Dec 2008 Oct 2007 Oct 2007

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
		1.1.7 Hold statewide activities for children's mental health awareness week in May of each year, participate in Oct events for Children & Youth Day, and Beyond the Blues.	Report provided to EMT regarding the activities held for each event	Planner to provide report Branch Chiefs, CSO, ASW to participate	June 2007 Nov 2007 June 2008 Nov 2008
		1.1.8 Pursue diverse funding opportunities to support anti-stigma initiatives	Quarterly reports to EMT re: Grants/other funding requests submitted	ASW Chair, CAMHD Planner	Feb 2008 May 2008 Aug 2008 Nov 2008
		1.1.9 Identify benchmarks and include measurable objectives in anti-stigma plan	Plan includes measurable objectives	ASW Chair	Oct 2007
		1.1.10 Profile success stories of youth/families in CAMHD's public work (newsletter, performance reports, website).	At least quarterly, there is one positive story in CAMHD's public work.	ASW Chair	Feb 2008 May 2008 Aug 2008 Nov 2008
		1.1.11 Provide training about stigma to CAMHD staff and providers.	Training schedule and sign in sheets	Training Comm. Chair	Jan 2009
1.2	***STRENGTHEN YOUTH VOICE IN THE INDIVIDUALIZED SERVICE PLANNING PROCESSES***	**1.2.1** Define the core components of a successful youth-guided planning meeting	Provide report to training committee on the expected components of "youth guided" individualized planning meeting	Branch Chiefs, HYHY, Wai Aka, CSO Practice Development	June 2007
		1.2.2. Provide training on the elements of youth guided individualized planning meetings (incorporate into MHCC foundation training and CSP booster training)	1.2.2.a –revised MHCC Training Curriculum approved by Training Committee 1.2.2.b -Training schedules incorporated in quarterly training reports to PISC	Practice Development to Training Comm. Chair, training Committee	Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008 Dec 2008
1.3	***STRENGTHEN YOUTH VOICE IN SYSTEM ISSUES & DEVELOPMENTS***	**1.3.1** Identify roles, responsibilities and skills needed for youth participation in councils	Youth/Young Adult Councils to provide recommendations to EMT.	HFAA, Wai Aka	June 2007

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
		1.3.2 Identify at least one youth from each FGC section to participate in a youth council (either HYHY or Wai Aka)	HFAA HYHY and Wai Aka council minutes would reflect CAMHD youth participation	FGC Chief	June 2007
		1.3.3 Develop a communication plan that reaches out to youth, and informs care coordinators how to engage in youth activities	Written communication plan on how to talk to youth about activities	HFAA, Wai Aka, FGC Branch Chiefs	June 2007
		1.3.4 Contracted provider agency's youth specialists participate in Youth Council meetings at least quarterly	Council minutes to reflect participation	HFAA, Wai Aka, PM	June 2007 Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008
		1.3.5 Implement anonymous youth survey about services and system	Survey results and recommendations shared with EMT and all CAMHD youth	HFAA, Wai Aka	Jan 2008
		1.3.6 Develop plan to strengthen youth involvement in legislative process	Youth and young people participating in legislative process	HFAA, Wai Aka	Mar 2008
		1.3.7 Request that DOE offer credit, or excused absences, for youth participation in council activities or treatment planning meetings	Letter sent to DOE Superintendent	HFAA, Wai Aka, FGC Branch Chiefs	June 2007
1.4	***STRENGTHEN FAMILY VOICE ACROSS ALL ASPECTS OF THE SYSTEM***	**1.4.1** Define the core components of a successful family-driven planning meeting, and family engagement in plan implementation.	Provide report to training committee on the expected components of "family-driven" individualized planning meeting	HFAA, CSO Practice Development	June 2007
		1.4.2 Provide training on the elements of family-driven individualized planning meetings (incorporate into MHCC foundation training and CSP booster training)	1.4.2.a - Curriculum approved by Training Committee 1.4.2.b - Training sign in sheets	Training Committee Chair CSO Practice Development	Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008 Dec 2008
		1.4.3 Provide booster training for all care coordinators and their supervisors on maintaining family engagement and empowering families to drive their individualized service plan implementation.	1.4.3.a - Training curriculum approved by Training Committee 1.4.3.b - Training sign in sheets	Training Committee Chair CSO Practice Development	Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008 Dec 2008

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MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
		1.4.4 Provide strong outreach and encouragement for FGC families to become involved with HFAA	1.4.4.a HFAA invitation letter 1.4.4.b HFAA invitation letter in quarterly Summary of Service Report 1.4.4.c QA check Care coordination notes for encouragement to contact HFAA	HFAA HFAA FGC QA Specialist	June 2007 Sept 2007 Sept 2008 Dec 2007 June 2008
		1.4.5 Increase parent partners as active partners in FGC	Each FGC has Parent Partner with office space and standing office hours in FGC	Branch Chiefs HFAA	June 2007
		1.4.6 Increase involvement of parent partners in intake process at FGC	QA monitoring report on % of families having Parent Partner active at intake	FGC QA specialist	June 2007 Sept 2007 Dec 2007
		1.4.7 Provide integrated training on engagement and advocacy for parent partners, CCC and FGC staff (all together)	Training Curriculum approved by Training Committee Training Attendance Sheets in all communities	CSO & Training Committee Chair CSO	Sept 2007 June 2008
		1.4.8 Sponsor Family Events at FGC	Each FGC Branch Chief reports to EMT on 2 family events per year (include date and attendance)	Branch Chiefs	Dec 2007 Dec 2008
		1.4.9 Assure Family Member participation on all FGC Management Teams	FGC Management Team Meetings show family participation	Branch Chiefs HFAA	Dec 2007 Dec 2008
		1.4.10 Secure funding to support family participation in system meetings	Funded obtained	PHAO, Rev.Max.Spclt	Dec 2007 Dec 2008
1.5	***IMPROVE ACCESS TO CARE FOR THE GENERAL COMMUNITY***	**1.5.1** Establish role of intake coordination at every branch to manage and facilitate referrals	Role and responsibility defined in each branch	Branch Chiefs	Sept 2007
		1.5.2 Develop plan for managing workload of care coordinators as census increases	Personnel task force submits plan for approval by EMT	Branch Chiefs, PHAOs, Pers. Spclt.	June 2007

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
		1.5.3 Revise the contracts with higher ed. to more clearly define roles in conducting mental health assessments in all FGCs	1.5.3.a - Revised contract language in all agreements 1.5.3.b-Multidisciplinary students in all FGCs	Contracts staff FGC Branch Chiefs, CSO; Univ. Partners	June 2007 Sept 2007
		1.5.4 Contract for social marketing plan about eligibility and services	1.5.4.a – contract executed 1.5.4.b - Plan approved by EMT	Contracts staff EMT	June 2007 Oct 2007
		1.5.5 Establish CAMHD Central Call Center	Call Center established	PHAO	Sept 2007
		1.5.6 Create profile stories of youth with a CAFAS of 80 and disseminate to all partners	Profiles sent to all partners	CSO & EMT	Oct 2007
1.6	***IMPROVE ACCESS TO CARE FOR THE CHILD WELFARE SYSTEM***	**1.6.1** Procure training for DHS staff in identifying children with mental health needs and doing functional assessments (CAFAS)	1.6.1.a Contract executed for training 1.6.1.b Training on "identification and mental health "treatment needs of children in child welfare training held	CSO & Contracts staff CSO	Sept 2007 Dec 2007
		1.6.2 Provide training for DHS staff and DHS foster parents on SEBD referral process	1.6.2.a SEBD referral Training curriculum approved 1.6.2.b – SEBD Training held for DHS workers and DHS foster parents	FGC Branch Chiefs to Training Committee Train. Comm.	Oct 2007 Dec 2007
		1.6.3 Assure timely identification and services to youth referred from Child welfare system	FGC Quarterly QA review shows services begin within 30 days of first contact	FGC Branch Chiefs & FGC QA	June 2007 Sept 2007 Dec 2007 Mar 2008; repeat
1.7	***IMPROVE ACCESS TO CARE FOR THE JUVENILE JUSTICE SYSTEM***	**1.7.1** Develop interagency agreements defining how mental health treatment is provided to youth who are deemed by judiciary to be a community safety risk	Interagency agreements completed	FGC Branch Chiefs to Division Chief	Jan 2008
		1.7.2 Provide training to Probation Officers on SEBD referral process	1.7.2.a SEBD referral Training curriculum approved 1.7.2.b – SEBD Training held for Probation Officers	FGC Branch Chiefs to Training Committee Train. Comm.	Oct 2007 Dec 2007
		1.7.3 Develop initiative to reduce # of youth with mental health needs in DH or HYCF	Cross System agreement between CAMHD/DH/HYCF developed	FGC Branch Chiefs to Division Chief	Sept 2007

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
		1.7.4 Resolve barriers to mental health treatment due to language of court orders	Clear orders allowing CAMHD to serve JJ youth upon all releases from HYCF	Branch Chiefs, Division Chief	Jan 2008
1.8	***STRENGTHEN ACCESS TO CARE FOR THE EDUCATION SYSTEM***	**1.8.1** Provide training to care coordinators on the ES criteria to assure that there are not undue barriers to services	1.8.1.a -Curriculum approved by training committee 1.8.1.b –All FGC Staff Meeting minutes show evidence of training	FGC Branch Chiefs, Practice Development to Training Comm. Branch Chiefs	Mar 2007 June 2007
		1.8.2 Assure that the interagency district QA is monitoring data regarding complex peer review meetings quarterly.	Review of Interagency District QA shows clear evidence of local oversight of peer review meetings	Interagency QA Chair	July 2007 Oct 2007 Jan 2008 Apr 2008 July 2008 Oct 2008
1.9	***STRENGTHEN ACCESS TO PRIMARY CARE***	**1.9.1** Develop and distribute education and information about CAMHD eligibility and services	1.9.1.a Pamphlets/profiles submitted to EMT for approval 1.9.1.b Mail out profiles of SEBD youth to pediatricians	Rev. Max,; CSO Rev. Max. Spclt	July 2007 Sept 2007
			Provide profiles to Hawaii Primary Care Association for distribution to their members	CSO	Sept 2007
		1.9.2 Recommend tools, such as PEDS and Strengths & Difficulties Questionnaire, for use by pediatricians	Included in profiles and pamphlets submitted to EMT for approval	Rev.Max; CSO	July 2007
1.10	***STRENGTHEN PARTNERSHIPS WITH COMMUNITY ORGANIZATIONS***	**1.10.1** Identify key community groups in each area, and outreach plan to each	FGC Branch Chiefs to provide report to EMT on the community analysis	FGC Branch Chiefs to EMT	Oct 2007
		1.10.2 Provide routine information and education to identified groups	Community Meeting Agenda and summary of written mail outs provided quarterly to EMT	FGC Branch Chiefs	Dec 2007, and quarterly
		1.10.3 Formalize community level partnership agreements	Agreements submitted to EMT	Branch Chiefs	June 2008

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MP #	GOAL	ACTIVITIES	DELIVERABLE PRODUCT	UNIT (S) RESPONSIBLE	DATE DUE
		1.10.4 Increase the identification and use of community groups in Coordinated Service Plans (CSP)	FGC QA quarterly report shows increasing trend in "use of community supports in Community Service Plans"	FGC QA & Branch Chiefs	Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008 Dec 2008
1.11	***STRENGTHEN OUTREACH TO YOUTH IN CRISIS (homeless & suicidal)***	**1.11.1** Clarify role of CAMHD Task Force Representative in State Suicide Intervention Plan	Clear report on role to EMT	CAMHD task force rep., EMT	Mar 2007
		1.11.2 Develop routine reporting structure from Task Force to CAMHD EMT.	Quarterly reports provided.	CAMHD Task Force rep.	Mar 2007 June 2007 Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008 Dec 2008
		1.11.3 Strengthen relationships with schools by providing suicide prevention materials and offering periodic trainings and outreach	1.11.3.a Suicide Prevention and Intervention materials provided to schools annually 1.11.3.b Quarterly meetings with schools on mental health outreach and suicide prevention	CAMHD task force rep; CAMHD Planner CSO, FGC Clinical Directors	Sept 2007 Sept 2008 June 2007 Sept 2007 Dec 2007; qrtly in 2008
		1.11.4 Assist Task force in developing a case review of all youth suicides	Protocol for youth suicide review presented to EMT	CAMHD Task Force rep	Sept 2007
		1.11.5 Establish Suicide Awareness and Prevention Week programs	Proclamation and week of events planned	CAMHD task force rep.	Jan 2008
		1.11.6 Expand services to homeless youth beyond those funded to Y.O. Program	1.11.6.a – Release bid for services outside of Waikiki 1.11.6.b – Execute contracts 1.11.6.c - Develop Joint Interagency agreements with AMHD	Planner, contracts Contracts Planner, Contracts	July 2007 Oct 2007 Oct 2007

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

PRIORITY AREA #2: IMPLEMENT AND MONITOR EFFECTIVENESS OF COMPREHENSIVE RESOURCE MANAGEMENT PROGRAM

Broadly stated 4 year goal: Develop "Real Time" Data feedback capacity
Each Community will have comprehensive array of mental health services

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
2.1	*IMPROVE QUALITY OF UTILIZATION MANAGEMENT (UM) DATA REPORTING*	**2.1.1** Develop implementation plan (with timelines) for producing "real time data analysis " for Out of Home UM reporting.	Plan presented to EMT for approval.	CSO – Resource Management; MIS	Mar 2007
		2.1.2 Monitor the plan for timely implementation	Quarterly updates on implementation to PISC	CSO – Resource Management; PISC Chair	July 2007 Oct 2007 Jan 2008 Apr 2008 July 2008 Oct 2008
		2.1.3 Develop implementation plan (with timelines) for producing "real time" waitlist information for use by system	Plan presented to EMT for approval.	CSO – Resource Management; MIS	Mar 20007
		2.1.4 Monitor the plan for timely implementation	Quarterly updates on implementation to PISC	CSO – Resource Management; PISC Chair	July 2007 Oct 2007
		2.1.5 Increase the usefulness of Quarterly UM Report by adding outcome data (i.e. CAFAS CALOCUS, MTPS, and other outcome measures as developed) to the Report	2.1.5.a Information system design completed to allow for the report to be run 2.1.5.b Quarterly reports are modified to include outcome measures	Research & Evaluation Specialist, CSO-RM and ISD CSO – Resource Management	Dec 2007 July 2008

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		2.1.6 Design annual UM plan that will guide CAMHD's management of resources.	Annual UM Plan presented to PISC and EMT to include: analysis of utilization of all levels of care and recommendations for contracted services	CSO – Resource Management	Oct 2007 Oct 2008
		2.1.7 Provide annual recommendations for contract amounts based upon UM analysis	UM Report to EMT regarding amount of services to b e contracted.	CSO – Resource Management	Apr 2007 Apr 2008
2.2	DEVELOP AND ADJUST RESOURCES IN A TIMELY & EFFECTIVE MANNER BASED UPON IDENTIFIED NEEDS	**2.2.1-** Design Access Plan to ensure access to needed services for youth with identified special needs	2.2.1.a - Special Populations Access Plan submitted to EMT for approval 2.2.1.b Quarterly meetings with FGC and Provider agencies to identify and address access barriers for special populations. Minutes and sign-in sheets completed	CSO – RM and FGC Branch Chiefs Chaired by CSO- RM	Oct 2007 Mar 2007 June 2007 Sept 2007 Dec 2007 Mar 2008 June 2008 Sept 2008 Dec 2008
		2.2.2 Develop protocols for developing new services and for adjusting capacity of CAMHD services in a timely and effective manner	Protocol with implementation plan for developing new services and adjusting capacity of services in a timely and effective manner submitted to EMT for approval	CSO – Resource Management; Contracts	Sept 2007
		2.2.3 Conduct a special UM Report on adequacy of the CAMHD service array for youth diagnosed with co-occurring mental health challenges and substance abuse issues with recommendations for system improvements	Report with system recommendations provided to EMT	CSO- Resource Management	Dec 2007

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		2.2.4 Conduct a special UM Report on adequacy of the CAMHD service array for youth diagnosed with co-occurring mental health challenges and developmental disabilities issues with recommendations for system improvements	Report with system recommendations provided to EMT	CSO- Resource Management	Mar 2008
		2.2.5 Conduct a special UM report on the adequacy of the comprehensive supports available for youth age 16-21 (including supported housing) to include recommendations for system improvements	Report with system recommendations provided to EMT	CSO- Resource Management	June 2008
		2.2.6 Conduct a special UM report on the adequacy of the comprehensive services available in the CAMHD system for Children age 3-9 to include recommendations for system improvements	Report with system recommendations provided to EMT	CSO- Resource Management	Sept 2008
		2.2.7 Conduct a report on the adequacy of the cultural competency of clinicians, CSP process, and use of culturally relevant supports in the CSP plan development	Report with system recommendations provided to EMT	CSO –practice development, Performance Manager, and QA Specialists	Mar 2008

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		2.2.8 Contract for Prevention Services based upon work of the Evidenced Based Primary Prevention Committee (EBPP)	2.2.8.a EBPPC report to EMT on findings 2.2.8.b Release of Prevention Service RFP and contract execution	EBPP Committee Chair Contracts Section	Jan 2007 May 2007
		2.2.9 Develop a plan to ensure the availability of competent trauma assessments and trauma focused treatment services	2.2.9.a Plan submitted to EMT for Approval 2.2.9.b - Training on assessments, treatments, and implementation strategies developed for increasing engagement skills in working with traumatized youth provided	CSO – Practice Development CSO Practice Development; Contracts	Mar 2007 Begin Mar 2007 and ongoing through 2008
		2.2.10 Develop comprehensive programs for girls in JJ system, to include services in DH and HYCF, and community based treatment services.	Plan for program development is submitted to EMT for approval, to include: assessment of current system and service/treatment recommendations.	CSO Practice Development, Resource Management	Sept 2007
		2.2.11 Explore blended funded options to serve girls in JJ system	Submit grant application for "girls who run" or engage in other high risk behaviors	CAMHD Planner, CSO, UH	Sept 2008
		2.2.12 Assess and strengthen the service array for neighbor islands and rural communities	2.2.12.a Submit needs assessment for neighbor islands and rural communities to EMT 2.2.12.b RFP issued based on needs assessment	CSO Resource Management Contracts	Dec 2008 Mar 2009
		2.2.13 Implement a CAMHD & Provider agency task force to increase TFH access	Minutes of quarterly meetings	CSO Chairs	Mar 2007, quarterly thereafter

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PRIORITY AREA #3: IMPLEMENT A PUBLICLY ACCOUNTABLE PERFORMANCE MANAGEMENT PROGRAM

Broadly stated 4 year goals: Implement an annual QAIP program meeting BBA/EQRO requirements
Strengthen the integration of performance data with all aspects of system management
Demonstrate consistent community engagement in performance evaluation

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
3.1	**Implement annual community and state Quality Assurance & Improvement Programs**	3.1.1 Develop standards for key components of quality management programs	Written standards for key components of quality management programs.	PM Chairs: Branches, Providers participate	July 2007
		3.1.2 Describe a "practice model" for Hawaii's mental health service system's performance management that will build uniform performance management theories and practices in all care settings.	Narrative description and supporting graphics of the practice model	PM Chairs: Providers, Branches participate	July 2007
		3.1.3 Define performance management infrastructure that needs to be in place at various levels of the service system and how describe how performance data review and decision making on improvements should flow in our systems	Written description and flowchart (of the structures and performance data flow	PM Chairs: Branches, Providers participate	Sept 2007

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		3.1.4 Conduct training on core components of quality management; train through didactic and modeling/ mentoring/ coaching	3.1.4.a Training curriculum approved by the QAS group 3.1.4.b Training sign in sheets from all Communities	QAS Group QA Specialists: PM	Oct 2007 June 2008
		3.1.5 Define & monitor for organizational practices and infrastructure supports needed to establish a performance management culture at all levels of system	3.1.5.a Monitoring tool to be used to evaluate submitted to EMT for approval. 3.1.5.b Report on the results of monitoring provided to EMT with recommendations for system changes	PM, QAS, Branch Chiefs PM and QAS group	Jan 2008 Dec 2008
		3.1.6 Monitor for the use of performance data at the level where program and quality of care decisions are made.	Annual report to EMT on the review of minutes of meetings in the Central Office, Branches and provider agencies reflecting discussion of performance and decisions about improvements based on review of data.	PM, and QAS group	Dec 2007 Dec 2008
		3.1.7 Provide technical assistance to anyone requesting it regarding how to build performance management systems and practices.	Log of requests/offers for TA	PM, RES, MIS	Dec 2007 Dec 2008

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		3.1.8 Execute contract to export use of "client to system" level data from CAMHMIS to providers as defined by data that is linked through the client-level to data about performance of MHCCs, to caseloads, to Branches, to the entire system.	Contract for provider access to specific data	Contractor	Jan 2008
		3.1.9 Monitor for whether the system is sharing best practices in QA that are working across system	QAS group to maintain minutes of their review of standing agenda and minutes of Provider Quarterly Meetings/Branch meetings and Newsletters	QAS, PM, Provider Relations Specialist, and Branches	Mar 2007; quarterly thereafter
		3.1.10 Strengthen monitoring protocols to more clearly evaluate and enhance clinician practices.	Revised Monitoring protocol	PM	Jan 2008
		3.1.11 Develop evaluation methodology to assess organizational climate and organizational culture including "real-time" observation of operations (e.g.: QA meetings, management meetings, case review meetings, trainings, and supervision sessions.	Methodology protocol	PM	Dec 2007

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		3.1.12 Execute a contract to conduct a study of variations in outcomes based on organizational culture and climate	Contract	PM/Contracts	Mar 2008
3.2	**Perform Annual Evaluation with recommendations for system refinements**	3.2.1 Use previous reports as standard for completing Annual Evaluation	Annual Report submitted to EMT with recommendations	UH; Research/Evaluation Specialist (RES); contracts	Mar 2007 Jan 2008
		3.2.2 Assure annual reports, report on actions taken on previous recommendations	Section of report on actions taken	UH/RES/ contracts	Jan 2008 Jan 2009 Jan 2010
		3.2.3 Provide branches timely feedback from Annual evaluation	Web posting of annual evaluation	CAMHD website manager	Apr 2007 Apr 2008 Apr 2009 Apr 2010
3.3	**Establish consistent partnerships with DOE and Child Welfare Services in Cross Agency case based reviews**	3.3.1 Maintain current listing of reviewer pool to include providers	Reviewer pool identified	PM	Jan 2007 Jan 2008 Jan 2009 Jan 2010
		3.3.2 Provide annual train to maintain active reviewer pool	Training sign in sheets	PM to coordinate with CWS, DOE	June 2007 June 2008 June 2009 June 2010
		3.3.3 Coordinate schedule and assign reviews	Reviewers names on schedule	PM	Mar 2007 Mar 2008 Mar 2009 Mar 2010
3.4	**Facilitate Interagency QA Group meetings at the community and state levels**	3.4.1 Continue current practices for Interagency QA	QA minutes	Interagency QA Committees	Jan 2007-Dec 2010
		3.4.2 Finalize and have Director's sign Interagency QA Memorandum of Agreement	MOA	PM	Feb 2007

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
3.5	**Demonstrate compliance with Balanced Budget Amendment 1997 (Medicaid Final Rules for Managed Care Organizations**	3.5.1 Develop a management plan for training on compliance and documentation requirements including list of all deliverables	Management plan	PM	Jan 2007
		3.5.2 Identify role groups to receive training	List of targeted role groups	PM	Jan 2007
		3.5.3 Conduct trainings	Training sign-in sheets	PM	Feb 2007 and ongoing
		3.5.4 rack deliverables	Deliverable tracking showing completion of all deliverables	PM	Mar 2007 and ongoing
3.6	**Consistently communicate performance data with community and stakeholders**	3.6.1 Determine what data should go to what stakeholders	Submit suggested data list to EMT for approval	PISC Chair	Sept 2007
		3.6.2 Develop detailed and specific Communications Plan with timetables	Communications Plan	PM/PISC	Oct 2007
3.7	**Strengthen Branch QA practices**	3.7.1 Establish core QA practices expected across Branches linked to CAMHD QAIP and QA practice model	Written description of core QA practices	QA Specialists, PM, Branch Chiefs	June 2007
		3.7.2 Identify barriers to implementing QA practices consistently across Branches	List of barriers	QAS and Branch Chiefs and other designated FGC staff	Dec 2007
		3.7.3 Implement strategies for addressing barriers, e.g.: training, efficiencies in data collection; policy development, etc.	Plans to address barriers for each Branch	Branch Management, QA Teams	Mar 2008
		3.7.4 Develop ways to create working relationships	Agenda/Minutes of Provider-Branch meetings	Branch Management Teams	June 2007

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		and partnerships with local providers around QA practices and sharing data.			
		3.7.5 Implement an "inter-rater" program for monitoring areas among the FGCs: example-Quality Assurance Specialist periodically rates Coordinated Service Plan Quality for another Family Guidance Center	Written program description	QAS/PM and Branch Chiefs and other designated FGC staff	Dec 2007
		3.7.6 Assure recommendations for improvement are implemented and are reported on (feedback loop) at Branch Quality Assurance meetings and to the CAMHD Performance Improvement Steering Committee (PISC)	Meeting minutes/recommendation forms	QAS/PM and Branch Chiefs and other designated FGC staff	Mar 2007
		3.7.7 Maintain community QAS meeting quarterly at a minimum, and evaluate need for more frequent meetings.	Meeting minutes	QAS/PM and Branch Chiefs and other designated FGC staff	January 2007- Dec 2010
3.8	**Strengthen the quality of performance monitoring practices with a focus toward improving provider practice competencies**	3.8.1 Implement newly created tools	Provider Monitoring Reports	PM	January 2007
		3.8.2 Evaluate the effectiveness of tools	Evaluation report provided to EMT	PM	May 2007
		3.8.3 Train monitoring staff to build their competencies and knowledge of best practices	Training curricula/sign-in sheets	PM, CSO	Dec 2007
		3.8.4 Assure timely reports.	Tracking reports measure met	PM	Jan 2007 and quarterly thereafter
		3.8.5 Strengthen feedback	Providers give positive	PM	May 2007

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		and data presentation of monitoring reports/feedback with a focus on presenting case based review findings and practice strengths and areas for improvement	evaluation of reports when surveyed		
		3.8.6 Strengthen linkages to and provision of technical assistance and training for improving practices	Training and consultation log	PM, CSO	Sept 2007
		3.8.7 Develop protocol for developing a system with levels to determine review intensity that addresses the frequency of reviews and/or depth of reviews	New Protocol submitted to EMT for approval	PM	Apr 2007

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PRIORITY AREA #4: IMPLEMENT AND MONITOR A COMPREHENSIVE PRACTICE DEVELOPMENT PROGRAM

Broadly stated 4 year goals: Demonstrate the availability of a diverse competent workforce at all professional levels in all communities of the state
Demonstrate the availability of EBS or EB practices in all communities of the state
Demonstrate strong cross agency partnerships with all institutions of higher ed.

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
4.1	**EXPAND/STRENGTHEN ACADEMIC LIAISONS TO IMPACT PRESERVICE EDUCATIONAL PROGRAMS**	**4.1.1** Clarify and modify language in ongoing UH MOAs (social work, nursing, psychology, psychiatry, and education) to emphasize exposure to system of care values and principles (CASSP), performance management and evidence based service elements. Incorporate all applicable initiative and deliverable products into the MOAs. identify scope of services; itemize learning objectives and train to objectives.	Finalized MOA's submitted to EMT	CSO/Contracts	June 2007
		4.1.2 Develop MOAs with Argosy, Chaminade and HPU Incorporate all applicable initiative and deliverable products into the MOAs.	Finalized MOAs submitted to EMT	CSO/Contracts	Jan 2008
		4.1.3 Develop MOAs with Community Colleges and/or other relevant units of UH (e.g. Family Relations in UHM Tropical Ag) regarding a system of care, direct care staff certification or curriculum and student placements within the CAMHD system a. Examine existing models (Alaska) of providing entry-level training to mental health care workers. b. Incorporate all applicable	Finalized MOAs submitted to EMT	CSO/Contracts	Jan 2008

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		initiatives and deliverable products into the MOAs.			
		4.1.4 Support higher education institutions in developing rural or distance learning opportunities	Finalized MOAs to all higher education institutions that include language specifying particular considerations for neighbor island students and distance learning as appropriate;	CSO/Contracts	Jan 2008
		4.1.5 Develop outreach program to high schools regarding career opportunities in children's mental health care a. Identify contacts at colleges and high schools to examine current recruitment efforts (including other disciplines). b. Explore options for partnering or adapting current existing recruitment models. Focus on recruitment into children's mental health.	Program Plan and Curriculum options provided to Division Chief	CSO/FGC staff	July 2009
		4.1.6 Upon completion of MOAs with Higher Ed, develop a group that discusses linkages and sustainability and a comprehensive approach to pre-service training for the children's mental health workforce	4.1.6.a Hold Child & Adolescent Mental Health Education Summit to initiate discussion and collaboration among institutions, and form a Consortium 4.1.6.b - Plan for interagency learning initiative incorporating distance-learning options provided to EMT/Higher Ed institutions.	Chiefs Office Consortium of Higher Ed Institutions who have formal relationships with CAMHD/CSO	Jan 2008 July 2009

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
4.2	**STRENGTHEN INTERAGENCY AGREEMENTS RE: WORKFORCE & PRACTICE DEVELOPMENT**	**4.2.1** Develop interagency (child welfare, education, juvenile justice, DD) agreement re: what is expected of UH in our separate academic liaison agreements. (So that we are asking for similar core competencies) Convene meeting with agency partners to compare individual needs and develop shared plan.	Interagency agreement executed	CSO/Contracts/Chief's Office	Jan 2008
		4.2.2 Create cross agency Practice Development Committee in order to assure that training needs are being met in a consistent manner across child serving agencies (child welfare, education, EIS, JJ)	Agenda and minutes from initial meeting submitted to PISC	Clinical Service Office (CSO)	Mar 2008 and on-going
4.3	**DISSEMINATION OF EVIDENCE BASED SERVICES AND MONITOR THE UTILIZATION OF EBS**	**4.3.1** Shift the focus of the activities of the EBS Committee to synthesis and dissemination	An annual work plan for EBS Committee submitted to PISC	CSO/UH	June 2007
		4.3.2 Develop annual priority areas for EBS coding focus	An annual work plan for EBS Committee submitted to PISC	EBS/CSO to EMT	June 2007
		4.3.3 Produce biennial EBS report	Reports posted on the WEB and disseminated to providers and CAMHD clinical staff	UH/CSO/Research and Evaluation Specialist/Webmaster	Sept 2008 and Sept 2010
		4.3.4 Develop & disseminate EBS fact sheets/pamphlets to youth, families, child serving partners	Fact sheets and pamphlets in at least 2 areas provided to FGC and partner agencies. Fact sheets and pamphlets in at least 4 additional areas provided to FGC and partner agencies.	UH/CSO UH/CSO	Sept 2008 Sept. 2009

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		4.3.5 Provide annual priority for the training on specific EBS services. This may include importing packaged E-B approaches into the state.	Annual Training Plan submitted to PISC	CSO to EMT	July 2007 July 2008 July 2009
		4.3.6 Evaluate MTPS practice element outcomes and continue development and use of system evaluation and refinement linking EBS and CAMHD research and evaluation	Research report provided to EMT	CSO/Research and Evaluation Team/UH	Sept 2008
4.4	**STRENGTHEN CORE COMPETENCIES OF CURRENT WORK FORCE**	**4.4.1** Define the core competencies of care coordinators, paraprofessional MH workers, line level staff, clinicians, and clinical supervisors, including evidence based practices.	Detailed objectives for foundation training to PISC	Discipline Groups/CSO to EMT	Dec 2007
		4.4.2 Develop annual plan for training on core competencies including foundation training and a basic EBS supervision model.	Annual training plan to PISC	Training Committee to PISC	July 2007 And on-going
		4.4.3 Develop standardized curricula for training on core competencies	Part one of training manual to PISC Completed Training manual to PISC	CSO	July 2007 June 2008
		4.4.4 Provide training based upon approved annual plan	Annual training calendar posted on the WEB	CSO	July 2007 and on-going
		4.4.5 Develop annual plan for training on special populations/issues including but not limited to: LGBTQ, Attachment, Trauma, Resiliency & Protective Factors, Recovery Model, Girls in JJ system, Serving	Annual training plan to PISC	CSO/Training committee	July 2007 and on-going

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		children 3-9 years old, Developmental Disabilities, etc			
		4.4.6 Provide training on special populations/issues	Annual training calendar posted on the WEB	CSO	July 2007 and on-going
		4.4.7 Assure that trainings are available to all child serving agencies, youth and families.	Annual training calendar including sessions for neighbor islands posted on the WEB; training schedules provided to HFAA for dissemination	CSO	July 2008 and on-going
		4.4.8 Maximize funding opportunities to support training	Report on utilizing Title IVE submitted to EMT	CSO/Resource Development/Planner	June 2007
		4.4.9 Develop a plan for measuring the impact of EBS dissemination activities on provider practice.	Plan to PISC	RET/UH/CSO	June 2008
4.5	**Increase collaboration with statewide professional guilds around training, professional development, EBS dissemination, etc.**	**4.5.10** Increase CAMHD staff participation in professional guilds	Listing of CAMHD staff on professional guilds	CAMHD State Planner and CSO	Mar 2007

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PRIORITY AREA #5: IMPLEMENT AND MONITOR STRATEGIC PERSONNEL MANAGEMENT PLAN

Broadly stated 4 year goals: Maintain reasonable workload for care coordinators
Maintain reasonable workload of state employed licensed clinicians
Demonstrated ability to recruit and retain personnel

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
5.1	**Monitor care coordinator workload to assure effective practices**	**5.1.1** Quarterly report on care coordinator workload and performance on established measures	5.1.1.a - Care Coordinator data provided 5.1.1.b - Performance analyzed based on caseload	PHAOs, personnel office PM	Jan 2007 Apr 2007 July 2007 Oct 2007 Feb 2008 and quarterly thereafter
5.2	**Maintain caseloads less than 20 in each FGC**	**5.2.1** Submit budget request for new care coordinator positions based upon quarterly caseload analysis	Supplemental and biennium budget requests show submission	PHAOs	Aug 2007 Aug 2008 Aug 2009
		5.2.2 Execute case management contracts in areas where caseloads are above 20	5.2.2.a – Release RFP 5.2.2.b – Execute contracts	Contracts/CSO Contracts	June 2007 Sept 2007
5.3	**Define workload structure for CAMHD licensed clinicians**	**5.3.1** Develop a task force to define workload expectations for licensed clinical staff	5.3.1.a - Task force formed 5.3.1.b - Executive summary report to EMT for consideration and approval	Branch Chiefs, CSO, Discipline Groups Chairs: M.D., and Chief Psychologist	Jan 2007 July 2007
5.4	**Implement task force recommendations approved by EMT**	**5.4.1** Revise position descriptions to reflect changes approved by EMT	Position Descriptions revised	Task Force	Sept 2007
5.5	**Assure Organizational framework supports effective practices**	**5.5.1** Complete CAMHD reorganizations	Reorganization proposals submitted to Department	Planner, CSO Resource Management	Mar 2007
		5.5.2 Complete annual checks of organizational structure for accuracy	Annual updates submitted as required	Branch PHAOs/ Planner	Aug 2007 Aug 2008 Aug 2009

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
5.6	**Strengthen Rural and Neighbor Island Workforce**	**5.6.1** Support higher education in developing distance learning programs	Execute MOAs for distance learning programs	Contracts/Chief's Office	July 2007
		5.6.2 Support adaptations of service array and supports based on smaller community need	Approval of waivers for rural communities	CSO	July 2007 July 2008 July 2009
		5.6.3 Support outreach to rural community members to pursue higher education programs	Offer stipends to rural community members to pursue higher ed	Branch Chiefs, Chiefs Office, Contracts	July 2007 July 2008 July 2009
		5.6.4 Develop incentives for psychologists, clinicians, and psychiatrists to work in rural areas	Rural Community Recruitment Incentive Plan submitted to EMT for approval	Branch Chiefs, Branch PHAOs, Contracts Management	Aug 2007
5.7	**Implement a Strategic Recruitment and Retention Initiative**	**5.7.1** Conduct salary evaluation of child psychiatrists working in Hawaii	Child psychiatry salary evaluation provided to Division Chief	Medical Director	Jan 2007
		5.7.2 Adjust psychiatrists salaries to maintain competitiveness	Submit request to Director of Health to adjust Child Psychiatrists salaries	Medical Director, Division Chief	Jan 2007
		5.7.3 Complete an evaluation of Clinical Psychologists salaries	Clinical psychologist salary report provided to Division Chief	CAMHD Personnel Office, PHAO	Mar 2007
		5.7.4 Request HRO and DHRD to take action to adjust salary level	Memo to HRO, DHRD submitted	CAMHD Personnel Office, PHAO, Division Chief	Apr 2007
		5.7.5 Obtain funding to support staff participation in conferences, trainings, professional development	Annual listing of staff participation in training programs reviewed by EMT	PHAO to EMT	July 2007 July 2008 July 2009
		5.7.6 Conduct annual survey on employee's satisfaction, to include items on retention factors	Survey results presented at PISC	PM, Personnel, PHAO	Dec 2007 Dec 2008 Dec 2009
		5.7.7 Implement organizational initiatives	Employee survey initiatives	CAMHD Personnel Office	Mar 2008 Mar 2009

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		based upon survey			

PRIORITY AREA #6: IMPLEMENT AND MONITOR A STRATEGIC FINANCIAL PLAN

Broadly stated 4 year goals:
Demonstrate a diversity of sustainable funding streams
Strengthen the expertise of Branches in financial operations
Achieved established thresholds for each funding source
Demonstrate braided and blended funding programs with all child serving agencies
Demonstrate routine system financial reporting to management team and community stakeholders

MP#	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBL E	DATE DUE
6.1	**STRENGTHEN TITLE XIX MEDICAID BILLING PRACTICES**				
	.	**6.1.1** Develop payment methods for manual bills (MST, MTFC, FFT, Crisis Outreach, Crisis Hotline, Travel, CBR I, Medicaid eligible clinical services through ancillary funding)	Standardized Procedures distributed to provider and relevant CAMHD sections by incremental dates provided.	Resource Development (PHAO, MIS, Fiscal)	MST – Jan 2007 Travel – Mar 2007 MTFT – Jun 2007 CBR I – Mar 2007 FFT – June 2008 Ancillary – June 2007 CMO – Sept 2008 Access line – Jun 08
		6.1.2 Implement training to target audience regarding Title XIX billing for above services	Sign in sheets for the training provided for standardized procedure	Resource Development (PHAO's, MIS, Fiscal)	MST – Mar 2007 Travel – May 2007 MTFT – Aug 2007 CBR I – May 2007 FFT – Aug 2008 Ancillary – Aug 2007 CMO – Nov 2007 Access line – Aug 08
		6.1.3 Modify and implement pCard database to support CMS billing through MIS	PCARD Database modification complete and distributed.	PHAO/MIS	Apr 2007
		6.1.4 Integrate ECR with Medicaid billing for our CAMHD employed providers	Integrated system for charting and billing	Resource Development/MIS/CSO	Dec 2010

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MP#	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBL E	DATE DUE
		6.1.5 Assure annual Medicaid reconciliation.	CAMHD receives reimbursements due as part of this reconciliation is complete	Division PHAO	Dec 2007 Dec 2008 Dec 2009 Dec 2010
		6.1.6 Assure MedQuest Division is contacted annually regarding renegotiation of capitated rate.	Formal communication/Letter From Division Chief written and submitted to MedQUEST	Division PHAO/Chief	July 2007 July 2008 July 2009 July 2010
		6.1.7 Obtain Medicaid State Plan Amendment to allow for invoicing of additional services in service array.	6.1.7.a – Execute contract with consultant to work with CAMHD and MQD on SPA 6.1.7.b – Agreed upon SPA draft received from consultant that is acceptable to CAMHD and MQD. 6.1.7.c – Request for SPA sent to CMS from Hawaii	Contracts management PHAO, contracts, Resource Development PHAO, Division Chief	June 2007 January 2008 Mar 2008
6.2	**STRENGTHEN RANDOM MOMENT SURVEY BILLING**	**6.2.1** Develop a standardized training module for all involved staff.	Handouts, Powerpoint presentations and self training manual completed.	Resource Development/CSO	June 2007
		6.2.2 Implement standardized training module across the state	Confirming documents that identified target audience was trained	Resource Development/CSO (Training Committee)	Dec 2007

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

MP#	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBL E	DATE DUE
		6.2.3 Assure accuracy of ASO's listing of CAMHD providers (staff) to include TA's, Temps, and new employees.	Submit quarterly listing of eligible CAMHD staff to ASO, and work with them to update	Personnel/PHAO	Apr 2007 and quarterly thereafter
		6.2.4 Provide quarterly RMS training to any new eligible staff.	Training schedule or log that matches p Procedures	Personnel/PHAO	Sept 2007 Dec 2007 Mar 2008 June 2008
6.3	**STRENGTHEN TITLE IVE BILLING FOR SERVICES PROVIDED TO ELIGIBLE CHILD WELFARE YOUTH**				
		6.3.1 Complete a systematic review of Federal Regulations that impact Title IVE operations	Summary of Title IVE allowable billings provided to EMT	Resource Development	Jan 2008
		6.3.2 Execute a CAMHD - DHS interagency agreement to allow for claiming of eligible services to eligible youth a standardized billing process for Title IVE	Interagency MOA	Resource Development	Jan 2008
		6.3.3 Collaborate with DHS to revise the State's Title IVE plan, if needed	State Title IVE plan that allows CAMHD to invoice for eligible services on eligible youth	Resource Development	June 2008
		6.3.4 Develop standardized procedures for invoicing for services	Procedures developed	Resource Development	June 2008
		6.3.5 Provide training on standardized procedures	Documentation of attendance maintained	Resource Development	Sept 2008

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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MP#	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBL E	DATE DUE
6.4	**STRENGTHEN TITLE IVE BILLING TRAINING OF DHS CASE MANAGERS**				
		6.4.1 Submit the indicated State Training Plan to DHS	Training plan submitted to DHS	CSO Practice Development, Resource Development, PHAO	Sept 2007
		6.4.2 Assure that CAMHD Annual Training Plan appropriately provides sessions and workshops that focuses on case management practice	CAMHD training plan shows evidence of case manager focused trainings workshops, seminars, etc.	CSO Practice Development, CAMHD Training Committee Chair	June 2007 June 2008 June 2009 June 2010
		6.4.3 Develop interagency agreement that allows CAMHD to invoice DHS for trainings of case workers	MOA	Resource Development	June 2008
		6.4.4 Develop standardized billing process	Procedures developed	Resource Development	June 2008
		6.4.5 Establish and meet annual targets for Title IVE billing for training.	Submit as part of annual revenue projections	CSO/Resource Dev/PHAO	Sept 2008 and annually thereafter
6.5	**STRENGTHEN BRAIDED AND BLENDED FUNDING AGREEMENTS – DHS, OYS, JJ, DOE, DDD, AMHD**				
	.	**6.5.1** Complete a review of all CAMHD involved agreements on joint funding	Summary of all agreements provided to EMT	Resource Development/ Contracts/ PHAO	June 2007
		6.5.2 Identify possible options for other joint funding opportunities	Analysis of potential agreements provided to EMT	Resource Development/ Contracts/ PHAO	Sept 2007
		6.5.3 Expand joint funding opportunities, by expanding number of agreements	Listing of Joint Funding MOAs presented to EMT	Contracts/PHAO	June 2008

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2007-2010 STRATEGIC PLAN WORK PLAN

MP#	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBL E	DATE DUE
6.6	**MAXIMIZE FEDERAL FUNDING & COMMUNITY GRANT OPPORTUNITIES**	**6.6.1** Assign duties to monitor funding and grant opportunities.	Monitoring Log	Resource Development	Feb 2007 ongoing monthly
		6.6.2 Develop the standardized start-up process for every new grant.	Standardized procedure/Flow chart	Resource Development/Fiscal	June 2007
		6.6.3 Increase amount of CAMHD grant funding by 25% per calendar year.	Contract Awards	Resource Development/UH partners	Dec 2010
6.7	**DEVELOP THIRD PARTY BILLING RELATIONSHIPS**				
	.	**6.7.1** Develop an internal expertise through a contracted expert regarding federal and state regulations/options for TPL.	6.7.1.a Execute contract for TPL consultation 6.7.1.b With contractor, develop Internal guidelines when CAMHD must drop a third party bill	Resource Development/Contracts Management/MIS Resource Development, MIS	Dec 2007 June 2008
		6.7.2 Complete a start-up plan to implement TPL billing	6.7.2 Consultant Report to EMT	Resource Development/Contracts/ MIS	Dec 2008
		6.7.3 Develop an implementation plan	6.7.3 Implementation Plan approved by EMT	Resource Dev./MIS	Mar 2009
6.8	**IMPLEMENT ROUTINE FINANCIAL REPORTING SYSTEM**				
		6.8.1 Establish procedures for the monitoring of monthly FGC financial indicators and statewide trends	Written Procedure	PHAO/Branch Chief	Mar 2007, ongoing monthly

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MP#	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBL E	DATE DUE
		6.8.2 Develop a process such as a control chart methodology to monitor and provide monthly feedback regarding FGC clinical expenditures	Standardized process	PHAO/MIS	Apr 2007
		6.8.3 Implement/monitor flexible clinical services budget for each FGC	Standardized process	PHAO/Branch Chief/MIS	Dec 2008

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

PRIORITY AREA #7: IMPLEMENT AND MONITOR STRATEGIC INFORMATION TECHNOLOGY PROGRAM

Broadly stated 4 year goals:
Evaluate and implement electronic clinical record system
Integrate and standardize CAMHD data system wide (all branches, FCLB, Kauai)
Implement data sharing among CAMHD providers and branches
Sustain an integrated clinical outcome, financial billing data system, and UM system
Implement electronic forms to streamline direct care work
Implement a youth developed, youth friendly mental health website
Implement a family focused, family friendly mental health website

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
7.1	**IMPLEMENT ELECTRONIC CLINICAL RECORD (ECR) INCLUDING INTEGRATED ELECTRONIC FORMS AND ELECTRONIC SUBMISSION OF FORMS**	**7.1.1** Develop an ECR implementation plan after collecting broad input and feedback and design specifications including feedback about data sharing among CAMHD providers and branches, integration with current CAMHMIS system, and integration for use with Fiscal and Performance Management	7.1.1.a – E.CR Task Force established	EMT to appoint task force, upon recommendations from ISD	Mar 2007
			7.1.1.b – Develop RFP requesting development of an ECR system specifications and timelines including specifications and requirements.	ECR Task Force, ISD	Aug 2007
			7.1.1.c – Execute contract for ECR consultant	Contracts staff	Jan 2008
			7.1.1.d Implement-ation Plan submitted to EMT	ECR Task Force Chair, Consultant	July 2008

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		7.1.2 Based on specifications and requirements in the implementation plan above, identify key system design and development work for the ECR System (to include Integrated Electronic Forms and Form Submission)	Identification of design and development work submitted to EMT	ECR Task force Chair, Consultant, HISO	July 2008
		7.1.3 Develop Integrated Electronic Forms and Form Submission Plan for ECR	Integrated Electronic Forms and Form Submission Plan submitted to EMT	ECR Task force Chair, Consultant, HISO	July 2008
		7.1.4 Catalog various CAMHD paper forms that are used routinely and evaluate usefulness; make recommendations to streamline work	Form Catalog in consultant report	ECR Task force Chair, Consultant	July 2008
		7.1.5 Submit funding request in budget request to support implementation	Budget request shows ECR request	PHAO	Aug 2008
		7.1.6 Develop mechanisms for forms to be on-line or intranet	Standardized accessible electronically	ECR Task Force	Dec 2008
		7.1.7 Develop timelines for system design and development	Timelines approved by EMT, provided funding available	ECR Task Force, EMT	Aug 2008
		7.1.8 Based on EMT approval and Funding, design and develop ECR system with Integrated Electronic Forms and Form Submission	ECR System Installed with User Customization	ECR Task Force and selected Developer, HISO, CAMHMIS Representative	Dec 2009
		7.1.9 Develop Implementation And Training Plan for ECR system	ECR Implementation and Training Plan	CSO, CAMHMIS, CAMHD Training Committee	Dec 2009
7.2	**EVALUATE QUALITY PERFORMANCE OF CAMHMIS ON ONGOING BASIS**	**7.2.1** Define specific performance expectations of the information system	List of Definitions of Performance Expectations submitted to EMT	ISD, CAMHMIS,	May 2007

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		7.2.2 Define specific performance targets/indicators expected	List of Definitions of CAMHMIS Performance Measures provided to PISC	ISD, CAMHMIS, PM	June 2007
		7.2.3 Develop annual MIS evaluation process	CAMHMIS Performance Evaluation Plan submitted to EMT	ISD, CAMHMIS, and Performance Management	Dec 2007
		7.2.4 Implement annual evaluations	CAMHMIS Performance Evaluation Implementation Plan	ISD, CAMHMIS, Performance Management	June 2008 June 2009 June 2010
		7.2.5 Disseminate findings, with recommendations	CAMHMIS Performance Results and Recommendations Report provided to FGCs and providers	ISD, CAMHMIS, and Performance Management	Sept 2008 Sept 2009 Sept 2010
		7.2.6 Implement improvement activities based on findings	Schedule for CAMHMIS Corrective Action Plan	CSO, CAMHMIS, and Performance Management	Dec 2008 Dec 2009
7.3	**IDENTIFY AND GAIN FUNDING SUPPORTS FOR CAMHMIS**	**7.3.1** Define 4 yr. Funding needs for current system (not incusive of ECR)	Funding Estimate Budget Projection	CSO CAMHMIS, and Fiscal Office	June 2007
		7.3.2 Identify potential funding sources	Funding Source Laundry List	CAMHMIS, Fiscal Office, Resource Management	June 2007
		7.3.3 Develop plans to access diverse funding	Funding Plan	CAMHMIS, Resource Management	July 2007
		7.3.4 Secure Funding for years 2008, 2009, 2010	Funding Authorized	IT, CSO, Contracts	May 2007 May 2008 May 2009
7.4	**IMPLEMENT YOUTH DEVELOPED INTERNET WEBSITE ON EMOTIONAL HEALTH**	**7.4.1** Obtain input from Youth about Web Site development	Youth Survey and Interview	HFAA, HYHY, Wai Aka, ISD	July 2007
		7.4.2 Define specs based on	Web Specifications	HFAA, Youth Council,	Dec 2007

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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		youth input, and information from anti-stigma initiative	for Youth Site	Wai Aka, ISD	
		7.4.3 Identify funding to support	Funding Plan	HFAA, HYHY,PHAO, Resource Management	Jan 2008
		7.4.4 Contract for website development	Contract executed	contract	July 2008
		7.4.5 Website developed and operational	Website functional	Contractor, ISD	Dec 2008
		7.4.6 Monitor for hits and usage	Monitoring web hits and usage Implementation Plan	HFAA, HYHY, Wai Aka, ISD	July 2009
		7.4.7 Increase Youth Awareness Of Web Site/CAMHD	Marketing and publicity plan	EMT, HFAA, Youth Council, Fiscal, CAMHMIS	Jan 2009
7.5	**STRENGTHEN QUALITY OF CAMHD WEBSITE**	**7.5.1** Updated design of CAMHD Website to make it more user friendly, useful, and contemporary	7.5.1.a - Web Task Force established by EMT 7.5.1.b - Website Redesign Plan developed, to include: need for consultation, usability and look, provider section, youth section care coordinator section, ability to change and update web-based calendar for CAMHD and FGC's events and trainings 7.5.1.c - Implemented Redesigned CAMHD Website	1. EMT, CAMHD Webmaster (TBD) Web Task Force and CAMHD Webmaster (TBD) EMT, Web Task Force and CAMHD Webmaster (TBD)	Feb 2007 Nov 2007 July 2008
		7.5.2 Maintain current versions of P&P's and forms on current CAMHD website	Online Maintenance Plan	CAMHD Webmaster	Aug 2008
		7.5.3 Put monitoring tools, training curriculum on current	As above	CAMHD Webmaster	Aug 2008

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
		CAMHD website			
		7.5.4 Put links to CMHS, FOF, HFAA, NMHA, etc., on current CAMHD website	As above	CAMHD Webmaster	Aug 2008
		7.5.5 Transfer all web content on current CAMHD website to Redesigned CAMHD Website	Online Maintenance Plan	CAMHD Webmaster	Aug 2008
7.6	**STABILIZE HARDWARE AND SOFTWARE ALLOCATION**	**7.6 1** Define typical use protocols for hardware and software upgrades	Hardware and Software Allocation P& P approved by EMT, to include Software & hardware Upgrade, Software and Hardware Deployment, and Maintenance and Upgrade Schedule including: User and administrative rights; user software installation and upgrades, and hardware installation and upgrade methods	ISD Committee, CAMHMIS, P&P committee	July 2008
		7.6.2 Develop budget projections considering hardware and software needs	Budget based on 6.6.1	CAMHMIS & Fiscal	Aug 2007 Aug 2008 Aug 2009
7.7	**STRENGTHEN QUALITY OF TRAINING RE: USE OF IT**	**7.7.1** All CAMHD staff have routine access to needed IT training	Annual Training Plan approved by EMT to address IT needs.	CAMHMIS	June 2007 June 2008 June 2009
7.8	**MAINTAIN DEVELOPMENT OF CAMHMIS FOR CRM, MTPS, TOOLS AND DASHBOARDS**	**7.8.1** Annual ISD priority plan to address Clinical Reporting Module upgrades, MTPS updates, and development of tools and dashboards to make use of the system more accessible to end user.	Maintenance Plan including obtaining user feedback to CAMHMIS to refine, modify, update, and new additions and to communicate changes to end users.	ISD Committee	Aug 2007 Aug 2008 Aug 2009

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
2007-2010 STRATEGIC PLAN WORK PLAN

MP #	GOAL	INITIATIVE	DELIVERABLE PRODUCT	UNIT(S) RESPONSIBLE	DATE DUE
7.9	**DEVELOP TELE-HEALTH SERVICES TO ASSIST SERVICE DELIVERY IN RURAL AND REMOTE AREAS**	**7.9.1** Explore possible funding sources (Medicaid, grants)	Tele-health/medicine funding sources available.	Resource Management	July 2007
		7.9.2 Identify statutory and supervisory issues that require attention	Report to EMT	CSO/Resource Management	July 2007
		7.9. 3 Implement telehealth services	Functional access to telehealth services	CSO/MIS	Dec 2007

SAMHSA Matrix of Priorities

Cross-Cutting Principles

- Science to Services/ Evidence-Based Practices
- Data for Performance Measurement & Management
- Collaboration with Public, Private & International Partners
- Reducing Stigma & Discrimination & Other Barriers to Services
- Cultural Competency/ Eliminating Disparities
- Community & Faith-Based Approaches
- Trauma & Violence (e.g. Physical & Sexual Abuse)
- Financing Strategies & Cost-Effectiveness
- Rural & Other Specific Settings
- Disaster Readiness & Response

Programs/Issues

- Co-Occurring Disorders
- Substance Abuse Treatment Capacity
- Seclusion & Restraint
- Strategic Prevention Framework
- Children & Families
- Mental Health System Transformation
- Suicide Prevention
- Homelessness
- Older Adults
- HIV/AIDS & Hepatitis
- Criminal & Juvenile Justice
- Workforce Development

A Life In The Community For Everyone

Building Resilience & Facilitating Recovery

APPENDIX A

CARING FOR EVERY CHILD'S MENTAL HEALTH
Systems of Care
CMHS
Child, Adolescent & Family Branch Logic Model
Vision
All children and their families live, learn, work, and participate fully in communities where they experience joy, health, love, and hope.
Mission
Through investment in and partnerships with community-based systems of care, the Child, Adolescent and Family Branch promotes the potential and well-being of children and youth who have, or are at risk of having, a serious emotional or behavioral disturbance, and their families.
Target Population
Children and youth with a mental health need and their families.
TRANSFORMING CHILDREN'S MENTAL HEALTH CARE IN AMERICA
Family Driven
Youth Guided
Evidence Based
Clinical Excellence
Cultural & Linguistic Competence
Context
Child, Adolescent & Family Level
• Create positive experience with services & supports
• Promote family strengths
• Develop child & youth potential & well-being
Practice Level
• Ensure effective and accessible service delivery
• Ensure sufficient and trained workforce
• Promote culturally & linguistically responsive service practices
System Level
• Raise awareness about child & youth mental health issues
• Ensure collaborations to integrate mental health as a component in overall health
• Ensure access to resources to address child and family mental health issues
Strategies
Programs
• Children's Mental Health Initiative
• Circles of Care
• Partnerships for Youth Transition
• Statewide Family Networks
• Child & Adolescent State Infrastructure Grants
Branch Functions
• Technical Assistance for grant preparation
• Oversee all implementation requirements of grants, cooperative agreements and contracts
Extensive Partner Network
• Communications
• Technical Assistance
• Research / Evaluation
• Agreements with other federal agencies
Outcomes
Child, Adolescent & Family Level
• Significant improvement in behavior & emotional functioning of children
• Increased satisfaction with services
• Family & youth have a decision-making role in service planning
Practice Level
• Increased use of evidence-based practice
• Increased workforce training
• Practice reflects the cultural and linguistic characteristics of the population being served
System Level
• Increased sustainability of grantees
• Increased collaboration across federal agencies
• Sustained or increased funding available for the support of programs
Continuous Quality Improvement

APPENDIX B

STATE OF HAWAII
Child and Adolescent Service System Program (CASSP) Principles

1. The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.

2. Access will be to a comprehensive array of services that addresses the child's physical, emotional, educational, recreational and developmental needs.

3. Family preservation and strengthening along with the promotion of physical and emotional well being shall be the primary focus of the system of care.

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

5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.

6. The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.

7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.

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

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

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

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.)

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

Cross-Tabulation of Services by Geographic Areas

For the Comprehensive Behavioral Health Service for Children, Youth and Families

APPENDIX D

Cross-Tabulation of Services by Geographic Areas

TABLE 1.	LIST OF SERVICES BY CATEGORY	
Emergency Public Mental Health Services	**Educationally Supportive Intensive Mental Health Services**	**Support for Emotional and Behavioral Development (SEBD) Program Services**
1. 24-Hour Crisis Telephone Service 2. Crisis Mobile Outreach 3. Crisis Therapeutic Foster Home 4. Community-Based Crisis Group Home	1. Ancillary Services 2. Respite Support 3. Psychosexual Assessments 4. Intensive Case Management 5. Intensive In-Home Intervention 6. Respite Therapeutic Foster Home 7. Respite Homes 8. Community Mental Health Shelter 9. Therapeutic Foster Home 10. Therapeutic Group Homes 11. Independent Living Programs 16-18 12. Independent Living Programs 18-21 13. Community-Based Residential Level III 14. Community-Based Residential Level II 15. Community-Based Residential Level I 16. Hospital-Based Residential 17. Multisystemic Therapy 18. Multidimensional Treatment Foster Care	1. Comprehensive Mental Health Assessment 2. Focused Mental Health Assessments 3. Summary Annual Assessments 4. Psychiatric Evaluation 5. Medication Management 6. Individual Therapy 7. Group Therapy 8. Family Therapy 9. Partial Hospitalization 10. Functional Family Therapy 11. Peer Support 12. Parent Skills Training 13. Intensive Outpatient Treatment for Co-Occurring Substance Abuse 14. Intensive Outpatient Services for Independent Living Skills 15. Community-Based Clinical Detoxification 16. Community Hospital Crisis Stabilization 17. Acute Psychiatric Hospitalization 18. Treatment Service Planning/Participation* 19. Individualized Education Program Planning/Participation* 20. School Consultation* 21. Case Consultation* 22. Family Court Testimony*

Total Service Levels: 44

***Provided by CAMHD staff**

TABLE 2.	SPECIFIC GEOGRAPHIC REGIONS

Island of Oahu
Hawaii County
East Hawaii
West Hawaii
Kauai County
Maui County
Lahaina, Molokai and Lanai
Central Oahu District
Honolulu District
Leeward Oahu District
Windward District
Central Maui
Statewide
Molokai
Lanai
Hana

Total Geographic Areas: 16

TABLE 3.	Abbreviation List
Abbreviation	**Contractor Name**
ALA	Alakai Na Keiki, Incl
ALO	Aloha House, Inc.
BBHS	Benchmark Behavioral Health System, Inc.
BBC	Bobby Benson Center
CARE	CARE Hawaii, Inc.
CATH	Catholic Charities of the Diocese of Honolulu, dba Catholic Charities Hawaii
CFS	Child and Family Service
HO	Hale Opio, Inc.
HK	Hale Kipa, Inc.
HBH	Hawaii Behavioral Health, LLC.
KBH	Kid's Behavioral Health of Hawaii, Inc.
MAR	Marimed Foundation For Island Health Care Training
MYFS	Maui Youth and Family Services, Inc.
PACT	Parents and Children Together
KAHI	Sutter Health Pacific dba Kahi Mohala Hospital
TIFFE	The Institute for Family Enrichment, Inc.
QMC	The Queens Medical Center
HNP	Waianae Coast Community Mental Health Center, Inc., dba Hale Na`au Pono

TABLE 4. EMERGENCY PUBLIC MENTAL HEALTH SERVICES					
Level of Care\Geographic Region	**Island of Oahu**	**East Hawaii**	**West Hawaii**	**Maui County**	**Kauai County**
24-Hour Crisis Telephone Service	AMHD (Statewide)				
Crisis Mobile Outreach	CARE	CFS	CFS	CFS	**
Crisis Therapeutic Foster Home				CFS	HO
Community-Based Crisis Group Home		CFS	CFS		

**Service level is in negotiation or re-procure

TABLE 5. EDUCATIONALLY SUPPORTIVE INTENSIVE MENTAL HEALTH SERVICES

Geographic Region →	Island of Oahu					East Hawaii	West Hawaii	Maui County			Kauai County
Level of Care	**Island of Oahu**	**Central Oahu District**	**Honolulu District**	**Leeward District**	**Windward District**	**East Hawaii**	**West Hawaii**	**Maui County**	**Lahaina, Molokai, Lanai**	**Central Maui**	**Kauai County**
Psychosexual Assessments	BBHS (Statewide)										
Intensive In-Home Intervention		ALA, HK, HBH, TIFFE	ALA, HK, HBH, TIFFE	ALA, HK, HBH, TIFFE	ALA, HK, HBH, TIFFE	HK, HBH, TIFFE	HK, TIFFE		ALO	ALO, HBH, MYFS	HK, HBH
Multisystemic Therapy		PACT	PACT	CFS	PACT	CFS	TIFFE	PACT (Maui and Molokai)			PACT
Respite Therapeutic Foster Home								CFS			HO
Respite Homes	HK					CFS	CFS				
Community Mental Health Shelter	HK (Statewide)										
Therapeutic Foster Home	CATH, CFS, HK, HBH, HNP					CATH, CFS, HK, HBH, MAR	CATH, CFS, HK, MAR	CFS, HBH, MYFS			HO, HBH
Multidimensional Treatment for Foster Care	HK					HBH					
Therapeutic Group Homes	CATH, CFS, HK, MAR					CATH, MAR	CFS	MYFS			HO
Independent Living Programs 16-18	HK, MYFS, HNP (Statewide)										
Independent Living Programs 18-21	HK, HNP(Statewide)										
Community-Based Residential Level III	BBC, CFS, KBH, MAR, MYFS, HK (Statewide)										
Community-Based Residential Level II	CATH (Statewide)**										
Community-Based Residential Level I	BBHS (Statewide)										
Hospital-Based Residential	KAHI, QMC (Statewide)										

**Service level is in negotiation or re-procure

TABLE 6. SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT PROGRAM SERVICES

Geographic Region →	Island of Oahu					East Hawaii	West Hawaii	Maui County					Kauai County
Level of Care	Island of Oahu	Central Oahu District	Leeward District	Honolulu District	Windward District	East Hawaii	West Hawaii	Maui County	Hana	Central Maui	Molokai	Lanai	Kauai County
Assessment and Outpatient Svc	ALA, HBH, TIFFE					HBH, TIFFE	TIFFE	HBH					
Partial Hospitalization	KAHI (Statewide)												
Peer Support	MAR					MAR	MAR		MYFS	MYFS	MYFS	MYFS	MYFS
Parenting Skills Training	HK, HBH, TIFFE					HK, HBH, MAR, TIFFE	HK, MAR, TIFFE		MYFS	HBH, MYFS	MYFS	MYFS	HK, HBH, MYFS
Functional Family Therapy	PACT					TIFFE	CATH			HBH			PACT
Intensive Outpatient Svc for Independent Living Skills		TIFFE		HBH		TIFFE	TIFFE			HBH			HBH
Intensive Outpatient Treatment for Co-occurring Substance Abuse		**		MAR, BBC		MAR	MAR			MYFS			MYFS
Community-Based Clinical Detox	**												
Acute Psychiatric Hospitalization	Statewide providers: KAHI and QMC												
Community Hosp. Crisis Stab. Svc.	**												

**Service level is in negotiation or re-procure

CAMHD's Service Array and Definitions Fiscal Year 2007

Source: RFP HTH 460-06-01

System of Care
The Child Adolescent Mental Health Division (CAMHD) system of care consists of an integrated network of placements, services and supports. It is managed through a public-private partnership consisting of contracted community-based agencies and state managed, community-based Family Guidance Centers with administrative and performance oversight functions at the state office. Since 1995 the system of care has developed a comprehensive array of evidence-based services and supports for children and youth with the most challenging emotional and behavioral needs, and their families.

Specifically, CAMHD system of care focuses on resource management and capacity for timely, consistent, and responsive mental health services in the following categories:

Emergency Public Mental Health Services
These services are available to all children and youth in Hawaii, ages 3 to 18 years, experiencing an imminent life threatening mental health crisis.

Youth Eligible for Educationally Supportive (ES) Mental Health Services
Students with an educational disability that have been determined to be in need of intensive mental health services to benefit from public education. These youth are enrolled in the ES program. The criteria for enrolling a youth in the ES program are IDEA eligibility, an IEP with recommendation for services from CAMHD, and an IEP meeting with CAMHD participation to determine the goals of mental health services to be provided.

AND/OR

Youth Eligible for the Support for Emotional and Behavioral Dev. (SEBD) Program
Medicaid eligible youth or MedQUEST enrolled youth requiring mental health services that exceed the scope or intensity that is able to be provided by their selected QUEST Healthplan. These youth are enrolled in the SEBD Program. The criteria for enrolling a youth in the SEBD program are QUEST or Medicaid eligibility, a DSM IV diagnosis of at least 6 months, and a CAFAS/PECFAS score of 80 or greater. SEBD eligibility is determined by the CAMHD Medical Director.

OR

Youth Eligible for Mental Health Only Category
Youth, ages 3 to 18 years, with emotional and/or behavioral challenges that are not eligible through either of the above two classifications (ES or SEBD), but who are determined to be in need of mental health services by the CAMHD Medical Director. These youth may present within the juvenile justice system or school system. This population includes youth who's school has found them eligible for Section 504 of the Rehabilitation Act, uninsured youth, youth who may have lost Medicaid eligibility due to incarceration and furlough, and youth with private insurance but uncovered service needs. CAMHD is able to serve these youth within the general funds legislatively appropriated.

Category	Svc. Code	Title	Service Definition/Provision
Emergency Public Mental Health Services			
	1101	**24 Hour Crisis Telephone Stabilization**	24-Hour Crisis Telephone Stabilization serves all youth whose immediate health and safety may be in jeopardy due to a mental health issue. After receiving support, consultation and referral that dissipate the crisis situation, the youth's natural environment has the capacity to allow the youth to remain safely in the community. The absence of this capacity would indicate need for mobile outreach services to assess situation and arrange appropriate course of actions.
	2101	**Crisis Mobile Outreach**	This service provides mobile face-to-face outreach assessment and stabilization services for youth in an active state of psychiatric crisis. Services are provided twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the youth's home, local emergency facilities, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, and immediate crisis resolution/stabilization and de-escalation if necessary.
	4101	**Community-Based Crisis Group Home**	This service offers short-term, acute residential interventions to youth experiencing mental health crises. This is a structured residential alternative to, or diversion from, Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization. Crisis stabilization services are for youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in a less restrictive setting. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health stabilization needs of the youth.
	4102	**Crisis Therapeutic Foster Home**	This service offers short-term, acute interventions to youth experiencing mental health crises in a Therapeutic Foster Home. This is a structured alternative to, or diversion from, Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization. Crisis stabilization services are for youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in a less restrictive setting. The home provides psychiatric services that address the psychiatric, psychological, and behavioral health stabilization needs of the youth.
Sub-Total: 4			
Educationally Supportive (ES) Intensive Mental Health Services			
	13101	**Intensive In-Home Intervention**	This service is designed to stabilize and preserve the family's capacity to improve the child's functioning in the current living environment and to prevent the need for placement outside the home. This service is a time-limited approach that incorporates evidence-based interventions. The service utilizes family and youth-centered interventions and adheres to the CASSP principles. This service may be delivered primarily to youth and their families in the family's home or community.

Category	Svc. Code	Title	Service Definition/Provision
Educationally Supportive (ES) Intensive Mental Health Services			
	13201	**Multisystemic Therapy (MST) services**	The MST approach uses an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders, youth at-risk of out-of-home placement due to behavioral problems, and youth at-risk of school failure because of behavioral problems. Thus, the primary goals of MST are to (a) reduce youth criminal activity, (b) reduce other types of antisocial behavior such as drug abuse, and (c) achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placements. MST aims to achieve these goals through a treatment that addresses risk factors in an individualized, comprehensive, and integrated fashion; and that empowers families to enhance protective factors.
	28401	**Therapeutic Foster Home**	This service is an intensive community-based treatment service provided in a home setting for youth with emotional challenges. Specialized therapeutic foster care incorporates evidence-based psychosocial treatment services. These homes provide a normative, community-based environment through therapeutic parental supervision, guidance, and support for youth capable of demonstrating growth in such a setting. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youth in transition from a more restrictive placement as these homes offer a family-like orientation. Foster homes with therapeutic services are appropriate for youth in need of relatively long-term treatment placements of six (6) to nine (9) months and/or shorter-term crisis stabilization.
	28601	**Multi-dimensional Treatment Foster Care**	Multidimensional Treatment Foster Care implementers recruit, train, and supervise foster families to offer youth treatment and intensive supervision at home, in school, and in the community. The program provides parent training and other services to the biological families of treated youth, helping to improve family relationships and reduce delinquency when youth return to their homes. Youth who participate in this program also receive behavior management and skill-focused therapy and a community liaison who coordinates contacts among case managers and others involved with the youth.
	28940	**Respite Homes**	Mental health respite homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This service provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care. (This home may be the same home used for the crisis group home.)
	28940	**Respite Homes**	Mental health respite homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This service provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care. (This home may be the same home used for the crisis group home.)
	28940	**Respite Therapeutic Foster Home**	Mental health respite foster homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These foster homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This service provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care. (This home may be same home used for the crisis therapeutic foster home.)

Category	Svc. Code	Title	Service Definition/Provision
Educationally Supportive (ES) Intensive Mental Health Services			
	28940	**Respite Therapeutic Foster Home**	Mental health respite foster homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These foster homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This service provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care. (This home may be same home used for the crisis therapeutic foster home.)
	29401	**Therapeutic Group Homes**	These homes provide twenty-four (24) hour care and integrated evidence-based treatment to address behavioral, emotional, or systemic issues, which prevent youth from taking part in family or community life. Therapeutic Group Homes are designed for those whose needs can best be met in a structured, small group, community-based setting. The youth usually remain involved in community-based educational, recreational, and occupational activities. These homes typically provide services for four (4) to eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessional staff that have been recruited and trained to work with youth with emotional and behavioral challenges.
	29602	**Independent Living Programs 18 – 21**	The programs provide twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues that prevent young adults from living independently in the community. Independent Living Programs are designed to assist residents in developing the skills necessary to live independently in the community upon discharge. The Independent Living Program is responsible for linking young adults to educational, vocational, employment, health services and community resources. At admission, residents are not necessarily involved in community-based educational, recreational, and/or occupational activities during the day. Independent Living Programs typically provide services for four (4) to eight (8) young adults per home. In this level of care, young adults are supervised and provided services by professionals and paraprofessionals that have been recruited and trained to work with transitioning adults.
	29603	**Independent Living Programs 16–18**	These programs provide twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues that prevent youth from living independently in the community. Independent Living Programs are designed to assist transitioning youth in need of emotional and behavioral supports to develop the skills necessary to live independently in the community upon discharge. The Independent Living Program links youth to educational, vocational, employment, health services and community resources. At admission, the youth are may be involved in community-based educational, recreational, and/or occupational activities. Independent Living Programs typically provide services for four (4) to eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessionals that have been recruited and trained to work with transitioning youth.
	29801	**Community Mental Health Shelter**	This service provides twenty-four (24) hour temporary short-term care for youth who are awaiting placement in an appropriate treatment facility. The youth usually remain involved in community-based educational, recreational, and occupational activities. These shelter homes typically provide services for eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessional staff that have been recruited and trained to work with youth with emotional and behavioral challenges.

Category	Svc. Code	Title	Service Definition/Provision
Educationally Supportive (ES) Intensive Mental Health Services			
	30201	**Community-Based Residential Level III**	This service provides twenty-four (24) hour care and integrated service planning that addresses the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose needs can best be met in a structured program of small group living that includes onsite educational programs and highly structured therapeutic activities. Community-based Residential programs may be specialized (e.g., substance abuse). Community-Based Residential programs provide therapy, support, and assistance to the youth and the family to enhance participation in group living and community activities, increase positive personal and interpersonal skills and behaviors and to meet the youth's developmental needs.
	30301	**Community-Based Residential – Level II**	This service provides twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression or deviance that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services. Community-Based Residential programs Level II provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.
	30403	**Community-Based Residential – Level I**	This service provides twenty-four (24) hour locked care and integrated evidence-based services that address the behavioral and emotional problems related to sexually aggressive or deviant offending, that prevent the youth from taking part in family and/or community life. This program provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth display responsible and accountable behavior for sexually abusive or antisocial behavior with minimizing risk of re-offending and externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems.

Category	Svc. Code	Title	Service Definition/Provision

Educationally Supportive (ES) Intensive Mental Health Services

	31101	**Hospital-Based Residential**	This service provides intensive in-patient treatment services to youth with severe emotional challenges who require short-term up to sixty (60) days hospitalization for the purposes of receiving intensive diagnostic, assessment and medication stabilization services. The highly structured program provides educational services, family therapy, and integrated service planning through a multi-disciplinary assessment of the youth, skilled milieu of services by trained staff who are supervised by a licensed professional on a twenty-four (24) hour per day basis. Services are provided in a locked unit of a licensed inpatient facility.

Sub-Total: 16

Support for Emotional and Behavioral Development (SEBD) Program Services

	5101	**Comprehensive Mental Health Assessment**	This assessment is performed (a) as part of the data collected to determine eligibility for youth/young adults referred for CAMHD services through the SEBD program, and/or (b) to provide needed comprehensive clinical information on youth/young adults in the SEBD program, to assist with coordination of services and with treatment planning. This strengths-based approach seeks to identify the needs of the youth or young adult in the context of their family and community. This service includes interviews, assessment activities, written report, and feedback to the young adult or youth and the parent(s) or guardian(s).
	5102	**Focused Mental Health Assessments**	This assessment is performed any time the treatment team determines that an in-depth evaluation of the youth/young adult is necessary for satisfactory clinical care. This assessment is done to clarify diagnostic and treatment issues when new clinical symptoms have emerged or when there is a lack of expected progress. The assessment builds upon previous evaluations, incorporates additional relevant data (e.g., from interviews and the review of new information) and answers one or more specific referral questions. This service includes assessment activities, written report, and feedback to the young adult or the youth and his/her parent(s) or guardian(s).
	5103	**Summary Annual Assessments**	This assessment is performed in order to describe the current status of the young adult or youth and his or her circumstances. It is performed yearly, when the CSP team determines that there are no clinical concerns that would call for a focused or comprehensive assessment to be performed instead. The service includes a brief assessment and report, with feedback to the young adult or youth and his/her parent(s) or guardian(s). The CAMHD contracted providers that are currently providing services and that have known the young adult or youth for at least three (3) months shall provide the Summary Annual Assessment when it is due or as defined in the specific service standard.
	7101	**Individual Therapy**	Individual Therapy is regularly scheduled face-to-face therapeutic services with a youth or young adult focused on improving his/her individual functioning. Individual therapy includes interventions such as cognitive-behavioral strategies, behavioral plans, skills training, systemic interventions, crisis planning and facilitating access to other community services and supports. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited, with interventions reduced and discontinued as the young adult or youth and family are able to function more effectively. The usual course of treatment is six (6) to twenty-four (24) sessions or six (6) months. This service most often will be provided in conjunction with at least occasional family therapy sessions.

Category	Svc. Code	Title	Service Definition/Provision
Support for Emotional and Behavioral Development (SEBD) Program Services			
	7102	**Group Therapy**	This service is regularly scheduled face-to-face therapeutic services for groups of three or more young adults or youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges and to provide support for the use of these skills. Group Therapy services are focused and time-limited. This service can include groups that address young adult or youths' needs utilizing a "multi-family group" format, in which the parents or guardian attend the group along with the young adult or youth.
	7103	**Family Therapy**	Family Therapy is regularly scheduled face-to-face interventions with a young adult or youth and his/her family, designed to improve young adult or youth/family functioning and treat the young adult or youth's emotional challenge. The family therapist helps the young adult or youth and family increase their use of effective coping strategies, healthy communication, and constructive problem-solving skills. The therapist also provides psycho-education about the nature of the young adult or youth's diagnosis. Frequently, Family Therapy sessions are held in the course of on-going Individual Therapy in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued, as young adult or youth/family are able to function more effectively.
	7104	**Functional Family Therapy**	This is an evidence-based family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression). The goals of Functional Family Therapy are the following. 1. Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems 2. Phase II: Behavior change – target and change specific risk behaviors of individuals and families 3. Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships Functional Family Therapy services range from eight to twelve (8 to 12) one-hour sessions for mild challenges, up to thirty (30) hours of direct service (i.e., clinical sessions, telephone calls, and meetings involving community resources) for more difficult situations, and are usually spread over a three to six (3 to 6) month period. Functional Family Therapy can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits.
	7201	**Peer Support**	This service is provided by peer counselors to youth, young adults and their families under the consultation, facilitation or supervision of a QMHP who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Youth, young adults and their families actively participate in decision-making and the operation of the programmatic supports.

Category	Svc. Code	Title	Service Definition/Provision
Support for Emotional and Behavioral Development (SEBD) Program Services			
	7301	**Parent Skills Training**	This service is the teaching of evidence based behavior management interventions to parents or caregivers in order to develop effective parenting styles. These interventions are designed to promote more competencies in the parent/caregiver's ability to manage the youth's behavior. The focus of training is on the parent and adjusting their responses to the youth. Parent Skills Training can occur in the home or community and be comprised of groups or individuals with or without the youth present. Parent Skills Training may be offered to the primary caregiver even if the youth is being served in an out-of-home service. In this case, the training is offered in anticipation of the youth's return.
	9101	**Psychiatric Evaluation**	Psychiatric diagnostic examination, specifically completed by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service is limited to an initial or follow-up evaluation for medically complex or diagnostically complex young adult or youth. This evaluation does not involve psychiatric treatment or medication management.
	10101	**Medication Management**	This service is the ongoing assessment of the young adult or youth's response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practical Registered Nurse with prescription privileges.
	11101	**Family Court Testimony**	Participation in a State of Hawaii Family Court hearing at the may include, but is not be limited to, sharing information about the young adult or youth's psychosocial history, diagnostic assessment and formulation, treatment planning/recommendations, and therapeutic progress. Participation can include oral testimony and/or the preparation of a written report. This participation is intended to ensure that the court has access to all relevant information needed for proper decision-making and is authorized by the MHCC and is provided by a CAMHD clinician.
	12101	**Treatment Service Planning/Participation**	Treatment/service planning participation is the development, review, and modification of a MHTP, CSP, Crisis Plan, Discharge/Transition Plan, and other interagency treatment/service plans when specifically requested by the MHCC and is provided by a CAMHD Clinician.
	12102	**Individualized Education Planning/Participation**	Attendance and active participation in multi-disciplinary educational planning meetings, including the development, review, and modification of an IEP, or other education related plan when specifically requested by the CAMHD MHCC and is provided by a CAMHD Clinician.
	13301	**Intensive Outpatient Treatment for Co-Occurring Substance Abuse**	Intensive outpatient substance abuse treatment services is defined as a package of services designed to assist youth and young adults who have co-occurring mental health and substance abuse issues. The service addresses both the youth's substance abuse treatment while stabilizing the mental health condition. This treatment allows youth to remain at home in their natural environment while being treated. These services are provided during the day and evening hours to enable the individual to maintain residence in the community, continue to work or go to school, and to be part of their family/community life.

Category	Svc. Code	Title	Service Definition/Provision
Support for Emotional and Behavioral Development (SEBD) Program Services			
	13302	**Intensive Outpatient Services For Independent Living Skills**	This is a comprehensive treatment service provided to older adolescents and young adults who need to work intensively on developing a range of skills to prepare for independent living. The youth or young adults remain at home while attending the program. This service focuses on developing skills and resources related to life in the community and to increasing the participant's ability to live as independently as possible, to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational, and vocational. The amount of time any individual spends in these services will vary, depending on the individual needs. Generally, participation will be more intensive at the beginning of the program and the time spent in the program will decrease as new skills are attained.
	14101	**School Consultation**	Consultation of a mental health professional with regular and special education teachers, school administrators and other school personnel regarding the behavioral management of a young adult or youth within the school setting. School consultation is authorized by the MHCC when requested by or agreed upon by the school, in collaboration with the young adult or youth's team. This service is provided by a CAMHD Clinician.
	14201	**Case Consultation**	Consultation by a mental health professional who has a particular area of expertise. The MHCC authorizes case consultation when requested by or agreed upon by the young adult or youth's clinical treatment team. This is provided by a CAMHD clinician.
	27101	**Partial Hospitalization**	This service is composed of day programming in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for coverage of partial hospitalization that allows for a more intensive milieu treatment with a focus on medical/psychiatric resources. This service is available to stabilize a youth whose psychiatric condition needs a high level of monitoring to stabilize symptoms or as a transition step for youth who have been in more restrictive settings. The primary goal of the partial hospitalization programs is to keep youth connected with his/her family/community while providing short-term intensive treatment.
	30501	**Community-Based Clinical Detoxification**	This service is a short-term, detoxification service delivered with medical and nursing support. This twenty-four (24) hour clinically managed detoxification is supervised by trained staff members who observe and support the youth undergoing withdrawal in a locked residential facility. The program is designed to provide clinically managed detoxification services while keeping the co-occurring mental health disorder stabilized. Detoxification is designed to alleviate the short-term symptoms of withdrawal while the body's physiology is adjusting to the absences of drug and alcohol. It must also include a period of psychological readjustment designed to prepare the youth to take the next step in ongoing treatment. Detoxification process is expected to take no more than one (1) month.
	32101	**Acute Psychiatric Hospitalization**	This service offers short-term, emergency implementation of life-saving medical and psychiatric interventions. This is a closely supervised, highly structured milieu that operates twenty-four (24)-hours, seven (7) days a week offering a full range of diagnostic and therapeutic services utilizing a multi-disciplinary team and integrated services planning. Services are provided in a locked unit of a licensed hospital facility.

Category	Svc. Code	Title	Service Definition/Provision

Support for Emotional and Behavioral Development (SEBD) Program Services

	32201	**Community Hospital Crisis Stabilization**	This service offers short-term, crisis intervention to young adults or youth experiencing mental health crises. This is a closely supervised, structured alternative to, or diversion from, Acute Psychiatric Hospitalization. Crisis stabilization service is designed for young adults or youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with life circumstances. The service is provided in an accredited community hospital, with crisis family therapy and child psychiatric services via telemedicine arrangements if not available in the hospital.

Sub-Total: 22

Grand Total: 42

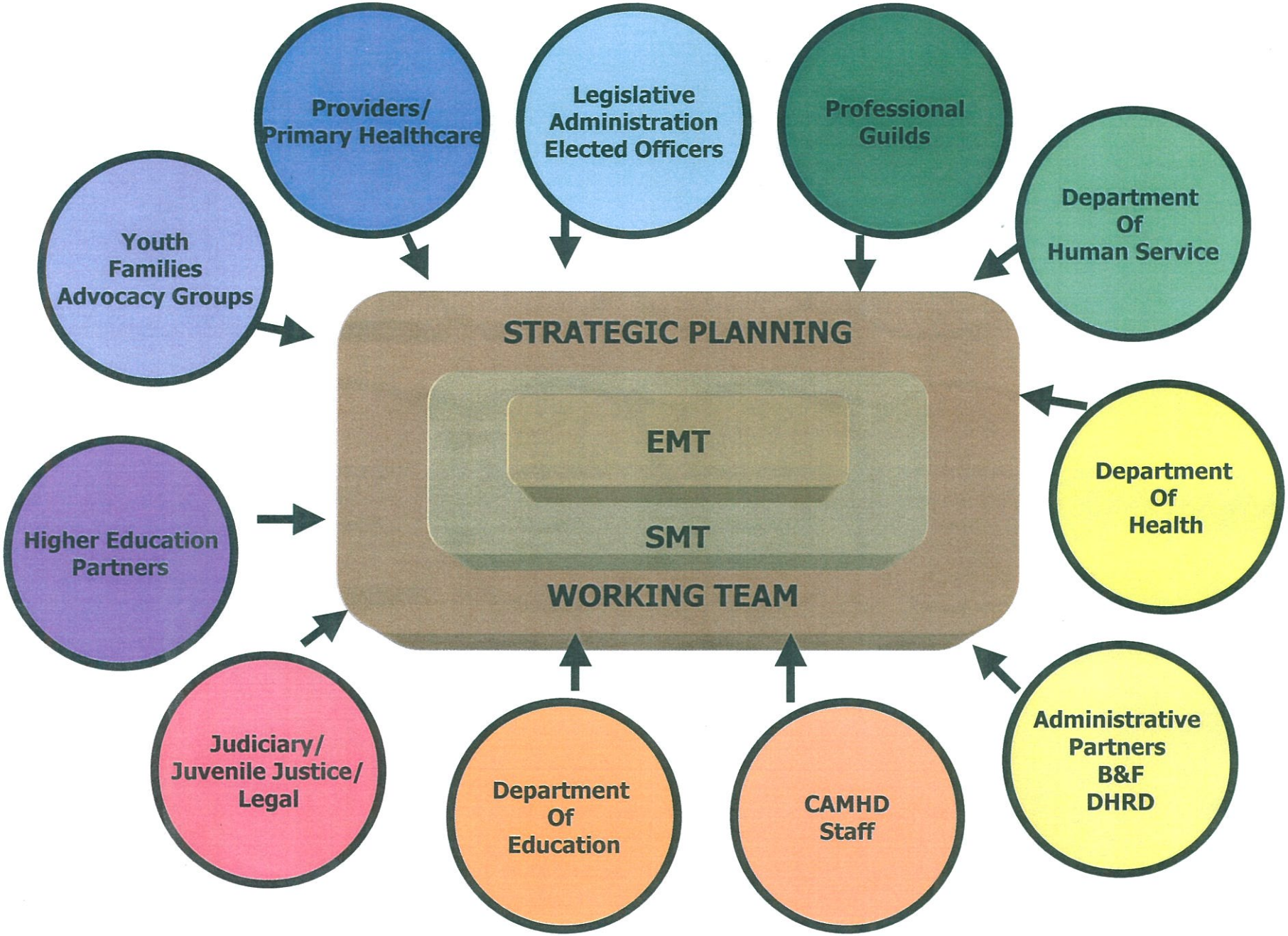
Other Services Under Educationally Supportive Intensive Mental Health Category

Ancillary Services

Ancillary services are services that are not available through existing contracted mental health services for youth. The funding for such services is limited and closely monitored to assure that disbursement is completed in the most clinically appropriate and fiscally responsible manner.

Respite Supports

Respite supports involve the provision of funds to families of eligible youth with serious emotional and/or behavioral challenges for the purpose of providing temporary short-term planned or emergency relief.


Providers/
Primary Healthcare
Legislative
Administration
Elected Officers
Professional
Guilds
Department
Of
Human Service
Youth
Families
Advocacy Groups
STRATEGIC PLANNING
EMT
SMT
WORKING TEAM
Department
Of
Health
Higher Education
Partners
Judiciary/
Juvenile Justice/
Legal
Department
Of
Education
CAMHD
Staff
Administrative
Partners
B&F
DHRD

APPENDIX F

Our Credo
CAMHD EMPOWERS

Excellence

We seek **excellence** through the on-going development of our own knowledge, skills, and abilities.

Multidisciplinary teams

We skillfully develop and implement plans through collaborative, **multidisciplinary teams.**

Privacy

We consciously honor and protect **privacy.**

Open listening

We demonstrate **open listening** to other viewpoints and if we disagree, we **politely advocate** for our opinion.

Work with whomever

We **work with whomever** is necessary to complete agreed upon tasks.

Encourage

We **encourage,** acknowledge positive contributions and celebrate progress.

Request clarification

We **request clarification** whenever necessary.

Self-manage

We **self-manage** our time and resources to accomplish the outcomes that we say we will accomplish in the time frame stated.

ACRONYMS AND GLOSSARY

ADAD	Alcohol and Drug Abuse Division, within DOH
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AMHD	Adult Mental Health Division, within DOH
BASC	Behavior Assessment System for Children
BBA	Balanced Budget Act of 1997
CAFAS	Child and Adolescent Functional Assessment Scale is a rating scale that assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use programs. It is rated on youth aged 6-17 years and is used to track clinical outcomes, to assign youth to appropriate levels of care and as part of the criteria used to determine a youth's eligibility for CAMHD's SEBD program.
CALOCUS	Child and Adolescent Level of Care Utilization System
CAMHD	Child and Adolescent Mental Health Division, within DOH
CAMHMIS	Child and Adolescent Mental Health Management Information System
CARF	Commission on Accreditation of Rehabilitative Facilities
Care Coordination	Activities involved in serving as central point of contact for a family. Functions include coordinating the mental health services, linking with all involved child serving agencies, monitoring provider delivery of service, assisting child/youth and family with accessing and receiving necessary services. Includes home visits, school visits, provider meetings, and routine evaluation of results of service delivery. Often referred to as intensive clinical case management in other agencies.
Case Management	Coordinating the provision of mental health services for children and their families who require services from more than one public or private provider.
Case Review	Case review is a clinical review of individual youth status and treatment progress, which includes assessing sentinel events, progress toward goal attainment and the effectiveness of current treatment strategies. The purpose of the case review is to ensure that treatment plans are monitored and adjusted based upon the results gained from data that has been gathered and used to measure change from a baseline reference point for each treatment goal.
CASII	Child and Adolescent Service Intensity Instrument (formerly called CALOCUS) is a tool to determine the appropriate level of care placement for a child or adolescent. The CASII links a clinical assessment with standardized "levels of care" and has a method for matching the two.
CASSP	Child and Adolescent Service System Program (CASSP) Principles
CCC	Community Children's Council. The organizational foundation for community participation in the system of care. Seventeen CCCs have been established across the state. CCCs are co-chaired by parents and provider agencies within each community.
CCCO	Community Children's Council Office
Child/Children	An individual(s) age birth through 12 years.
Child Serving Agencies	Most commonly used to identify the public agencies responsible for various aspects of supporting and serving children and families. Typically implies the Department of Education, Department of Human Services for Child Welfare Services, Child & Adolescent Mental Health Division, Office of Youth Services and the Judiciary.
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (federal), within SAMHSA
CMS	Centers for Medicare & Medicaid Services (federal)
CPS	Child Protective Services, a function within the DHS Child Welfare Services Branch
CRM	Clinical Report Module. Also known as “dashboards”, the CRM provides customizable screens to track changing treatment issues.

CSP	Coordinated Service Plan. A written design for service that describes the roles and responsibilities of multiple agencies or programs that provide therapeutic or supportive interventions or activities essential to the youth and family's treatment.
Coordinated Service Plan (CSP) Process	A process of bringing together the family, multiple agencies and providers, and the child/youth, when appropriate, to develop a comprehensive and integrated plan of individualized care for the child/youth that is based on the child's/youth's strengths and needs.
CWS	Child Welfare Services Branch, within DHS
DD/MR	Developmentally Disabled/Mentally Retarded
DDD	Developmental Disabilities Division, within DOH
DH	Detention Home
DHS	Hawaii State Department of Human Services
DSM-IV	A publication titled the **Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition** that is used to guide diagnostic formulations of individuals with emotional disorders.
DOE	Hawaii State Department of Education
DOH	Hawaii State Department of Health
EBS	see Evidence-based services below
EIS	Early Intervention Section, within DOH
Emotional Disturbance	An emotional or behavioral condition, categorized by a DSM IV diagnosis, which impacts the functioning of many children/youth.
EMT	CAMHD's Executive Management Team
EPSDT	Early, Periodic, Screening, Diagnosis, and Treatment Program. A federally mandated program for children up to age 21 which emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.
EQRO	External Quality Review Organization. A private accreditation organization. Federal law and regulations require State to use an EQRO to review the care provided by capitated managed care entities.
Evidence-Based Services (EBS)	Those strategies and interventions for which credible, published research exists demonstrating positive effects, including uncontrolled, open trials or case studies.
Evidence Based Services (EBS) Committee	An interdisciplinary committee responsible for routinely reviewing and reporting on the scientific literature to identify evidence based services and best practices. Members represent multiple stakeholder groups including CAMHD, DHS, DOE, Family Court, Families, Providers, and the University of Hawaii
FCLB	CAMHD's Family Court Liaison Branch
Fee-For-Service	The plan is paid for providing services to enrollees solely through fee-for-service payments, plus in most cases, a case management fee.
FY	Fiscal Year. State of Hawaii FY: July 1 - June 30
Grievance	Any oral or written communication, made by or on the behalf of a consumer, provider, and others that expresses dissatisfaction with any aspect of the CAMHD operations, activities, behavior, or providers and its sub-contractor(s).
HFAA	Hawaii Families As Allies
HHS	Department of Health and Human Services (federal)
HIPAA	Health Insurance Portability and Accountability Act of 1996. This act requires the confidentiality and privacy of protected health information and requires the development of a health information system, including the standards and requirements for the secured electronic transmission of certain health information and for policies and procedures in compliance with HIPAA's Privacy Rule.

HRS	Hawaii Revised Statutes
HYCF	Hawaii Youth Correctional Facility
IDEA	Individuals with Disabilities Education Act. A federal law that requires that all children with disabilities have access to a free appropriate public education, and emphasizes special education and related services designed to meet the unique needs of the child and prepare the child for employment and independent living.
IEP	IEP (DOE). A written statement for each child with a disability that includes a description of the student's present levels of educational performance, annual goals including short-term objectives, special education and related services, dates for beginning and duration of services, and measures for how progress on implementation of the services will be evaluated.
IPSPG	Interagency Performance Standards and Practice Guidelines; "Purple Book"
MCO	Managed Care Organization - a health maintenance organization
Mental Health Treatment	A broad range of emergency, out-patient, intermediate, and in-patient services and care, including diagnostic evaluation, medical psychiatric, psychological, and social services care, vocational rehabilitation, career counseling, and other special services that may be extended to individuals with mental health disorders.
MHCC	Mental Health Care Coordinator. CAMHD staff at each Family Guidance Center who is responsible for the coordination of home visits, school visits, community contacts, convening the initial CSP meeting, referral for services, family engagement, maintaining contact with the youth, ensuring timely delivery of services and continuous monitoring of youth progress. See also Care Coordination and Case Management.
MHTP	Mental Health Treatment Plan. A comprehensive plan, developed by CAMHD's contracted providers to address the mental health needs of a youth and his/her family that includes specific goals, measure objectives, target dates to reach objectives, appropriate interventions to achieve these objectives, a crisis plan identifying specific actions to take in case of a mental health emergency, and a discharge plan to prepare for a smooth transition to eventual termination of services.
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MQD	MED-QUEST Division of DHS
MR	Mental Retardation
NAMI	National Alliance for the Mentally Ill
NCLB	No Child Left Behind Act of 2001. A federal law that requires that DOE must ensure that all students meet or exceed a "proficient" level of academic achievement on required State assessments and other academic measures. Requires that subgroups of students, including economically disadvantaged, those from racial and ethnic groups, those with disabilities, and those with limited English proficiency also make adequate yearly progress on all required assessments.
NCQA	National Committee for Quality Assurance
NIH	National Institutes of Health (federal)
NIMH	National Institute of Mental Health (federal), within NIH
OYS	Office of Youth Services, within DHS
PCP	Primary Care Physician
PECFAS	Preschool and Early Childhood Functional Assessment Scale. A rating scale that assesses a child's degree of impairment in day-to-day functioning due to emotional, psychological or psychiatric problems. It is rated on children aged 3-6 years and is used to track clinical outcomes, to assign children to appropriate levels of care and as part of the criteria used to determine a child's eligibility for CAMHD's SEBD program.

Performance Improvement Projects	Projects that examine and seek to achieve improvements in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State.
Performance Measures	Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.
POS	Purchase of Service (contracts)
QA	Quality Assurance
QAIP	Quality Assurance and Improvement Program. A methodical and objective approach to monitoring and evaluating the appropriateness and quality of individual care in order to improve an organization's performance. A written and comprehensive plan that establishes and coordinates review mechanisms.
QUEST	A Hawaii state government program that provides medical assistance coverage through managed care plans for income-eligible Hawaii residents.
Restraint	The restriction of freedom of movement through personal, drug or mechanical means in order to protect the individual from injury to self or others.
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration (federal), within HHS
SBBH	School-Based Behavioral Health. DOE behavioral and mental health services provided to students in their respective school environments.
SEBD	Serious Emotional Disturbance or Serious Emotional/Behavioral Disturbance (SED/ SEBD) – An emotional or behavioral condition which greatly impacts the functioning of many children/youth. Typically the individual meets the following criteria: · From birth to 18 years AND · Who currently, or at any time during the past year have, or had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria of the Diagnostic & Statistical Manual for Manual Disorders, Vol. IV. (DSM IV) AND · This diagnosis resulted in functional impairment that substantially interferes (d) with, or limits, the child's role or functioning in family, school, or community activities. AND · These disorders exclude V codes, substance use, and developmental disorders, unless they co-occur with another diagnosable serious emotional disturbance.
SED	Severe Emotional Disability
Seclusion	The involuntary confinement of a youth in a locked and/or secured room to ensure the safety of the youth or others. Any such isolation in a secure environment from which the youth is not potentially free to leave is considered seclusion.

Sentinel Event	An occurrence involving serious physical or psychological harm to anyone or the risk thereof. A sentinel event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected t o result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring attention by a medical professional or transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill or hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.
SMI	Serious Mental Illness
SPMI	Serious and Persistent Mental Illness
Stakeholders	Individuals, entities and agencies that have a vested interest in the children's mental health system, including families, community associations, advocacy groups, child serving agencies, and the legislature.
System	The resulting whole, whose elements stay together because they continually affect each other over time and operate toward a common purpose.
System of Care	A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.
Title IV-E	Part E of Title IV of the Social Security Act provides federal funding to support certain foster care placements with maintenance payments.
Title XIX	Title XIX of the Social Security Act. The federal legislation which established Medicaid, a joint federal and state program that provides Medical Assistance to low-income consumers of all ages who need care but cannot afford it.
Young Adult	An individual, age 18 to 21 years.
Youth	Most broadly may be used to refer to individuals ages 3 – 20 years, but most commonly use refers to individuals, age 13 through 18 years.

This strategic plan is developed in accordance with
Hawaii Revised Statutes 321-175, which obligates the
Department of Health,
Child & Adolescent Mental Health Division
to develop and implement a
4-year Strategic Plan.

For information about
accessing CAMHD services,
you may call 733-9339 or 1-800-294-5282
or you may go to the CAMHD website
for information about the Family Guidance Center
in your community
www.state.hi.us/health/mental-health/camhd

Child & Adolescent Mental Health Division
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