



## *Performance Report*

*Performance Period April 2009-June 2009*

### About This Report

This report presents the most current available information about the performance of the Child and Adolescent Mental Health Division (CAMHD) during the fourth quarter of fiscal year 2009 (April 2009-June 2009). Where possible, data are aggregated at both statewide and district or complex levels. The goal is to provide CAMHD stakeholders with information about how well the CAMHD program is doing in providing timely and effective services for youth and their families.

Reporting includes data on how well CAMHD is delivering case management and therapeutic services, as well as child outcomes. CAMHD managers and State leadership use this information to guide decisions and make improvements to the children's mental health program.

Data in this report are presented for four major areas:

- **Population**: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- **Service**: Service information is compiled regarding the type and amount of direct care services provided.
- **Cost**: Cost information is gathered about the financial aspects of services.
- **Performance Measures**: Performance Measures, including outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families. CAMHD's accountability system uses Performance Measures to track the quality and performance of its program. Performance trends are monitored to determine how well services are provided, and how well the service delivery infrastructure is functioning. Measures are used throughout the CAMHD system to align organizational goals with achieving results. They coordinate the work of the organization in order to achieve timely, cost-effective services that are designed to improve the lives of children, youth and families served.

Further studies and special reports on the CAMHD population and services, including past editions of this report, can be accessed at the CAMHD website at <http://www.hawaii.gov/health/mental-health/camhd/resources/index.html>.

## Executive Summary

- ⇒ **Overall Performance of Measures.** Overall performance of the system, as measured by CAMHD Performance Measures, declined over the previous quarter with 65% of CAMHD's measures met, as compared to last quarter when 72% of measures were met.
- ⇒ **Care Coordination.** The Performance Measure for filled Care Coordinator positions was not met at the targeted level. In the quarter, 89% of positions were filled statewide. Caseloads within the expected range were not met for Leeward, Maui, Honolulu, and Kauai FGCs. Due to budgetary constraints and the current economic situation, both the vacant position and caseload data have been impacted.
- ⇒ **Population Growth.** The population of youth registered with CAMHD decreased by one (1) from the previous quarter. As compared to the same quarter last fiscal year, (FY2008.4), the population has decreased by 2% this quarter. A comparison of average year-to-year data finds that the average registered population for fiscal year 2009 increased by 2% from fiscal year 2008. This is a decrease from the average year-to-year growth increase of 6% from fiscal year 2007 to 2008. Although there has been a steady increase in population from year-to-year since fiscal year 2005, the growth rate seen in the past several years appears to have slowed.

Increases in the registered population were experienced by five of the eight Branches during the reporting period. Maui, Hawaii, and Kauai FGCs had fewer youth registered in the current quarter than last quarter.

- ⇒ **Utilization of Services.** This quarter, an average of five youth received treatment outside of Hawaii, up from last quarter's average of four. Service utilization of Hospital-Based Residential and Community-Based Residential services decreased slightly this quarter over the previous quarter. A focused initiative to closely track the utilization of Hospital-Based Residential services may have contributed to the decline in utilization. The percentage of families in the CAMHD population receiving Intensive In-Home services remained the same, but utilization of Multisystemic Therapy slightly increased over the previous quarter. Utilization of Therapeutic Foster Homes was slightly higher than the previous quarter, which is the same as the previous quarter's lower utilization of this level of care.
- ⇒ **Service Cost.** Service costs in this report are for the third quarter of FY 2009 to allow for the adjudication of all billing. Costs for out-of home treatment decreased in the quarter, and accounted for 74.9% of all service expenditures. The highest cost per youth per quarter is the hospital-based residential level of care (\$34,055). Among the lowest cost were intensive in-home services, which cost \$2,529 per youth over the quarter.
- ⇒ **Quality of Contracted Services.** At least annually, provider agencies are reviewed across multiple dimensions of quality and effective practices. In the reporting quarter, three of the four provider programs reviewed were determined to be performing at an acceptable level, which did not meet the performance goal for this measure. The CAMHD Performance Management Office is closely monitoring the improvement activities developed by the provider to assure quality services will be provided to the youth and families.

## Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers (FGC) or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

## Quality Improvement Highlights during the Reporting Quarter

Highlights of key quality improvement activities conducted during the quarter include:

⇒ ***Dissemination of Evidence-Based Practices.*** CAMHD's Practice Development Section (PD) is continuing to provide training to providers, Family Guidance Center (FGC) staff and agency partners on Evidence-Based Practice Elements through the "What Works Shop" series of trainings through the end of August. The specific workshops provided this past quarter were "Motivation/Engagement I (2 sessions – Maui, Kauai), Disrupting Disruptive Behaviors I," (1 session – Kauai), and "Inside Internalizing Behaviors I" (1 session - Hilo). The PD Section continues to maintain a What Works Shop website that provides easy access to training materials and a forum to discuss implementation issues: [www.whatworksshop.blogspot.com](http://www.whatworksshop.blogspot.com). The PD Section staff members are working with CAMHD's Evidence-Based Services Committee (EBS) to develop a project aimed at broader dissemination of these training materials. This project would train provider agency and DOE clinicians to be trainers and to supervise others in implementing Evidence-Based Practice Elements.

During this fourth quarter of FY09, the PD Section has continued to support the provision of several packaged Evidence Based Practices. Functional Family Therapy (FFT) remains an established part of the array of services on Oahu, Kauai and Hawaii Island. Multidimensional Treatment Foster Care (MTFC) is offered on Hawaii Island. Multisystemic Therapy (MST) is available on Oahu, Maui, Hawaii Island and Kauai. Practice development staff members provide regular phone consultation and other support to all three programs. The current MST contracts were extended until August 30, 2009. The new MST contracts are set to begin on September 1, 2009.

The PD Section continues to offer training for Family Guidance Center and Provider staff on evidence based practices (primarily Motivational Interviewing) for Transition Age Youth throughout the State. A Hawaii Transition Age Youth Resource Map is in development and will become an integral part of this effort.

⇒ ***Providing Alternatives to Restraint and Seclusion.*** The PD Section is continuing to work with programs and meet with providers as needed to continue sustaining our past success at reducing the use of coercive behavior management approaches and improving the quality of residential care in Hawaii. As part of this

effort, targeted trainings will be provided to provider agencies by PD staff as needed.

In addition, the PD Section received a small grant from the Hawaii Mental Health Transformation Grant project in partnership with Queens Family Treatment Center to cosponsor an intensive training event in June on Life Space Crisis Intervention for residential providers statewide. LSCI is a group of techniques for turning crisis situations into learning opportunities for youth with self-defeating behaviors in residential milieus or school program settings. The five-day workshop took place from June 22-26 and provided provider agency staff who train direct care workers the tools to offer this training on an on-going basis in their programs. More information is available at: <http://hawaiiitc.blogspot.com/>

- ⇒ ***Efficient Use of System Resources.*** As part of CAMHD's effort to increase cost effectiveness and promote community based levels of care, the PD Section continues to meet together with Resource Management staff to review youth with long lengths of stay in highly restrictive care. These youth often become "stuck" in these levels of care and require additional assistance to be returned to their communities. The Clinical Services Office is meeting twice weekly as a team to identify cases proactively where we might be able to assist and respond quickly to emergent situations. This augments our practice of offering clinical support to FGCs at their request. Hospital census of CAMHD youth and average lengths of stay have been reduced significantly in the last quarter, at least partly as a result of these efforts.

## Population Characteristics

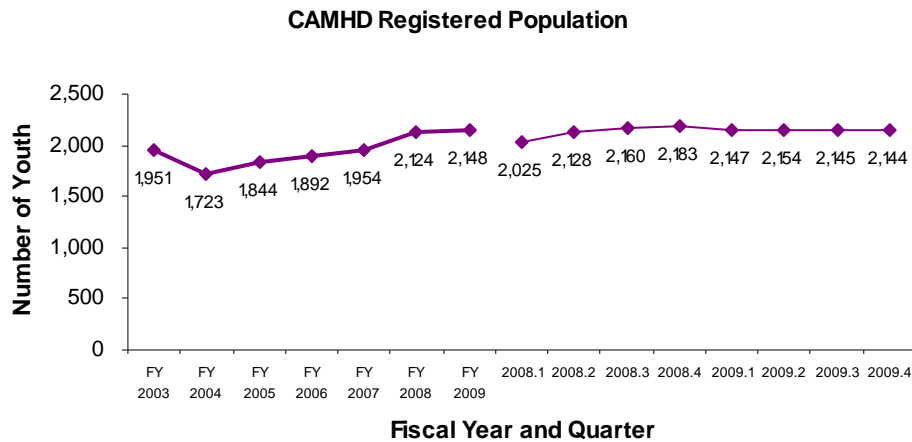
### Population Trends

Population data presented here are for youth registered at the CAMHD Branches (Family Guidance Centers and the Family Court Liaison Branch) during the fourth quarter of fiscal year 2009 (April 2009-June 2009). In the fourth quarter, CAMHD provided care coordination and services for 2,144 youth across the State. This is a decrease of 1 youth from the previous reporting quarter (January 2009-March 2009) and is based on data as of June 30, 2009. This represents a minor decrease in the total population over the previous quarter.

CAMHD experienced a 2% year-to-year decrease in its registered population compared to the same period last year (April 2008-June 2008). As compared to the same quarter last fiscal year, (FY2008.4), the population has decreased by 2% this quarter. A comparison of average year-to-year data, finds that the average registered population for fiscal year 2009 increased by 2% from fiscal year 2008. This is a decrease from the average year-to-year growth increase of 6% from fiscal year 2007 to 2008. Although there has been a steady increase in population from year-to-year since fiscal year 2005, the growth rate seen in the past several years appears to have slowed.

These data are reflective of the efforts by CAMHD to improve access to care. The data are especially important to track as CAMHD’s budget and contracted services need to accommodate the steady increase in the population.

The chart below reflects changes in the CAMHD population over time.



The numbers of youth registered during the fourth quarter at each of the branches are displayed in Table 1 below. Also displayed for each Branch are the numbers for the preceding quarter (Quarter 3, FY 2009), and the numbers for the same period one-year ago (Quarter 4, FY 2008).

As can be seen in Table 1, increases in the registered population were experienced by five of the eight Branches during the reporting period. Maui, Hawaii, and Kauai FGCs had fewer youth registered in the fourth quarter than in the third quarter of the fiscal year.

Consistent with historical data, in the current quarter (Fiscal Year 2009, Quarter 4), the largest population was served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 25.9% of the total CAMHD population during the quarter, but experienced a decrease in population. The Leeward Oahu Family Guidance Center (LOFGC) served the largest population on Oahu (304), which is 14.2% of the total of CAMHD registered youth.

Leeward Oahu in addition to the Big Island has the largest population of youth receiving services in the Hospital-based Residential levels of care. The Mokihana Project on Kauai serves both youth with less serious emotional challenges as well as youth with more serious and prolonged needs. Mokihana’s overall population decreased by sixty-one youth and the more intensive population decreased by twelve. Of the 589 youth registered in Mokihana during the fourth quarter, 14.8% were receiving more intensive mental health services.

The Family Court Liaison Branch (FCLB) had an increase in the number of youth they case manage over the previous quarter. FCLB provides services to youth detained at the Detention Home and the Hawaii Youth Correctional Facility.

Table 1. Population of Youth Registered by Branch

	COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
<b>Fourth Quarter FY 2009</b>	145	304	159	156	164	556	589	70
							87	
<b>Third Quarter FY 2009</b>	131	298	163	115	155	577	650	55
							99	
<b>Fourth Quarter FY 2008</b>	136	330	157	138	170	584	629	38
							118	

The total number of registered youth are described by four subgroups: (i) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (ii) youth who were in the process of having services arranged (new admissions), (iii) youth who received less intensive services through Mokihana on Kauai, and (iv) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth (2,144), 1,051 had services that were authorized within the quarter.

### ***New/Recurring Admissions and Discharges***

Of the total registered population statewide (2,144), 196 youth (9.1%) were newly registered (had not previously received services) in the fourth quarter of fiscal year 2009. This is an increase in the number of new admissions from the previous quarter (January 2009-March 2009), when 178 youth were newly admitted.

Table 1. Admissions and Discharges

<b>Registered (Case Management)</b>	<b>N</b>	<b>%</b>
Total Registered Youth	2,144	
Youth with New Admissions	196	9.1%
Youth with Repeat Admissions	157	7.3%
Youth with Discharges	307	14.3%

One hundred fifty-seven (157) youth (7.3%) who had previously received services from CAMHD were reregistered. This represents an increase from last quarter's readmissions of 110 youth.

CAMHD discharged a total of 307 youth during the quarter, or 14.3% of the registered population. This is a decrease of 31 youth from last quarter's discharge of 338 youth, which was 15.8% of the registered population. Discharges are constituted of youth who have met treatment goals and are clinically discharged, as well as youth whose family refuse services or youth who are on the run.

Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal or program elopement, or moving out of state.

### ***Gender and Age***

Just over two-thirds (67%) of youth served during the fourth quarter were male, which has been consistent over time (see Table 2).

Table 2. Gender of CAMHD Youth

<b>Gender</b>	<b>N</b>	<b>% of Available</b>
Females	716	33%
Males	1,428	67%

The average age of registered youth served in the CAMHD system was 14.2 years with a range from 3 to 20 years. The average age of youth was comparable to previous quarters, and the age range of youth remained stable.

### ***National Origin and Race***

The national origin of youth is displayed in Table 3. The races of youth registered in the reporting quarter are displayed in Table 4.

Table 3. National Origin of Youth (Unduplicated)

<b>National Origin</b>	<b>N</b>	<b>% of Available</b>
Not Hispanic	916	71.2%
Hispanic or Latino/a	370	28.8%
<b>Not Available (% Total)</b>	<b>858</b>	<b>40.0%</b>

Table 4. Race of Youth (Unduplicated)

<b>Race</b>	<b>N</b>	<b>% of Available</b>
American Indian or Alaska Native	13	0.7%
Asian	167	9.3%
Black or African-American	23	1.3%
Native Hawaiian or Pacific Islander	301	16.7%
White	277	15.4%
Other Race	24	1.3%
Multiracial	994	55.3%
Based on Observation	152	8.4%
<b>Not Available (% Total)</b>	<b>345</b>	<b>16.1%</b>

In the quarter, Multiracial youth represented the largest race group among CAMHD youth (55.3%), followed by Native Hawaiian or Pacific Islanders (16.7%), and then White youth (15.4%). Data indicate that for this quarter and the preceding two quarters, there were more Native Hawaiian or Pacific Islanders than White youth.

The valid completion rates for collecting these data continued to be somewhat low with 40.0% of youth missing national origin information and 16.1% of youth missing race information, which limits the generality of the available data. Race data was less available last quarter than this quarter, when 19.3% of youth did not have race data recorded. Overall data indicate completion rates improved this quarter over the previous quarter.

### **Agency Involvement**

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 5).

In the quarter, 8.9% of the population had DHS involvement. This represents both a slight decrease in DHS involvement from last quarter (9.5%) and a 0.1% increase from the same period of FY 2008. At some point during the quarter, 15.1% of the registered population had a Family Court hearing and 1.3% were incarcerated at HYCF or detained at the Detention Home. The proportion of youth who had a Family Court hearing decreased from the previous quarter (16.5%). There was also a slight decrease in the proportion of youth who were incarcerated or detained (1.3%) as compared to the previous quarter of 1.6%. Both proportions remained below the same period as last year (17.2% and 2.1%, respectively).

Table 5. Agency Involvement

<b>Agency Involvement</b>	<b>N</b>	<b>%</b>
DHS	191	8.9%
Court	324	15.1%
Incarcerated/Detained	28	1.3%
Quest	954	44.5%
Medicaid Fee-for-Service	15	1.4%

These data are reported only for youth in CAMHD who are eligible for services by virtue of being QUEST enrolled and who are Medicaid fee-for service. Please note QUEST-eligible youth may also be eligible for services through CAMHD because of their educational status.

Youth who were eligible for services through the Medicaid process numbered 954 in total and were 44.5% of the registered population. This was a decrease of 92 youth, or a 4.3% decrease in this category over the previous quarter. This quarter is a reversal of the previous quarter, which showed an increase in the number of QUEST-eligible youth served in CAMHD.

### Diagnoses of Youth

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 6). The reported percentages may exceed 100% because many youth receive diagnoses in multiple categories.

Table 6. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	878	47.1%
Attentional	785	42.1%
Mood	555	29.8%
Miscellaneous	487	26.1%
Anxiety	379	20.3%
Substance-Related	294	15.8%
Adjustment	213	11.4%
Mental Retardation	56	3.0%
Pervasive Developmental	66	3.5%
Multiple Diagnoses	1,298	69.6%
Ave. Number of Diagnoses	1.8	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of registered youth in the quarter remained Disruptive Behavior disorders (47.1%), Attentional disorders (42.1%), and Mood disorders (29.8%), a pattern consistent over the past seven years.

Miscellaneous diagnoses accounted for 26.1% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

Of note is the vast majority of youth in the CAMHD registered population having co-occurring, or more than one diagnosis. In the reporting quarter, 69.6% of registered youth had more than one diagnosis. This is an average of 1.8 diagnoses per youth, which is slightly more than last quarter when 69.0% had co-occurring disorders.

For those with services authorized, the percentage of youth with multiple diagnoses was even higher (75.8%) with an average of 2.2 diagnoses per youth. This continues a long-term pattern of increasing diagnostic comorbidity, implying complex service needs, among youth receiving CAMHD services. The co-occurring diagnoses category includes any DSM-IV-TR identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with co-occurring disorders that had a substance-related diagnosis represented 15.8% of the registered population, an increase of 0.7% from the previous quarter and a 0.1% increase over the same period as last year. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

## Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are systematically reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

The utilization of services data (based on authorized services) for Quarter Four, Fiscal Year 2009 (April 1, 2009-June 30, 2009) are displayed below in Table 7.

Table 7. Service Authorization Summary (April 1, 2009-June 30, 2009).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
<b>Out-of-Home</b>	<b>296</b>	<b>354</b>	<b>16.5%</b>	<b>33.7%</b>
Out-of-State	5	6	0.3%	0.6%
Acute Hospitalization or Detoxification	19	36	1.7%	3.4%
Hospital Residential	17	31	1.4%	2.9%
Community High Risk	10	10	0.5%	1.0%
Community Residential	80	98	4.6%	9.3%
Therapeutic Group Home	37	49	2.3%	4.7%
<i>Therapeutic Group Home</i>	33	40	1.9%	3.8%
<i>Community Mental Health Shelter</i>	5	11	0.5%	1.0%
Therapeutic Foster Home	151	183	8.5%	17.4%
<i>Multidimensional Treatment Foster Care</i>	14	17	0.8%	1.6%
<i>Therapeutic Foster Home</i>	138	167	7.8%	15.9%
<b>Intensive Home and Community</b>	<b>577</b>	<b>696</b>	<b>32.5%</b>	<b>66.2%</b>
Partial Hospitalization	2	3	0.1%	0.3%
Multisystemic Therapy	103	140	6.5%	13.3%
Intensive In-Home	477	571	26.6%	54.3%
Intensive Outpatient	0	0	0.0%	0.0%
<b>Outpatient</b>	<b>114</b>	<b>215</b>	<b>10.0%</b>	<b>20.5%</b>
Treatment	37	56	2.6%	5.3%
<i>Medication Management</i>	1	2	0.1%	0.2%
<i>Functional Family Therapy</i>	20	32	1.5%	3.0%
<i>Outpatient Therapy</i>	16	23	1.1%	2.2%
<i>Parent Skills Training</i>	0	0	0.0%	0.0%
Consultation	56	100	4.7%	9.5%
Assessment	22	67	3.1%	6.4%
<b>Supportive Services</b>	<b>72</b>	<b>127</b>	<b>5.9%</b>	<b>12.1%</b>
Respite Home	3	4	0.2%	0.4%
Respite Support	4	7	0.3%	0.7%
Peer Support	0	0	0.0%	0.0%
Ancillary Service (Flex-Funded)	65	117	5.5%	11.1%
<b>Crisis Stabilization</b>	<b>7</b>	<b>13</b>	<b>0.6%</b>	<b>1.2%</b>

Note: Peer Support services were not included in the standard service array during the current reporting period. Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment CAMHMIS data to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (April 2009-June 2009). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

Services represent many of the additional levels of care that were implemented beginning last fiscal year subsequent to the awards of new contracts for an expanded service array. Substance-Abuse Detoxification, Parenting Skills Training, and Peer Support services for Medicaid eligible youth have not yet been initiated, as they are not part of Hawaii's Medicaid State Plan. Intensive Outpatient Services does not yet show utilization, as the service has not been brought up by awarded provider agencies.

For the purposes of clarification, the following terms are defined:

- Registered CAMHD population: 2,144 youth
- Youth with services authorized: 1,051 youth

**Summary.** In the reporting quarter, of youth with services authorized, 33.7% received services in out of home treatment settings at some point during the quarter. Another 66.2% received an intensive home/community based service including Multisystemic Therapy, and 20.5% received an outpatient service. (Outpatient services include services provided by CAMHD-employed psychiatrists and psychologists.) Supportive services were provided for 12.1% of youth with services authorized.

**Out of State.** The number of youth receiving treatment in out of state settings has remained fairly stable over time. This quarter, an average of five (5) youth or 0.3% of the registered CAMHD population received treatment outside of Hawaii. There were four youth in April, four youth in May, and six youth in June receiving services in out-of-state treatment settings. Please see the Performance Measure for *% of Youth Receiving Treatment Within the State of Hawaii* for a full display of the trend. The numbers of youth in out of state treatment facilities is a measure that CAMHD tracks very carefully in order to assure only youth that absolutely cannot be served in Hawaii utilize Mainland programs.

**Inpatient Hospital Services.** Hospital-based residential services were used at some point during the quarter by 2.9% of youth with services. This utilization decreased slightly from the previous quarter (3.3%) and from the same period last year (3.4%). A focused initiative by the CAMHD to closely monitor the utilization of Hospital-based residential services and transition youth to less-intensive services seems to have impacted the utilization of hospital services.

Acute Hospitalization services were utilized in the reporting quarter by thirty-six youth (36) or 1.7% of the registered CAMHD population. This is the same number of youth that experienced an acute psychiatric hospitalization last quarter. As this is identical to the Acute Hospitalization utilization from the previous quarter, CAMHD continues to closely monitor the utilization of this service. CAMHD began managing these services for SEBD Medicaid-eligible youth in August 2007.

**Community-Based Residential Services.** Youth receiving treatment in Community-Based Residential (CBR) programs at some point during the quarter accounted for 9.3% of youth with services authorized. This represents a slight decrease from the previous quarter of 10.1%. Utilization of CBR programs continues to be higher than use of Group Homes, which provide services in less restrictive settings than CBRs.

**Community High Risk.** The service provides treatment primarily for youth who have been adjudicated of a sexual offense and need to live in a secure treatment setting. In the quarter, a total of 10 youth, or 0.5% of the registered CAMHD population received these services. This is identical in number and proportion to last quarter, when 10 youth, or 0.5% of the registered CAMHD population were in this group.

**Therapeutic Group Home Services.** Utilization of Therapeutic Group Homes decreased slightly this quarter (3.8% of youth with services authorized compared to 4.1% last quarter). This was also a decrease in the utilization for the same period last year when 4.5% of youth with services authorized used the service. Community Mental Health Shelters, which are provided in group home settings, were utilized by eleven (11) youth, or 0.5% of the registered CAMHD population. This was slightly less than last quarter's utilization of this service when 12 youth, or 0.6% of the registered CAMHD population, accessed shelter services.

**Therapeutic Foster Home Services.** Therapeutic Foster Homes (TFH) were used by 15.9% of the registered CAMHD population in the quarter. This was a slight increase in utilization over the previous quarter when 15.6% of the population used TFHs. It is also an increase from the same period last year when 14.9% of the registered CAMHD population used the service.

**Multidimensional Treatment Foster Care (MTFC).** Utilization of this evidence-based service was fairly consistent with the previous quarter. A total of 17 youth used MTFC during the quarter, a decrease of three youth from the previous quarter. These numbers may represent youth who were in a MTFC setting in both quarters. MTFC is known to be a cost-effective alternative to regular foster care, group or residential treatment, and incarceration for youth who have problems with chronic disruptive behavior. The evidence of positive outcomes from this unique multi-modal treatment approach is compelling. MTFC was one of thirteen treatment programs evaluated for cost effectiveness by the Washington State Public Policy Group in the publications *The Comparative Costs and Benefits of Programs to Reduce Crime* (Aos, Phipps, Barnoski, & Lieb, 2001 and 1999: [www.wa.gov/wsipp](http://www.wa.gov/wsipp); document #01-05-1201).

**Partial Hospitalization Services.** In the reporting quarter, three (3) youth utilized Partial Hospitalization services, which is four (4) less than the previous quarter. Youth who are eligible for this service are part of CAMHD's SEBD program.

**In-Home Services.** Services provided in homes and in the community continued to be used by the largest number and percentage of the CAMHD population. In the quarter, 26.6% of the registered CAMHD population received Intensive In-Home (IIH) services and 6.5% received Multisystemic Therapy (MST). This is the same as last quarter's IIH utilization and a slight increase of MST utilization over last quarter, when 6.3% of the registered CAMHD population received the service.

**Outpatient Services.** An array of outpatient services is available for youth who are eligible for CAMHD services through the SEBD program. The services are provided by contracted providers as well as by CAMHD-employed clinicians. In the quarter 10.0% of the registered CAMHD population, or 215 youth received outpatient services. This is a slight increase compared to 9.5% or 204 youth last quarter. The primary type of service used was Consultation, which is provided by the CAMHD-employed clinicians. Consultation was provided for 100 youth, or 4.7% of the registered CAMHD population. Medication Management, also a subset of Outpatient Services, was provided for 2 youth or 0.1% of the registered CAMHD population. Assessments were provided for 67 youth or 3.1% of the registered CAMHD population, which is a significant increase from the previous quarter of 40 youth or 1.9% of the registered CAMHD population.

Functional Family Therapy was utilized by a total of 32 youth, which is identical to last quarter's utilization of 32 youth. This evidence-based service is available on the Big Island and Oahu.

**Supportive Services.** Supportive Services are provided to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. They include Respite Homes, Respite Support, Peer Support, and Ancillary Services funded through Flexible Funding.

Ancillary Services were provided for 11.1% of youth with services authorized, which was a slight decrease from last quarter's utilization of these services (11.9%). The largest use of Ancillary Service funding continued to be to pay for travel cost for youth in out of home settings.

Respite Homes are designed to support caregivers' capacities and prevent potential out-of-home placements. In the reporting period, four (4) youth utilized Respite Homes and the monthly average was three (3).

Respite Support services are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature. Utilization of Respite Support services decreased slightly from last quarter (0.7%) with 0.3% of the registered CAMHD population accessing these services in the quarter. This is less than the same period last year, when 2.2% of youth utilized this service.

**Crisis Stabilization.** Crisis Stabilization services, provided in foster and group homes, were utilized by thirteen youth, or 0.6% of the registered CAMHD population. Utilization was more than last quarter, when five or 0.2% of the registered CAMHD population accessed these services. Crisis stabilization services will often divert youth from needing to be hospitalized and promote easier re-entry back home for youth. Because of the very low to no utilization of Crisis Therapeutic Foster Homes on Maui and Kauai, contracts for these services have been recommended to be terminated. Note: these are the same contracts as Respite Homes provided in TFH settings (the same home could be used for both services).

## Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Cost data are available the quarter following the adjudication of all claims, the cost data presented below represents expenditures for services provided during the third quarter of fiscal year 2009 (January 2009-March 2009). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Services' Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for the central and branch offices that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed financial analysis is conducted by CAMHD Administrative Services.

***Costs for Treatment of Youth in Out-of-Home Settings.*** For the reporting quarter, cost for all Out-of-Home residential treatment services accounted for 74.9% of service expenditures, which is 0.6% below the previous quarter's percentage of cost. The unduplicated cost for the Out-of-Home level of care services was \$6,695,114, which was a decrease over last quarter's cost of \$7,065,436. Costs in this category include cost for inpatient services (Acute and Hospital-based Residential). Please note though that these data do not include, and do not traditionally include, all costs for High-Risk Community Based Residential care as billing tends to lag for this program.

Based on available data, the unduplicated cost per youth for Out-of-Home services was \$19,463 during the quarter, a decrease from last quarter's cost per youth of \$19,626.

Youth in Out-of-State treatment settings accounted for 1.3% of total expenditures, which is slightly less than the previous reporting quarter's (October 2008-December 2008) proportion of cost. The unduplicated cost per youth in an out-of-state treatment setting was \$30,040, which was more than last quarter's \$23,135 per youth. Total unduplicated cost for this service was \$120,162, which was a decrease in cost for this service over last quarter's \$146,126.

Total unduplicated cost of Hospital Residential services during the quarter increased from \$1,119,616 in the previous quarter, to \$1,123,800 for the 31 youth who received the service. In the reporting quarter, the unduplicated cost per youth for the level of care increased from \$29,464 to \$34,055. Billing was complete for this service.

The cost of CBR services decreased in the reporting quarter (i.e., third quarter compared to second quarter of fiscal year 2009) in terms of total dollars, but increased in the average cost per youth for this level of care.

The total cost for youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter was reflected as \$37,693, which is substantially lower than the actual cost due to incomplete billing for this service.

For other types of residential treatment, the lowest cost per youth for specific levels of care was for those who received services in Therapeutic Foster Homes (\$13,125 per youth), which has been fairly consistent over time, and stands out as the most cost-effective residential service in addition to being the least restrictive.

***Cost for Treatment Provided through In-Home Services.*** In-Home (Intensive In-Home and MST) services accounted for 22.5% of the unduplicated cost of services. This is an increase from the last reporting quarter's percentage of total costs for those categories. Youth receiving Intensive Home and Community services at some point during the quarter cost an average of \$3,169 per youth (\$2,529 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program. The cost per youth for Intensive Home and Community services was more than last quarter, but lower for Multisystemic Therapy services.

***Ancillary Services Costs.*** For those youth who received Ancillary Services, average cost per youth for this service was \$1,167 per month. The average cost per level of care for a child receiving an ancillary service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of-home placements account for a high percentage of youth receiving an Ancillary Service. A high proportion of Ancillary Services are travel-related and include family visits when placement is off-island. As previously reported, CAMHD is in the process of trying to recoup travel costs through the Med-QUEST Division for QUEST-eligible youth.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 8.

Table 8. Cost of Services (January 1, 2009-March 31, 2009)

Services Procured (Accepted Billing Records)	Cost per LOC (\$) <sup>a</sup>	Cost per LOC per Youth (\$) <sup>a</sup>	% of Cost per LOC	Total Cost (\$) <sup>b</sup>
<b>Out-of-Home</b>	<b>\$6,695,114</b>	<b>\$19,463</b>	<b>74.9%</b>	<b>\$7,085,564</b>
Out-of-State	\$120,162	\$30,040	1.3%	\$120,162
Acute Hospitalization *	\$0	\$0	0.0%	\$0
Hospital Residential	\$1,123,800	\$34,055	12.6%	\$1,280,615
Community High Risk **	\$899	\$90	0.0%	\$37,693
Community Residential	\$2,388,068	\$22,529	26.7%	\$2,633,753
Therapeutic Group Home	\$785,625	\$19,162	8.8%	\$881,932
<i>Therapeutic Group Home</i>	<i>\$785,625</i>	<i>\$19,162</i>	<i>8.8%</i>	<i>\$881,932</i>
<i>Community Mental Health Shelter</i>	<i>\$0</i>	<i>\$0</i>	<i>0.0%</i>	<i>\$0</i>
Therapeutic Foster Home	\$2,276,560	\$13,313	25.5%	\$2,704,342
<i>Multidimensional Treatment Foster Care</i>	<i>\$215,954</i>	<i>\$15,425</i>	<i>2.4%</i>	<i>\$239,314</i>
<i>Therapeutic Foster Home</i>	<i>\$2,060,606</i>	<i>\$13,125</i>	<i>23.1%</i>	<i>\$2,465,028</i>
<b>Intensive Home and Community</b>	<b>\$2,046,945</b>	<b>\$3,169</b>	<b>22.9%</b>	<b>\$3,533,744</b>
Partial Hospitalization	\$35,100	\$5,014	0.4%	\$105,199
Multisystemic Therapy	\$714,436	\$5,215	8.0%	\$927,539
Intensive In-Home	\$1,297,409	\$2,529	14.5%	\$2,611,252
Intensive Outpatient	\$0	\$0	0.0%	\$0
<b>Outpatient</b>	<b>\$42,868</b>	<b>\$529</b>	<b>0.5%</b>	<b>\$290,197</b>
Treatment	\$24,880	\$478	0.3%	\$134,787
<i>Medication Management</i>	<i>\$159</i>	<i>\$159</i>	<i>0.0%</i>	<i>\$10,502</i>
<i>Functional Family Therapy</i>	<i>\$1,368</i>	<i>\$46</i>	<i>0.0%</i>	<i>\$13,995</i>
<i>Outpatient Therapy</i>	<i>\$23,353</i>	<i>\$1,112</i>	<i>0.3%</i>	<i>\$110,290</i>
<i>Parent Skills Training</i>	<i>\$0</i>	<i>\$0</i>	<i>0.0%</i>	<i>\$0</i>
Consultation	\$0	\$0	0.0%	\$0
Assessment	\$17,988	\$600	0.2%	\$166,033
<b>Supportive Services</b>	<b>\$151,839</b>	<b>\$1,026</b>	<b>1.7%</b>	<b>\$2,763,917</b>
Respite Home	\$319	\$80	0.0%	\$84,527
Respite Support	\$4,429	\$233	0.0%	\$51,142
Peer Support	\$0	\$0	0.0%	\$0
Ancillary Service (Flex-Funded)	\$147,091	\$1,167	1.6%	\$2,671,037
<b>Crisis Stabilization</b>	<b>\$56</b>	<b>\$19</b>	<b>0.0%</b>	<b>\$15,681</b>

Note: Peer Support services were not included in the standard service array during the current reporting period. a Cost per LOC represents the unduplicated cost (US\$) for services at the specified level of care. b Total Cost represents the cost for all services that youth received during the period allocated to level of care based on duplicated youth counts. Thus, if youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US\$).

\* Data for Acute Hospitalization services were not available at the time of this report

\*\* Cost for Community High-Risk Residential services are not reflective of actual costs due to incomplete billing information.

## Performance Measures

CAMHD performance measures demonstrating adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

Performance measures linked to “measures of sustainability” are noted by an asterisk (\*).

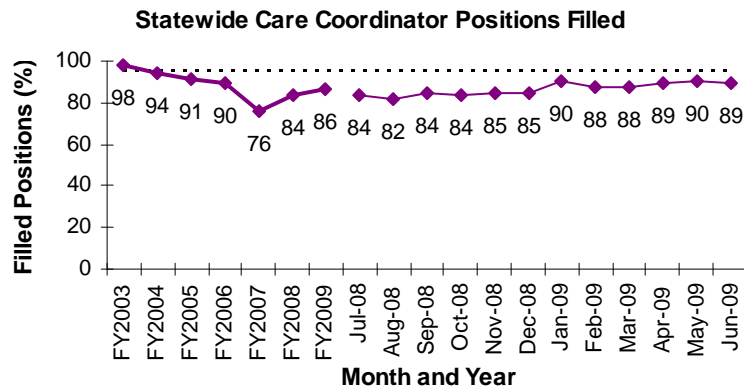
***CAMHD will maintain sufficient personnel to serve the eligible population***

**Goal:**

⇒ **95% of Care Coordinator positions are filled.\***

Performance on this measure was the same as last quarter. During the reporting period (Quarter Four, Fiscal Year 2009) CAMHD had an average of 89% of Care Coordinator (CC) positions filled statewide.

The data for this measure reflects the actual number of filled Care Coordinator positions, and does not include positions filled by temporary employees (89-day hires).

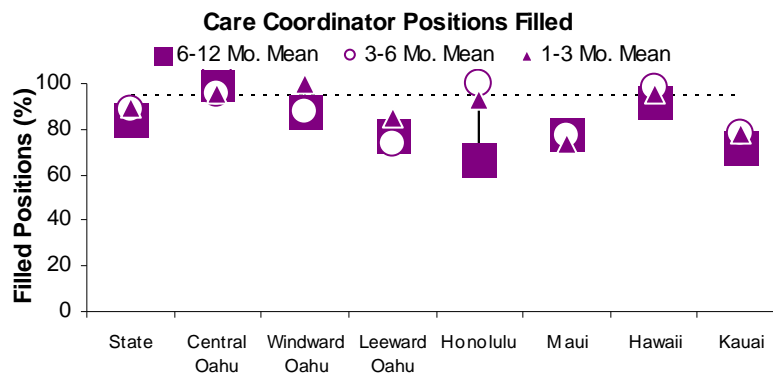


The shortage in the number of qualified candidates as well as the length of time it takes to fill Care Coordinator positions within the State personnel hiring process impacts this measure. Further, the current economic situation and budgetary crisis has required that a hiring freeze be implemented and all 89-day hire positions will not be renewed after the end date. This measure may continue to impact the number of statewide care coordinator positions that are filled. The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below:

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
96%	86%	74%	100%	93%	96%	78%

Three Family Guidance Centers, Central, Windward, and Big Island, met the performance goal of having 95% of their care coordinator positions filled during the quarter. Leeward, Maui, Honolulu, and Kauai experienced significant to moderate vacancies. Central and Kauai had the same number of vacancies. Leeward and Windward showed improvement over the preceding quarter, whereas Maui, Honolulu, and Big Island had more than last quarter.

Each of the centers that did not meet the goal experienced 1 to 2.5 vacancies during the quarter. Central filled one position midway through the quarter, whereas Honolulu and Leeward FGCs each lost one Care Coordinator position midway and at the end of the quarter respectively.

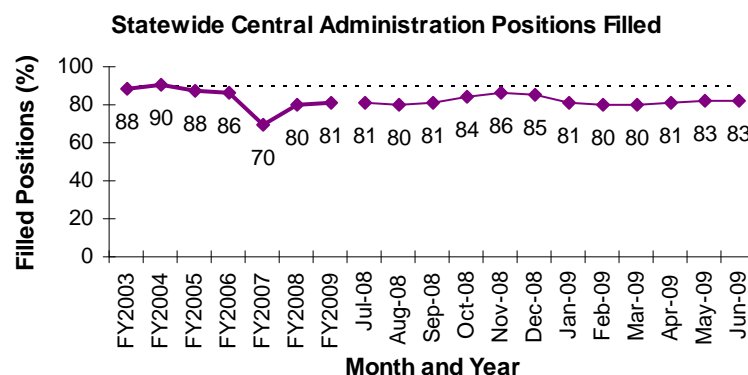


The vacancy trends for each Family Guidance Center and the State are displayed above. The triangle (▲) symbol represents the current quarter's performance.

**Goal:**

↪ **90% of Central Administration positions are filled.\***

An average of 82% of positions in the central administrative offices were filled during the quarter, which constitutes a 2% increase in performance over the previous quarter (January-March 2009) and does not meet the targeted performance goal.



Central Administrative Office staff perform core functions that support the overall management of the service system including provider agency and system monitoring, quality management, federal Medicaid reimbursement, billing, information system management, contracting, and training.

Like the percentage of care coordinator positions filled measure, this measure was adjusted at the beginning of fiscal year 2007 to include only actual filled and not temporarily filled positions.

At the end of the quarter, 14 of the 80.25 positions (17%) in this category were vacant. However, only 3 of the 80.25 positions are under active recruitment for a 4% adjusted vacancy rate (96% filled) in the CAMHD Central Administrative Offices. Eleven positions are on executive hold to address spending restrictions.

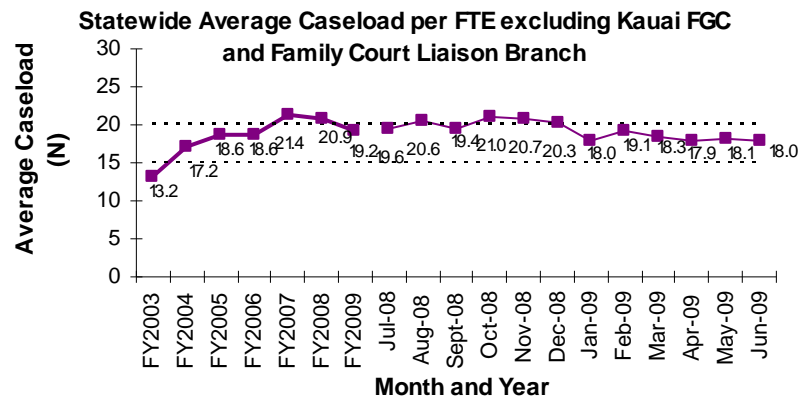
Vacant positions are distributed throughout central administration. In the quarter, four (4) positions in the Clinical Services Office, five (5) positions in the Performance Management Office, three (3) positions in Management Information System, and one (1) position each in Administration and the Chief’s Office were vacant. As described above, a number of these positions are being held administratively in order to address budget constraints.

**Goal:**

⇒ **Average care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.**

CAMHD’s standard is to assure that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services.

The statewide average caseload for the fourth quarter was inside the desired range at 18.0 youth per full time care coordinator equivalent (FTE). It represents a slight increase in performance from last quarter, when the average caseload was 18.5 youth per full time care coordinator and fell inside the targeted range.



The calculation of the average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from other Family Guidance Centers.

The average caseload performance target was not met for Leeward FGC, as caseloads were beyond the expected range. Leeward, Windward, and Hawaii showed an improvement in their average caseloads over the previous quarter, whereas Central and Maui showed slight declines. Honolulu FGC’s caseloads remained the same from the previous quarter. Leeward’s average caseload, well above the expected range, was impacted by two vacant positions at the end of the quarter. Leeward’s caseloads have decreased since the previous quarter’s average of 30. Higher caseloads impact the ability to provide more individualized services and family engagement.

Average Caseloads (Client: MHCC) by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
4 <sup>th</sup> Quarter Average	16:1	25:1	19:1	14:1	14:1	19:1

Leeward, Hawaii and areas of Maui County include communities that are impacted by socio-economic variables and demographics that include high multi-agency involvement and higher functional impairment of youth. High caseloads tend to impact these FGCs much harder than other areas.

**CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight**

**Goal:**

⇒ **Sustain within quarterly budget allocation.**

CAMHD met the goal for sustaining within its budget. Total variance from the budget for the reporting quarter was below projection by a total of \$23,000. The reporting quarter for this performance measure is January 2009-March 2009, which allowed for closing of the contracted agency billing cycle. Expenditure totals for the Branches (\$19,000) and the Central Office (\$6,000) were below budget. The Services total exceeded budget by \$2,000. Funding was reallocated accordingly.

The Executive and legislative restrictions will make it necessary for CAMHD to enact a number of cost-savings measures in order to sustain within its allocation in FY 2009. Measures are being taken to realize efficiencies across the CAMHD program in order to meet all costs for FY 2009.

	Variance from Budget (in \$1,000's)											
	FY 2005	FY2006	FY2007	FY2008	FY2009	Fiscal Year and Quarter						
	Average	Average	Average	Average	Average	2008.1	2008.2	2008.3	2008.4	2009.1	2009.2	2009.3
Branch Total	\$20	-\$261	-\$275	-\$25	-\$6	-\$20	-\$3	-\$32	-\$46	\$0	\$0	-\$19
Services Total	-\$1,849	-\$181	-\$1,968	-\$264	\$2	-\$1,003	-\$125	\$34	\$37	\$5	\$0	\$2
Central Office Total	-\$314	-\$8	\$1	\$287	-\$2	\$1,023	\$135	-\$9	-\$1	\$0	\$0	-\$6
Grand Total	-\$2,142	-\$450	-\$2,242	-\$2	-\$6	\$0	\$7	-\$7	-\$10	\$5	\$0	-\$23

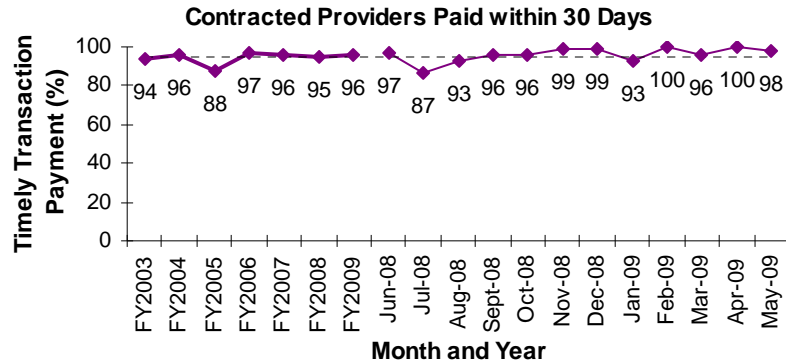
***CAMHD will maintain timely payment to provider agencies***

**Goal:**

⇒ **95% of contracted providers are paid within 30 days.**

Over the quarter, an average of 99% of contractors were paid within the 30-day window, which met the performance goal.

As is standard for this report, the quarter’s data is available for the first two months of the quarter (April and May 2009) and includes March 2009.

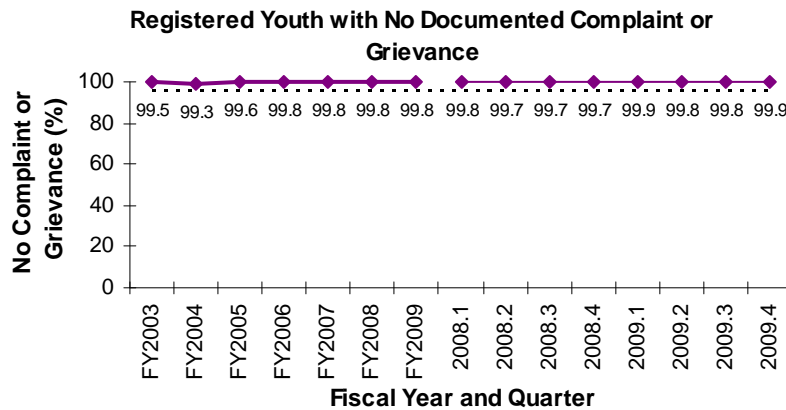


***CAMHD will timely and effectively respond to stakeholders’ concerns***

**Goal:**

⇒ **95% of youth served have no documented complaint received.\***

In the quarter, 99.9% of youth had no documented complaint, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in July 2001.

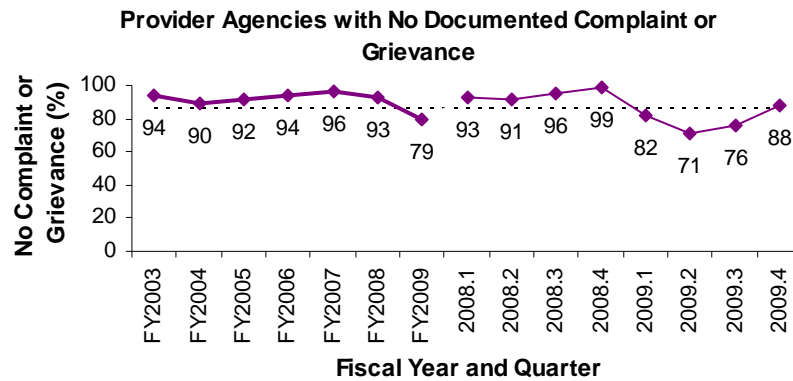


In the quarter, the complaints received were two (2) youth (or someone complaining on their behalf) and one (1) non-client related. The complaints statewide were from two (2) complexes (Waipahu and Mililani). This compares to six (6) youth with documented complaints representing four (4) complexes last quarter. Waipahu and Mililani Complexes each received one complaint.

**Goal:**

⇒ **85% of provider agencies have no documented complaint received.**

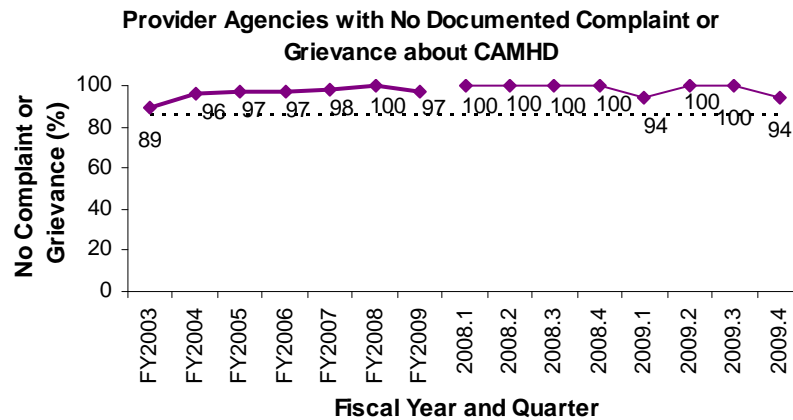
The goal was met this quarter as 88% of provider agencies had no documented complaint registered about their services. Performance for this measure had been consistently met since the second quarter of fiscal year 2004, but showed a decline during the current fiscal year. Complaints that were received were about medication management, service dates, supervision by program staff, and provider/youth staff communication and interaction.



**Goal:**

⇒ **85% of provider agencies will have no documented complaint about CAMHD performance.\***

In the quarter, 94% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which is slightly lower than last quarter’s performance, but meets the targeted goal. This measure has consistently met the performance goal since the beginning of FY 2003.



**Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting**

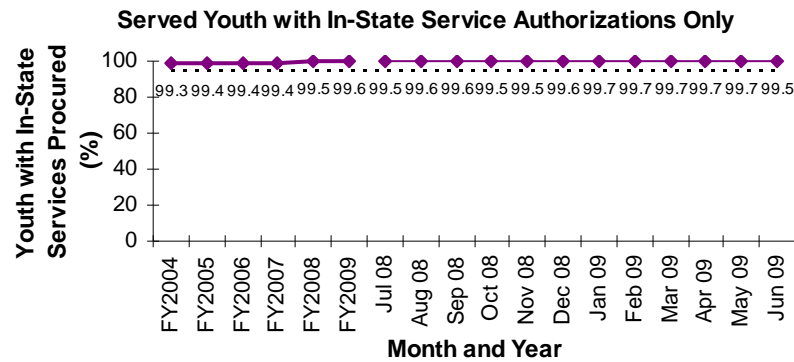
**Goal:**

⇒ **95% of youth receive treatment within the State of Hawaii.\***

In the quarter, an average of 99.6% of CAMHD registered youth served received treatment within the State, which exceeds the goal. There was an average of five youth out of state over the quarter. Four youth in April, four youth in May, and six youth in June received services in out-of-state treatment settings. This is more than the number of youth who were out of state last quarter.

Careful tracking of this indicator is needed to assure youth are served in the least restrictive environment, and as close to their families and communities as possible.

These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter.



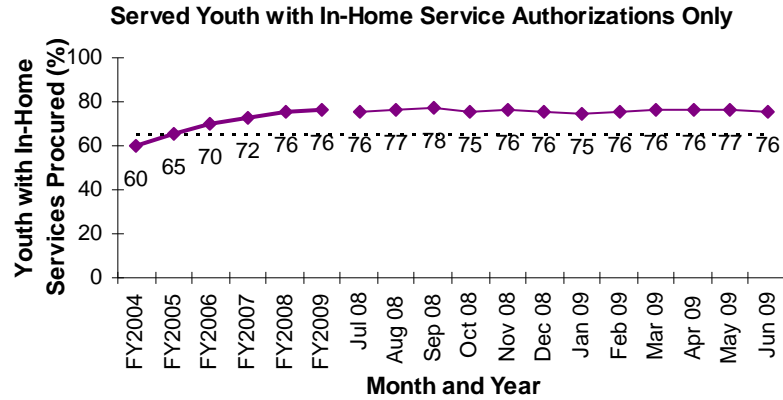
**Goal:**

⇒ **70% of youth are able to receive treatment while living in their home.**

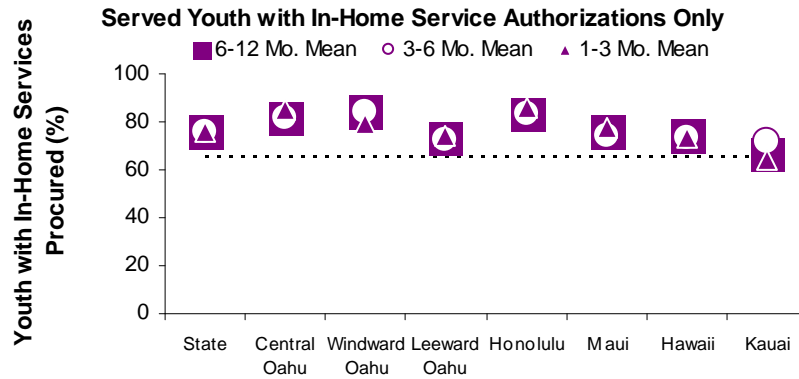
An average of 76% of the CAMHD population of youth was served in their home communities during the quarter, which is 6% better than the performance goal of 70%.

Please note that the benchmark for this measure was raised beginning this fiscal year from 65% to 70%. Over the last several years, CAMHD has been able to serve a growing number and percentage of the total population through in-home services. This data reflects in part the commitment to serve youth in the least restrictive environment.

This quarter’s performance is consistent with last quarter’s average of youth served in their homes.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. Results appeared fairly consistent within each FGC’s own historical patterns. It should be noted that Kauai operates under a markedly different service delivery model than the rest of the State, resulting in a smaller percentage of the overall population of youth on Kauai receiving high-end services.



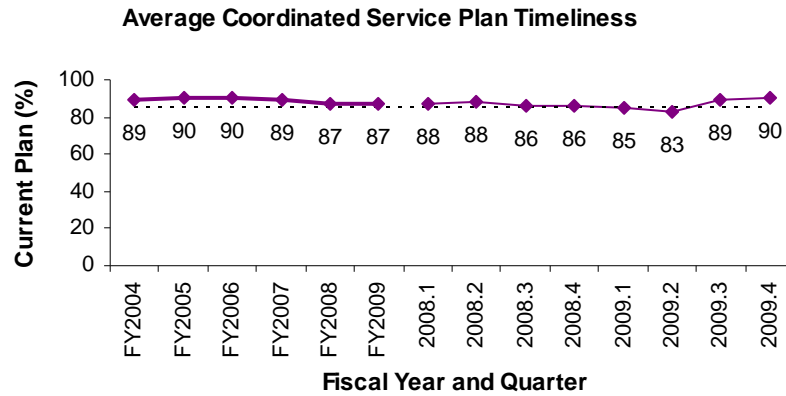
The goal was met for all Family Guidance Centers with the exception of Kauai FGC.

***CAMHD will consistently implement an individualized, child and family centered planning process***

**Goal:**

⇒ **85% of youth have a current Coordinated Service Plan (CSP).\***

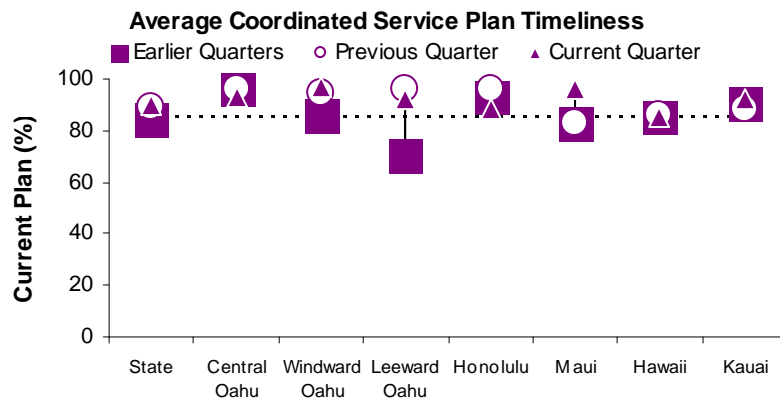
CAMHD’s performance in this measure met the performance goal for the reporting quarter with 90% of youth across the state having a current CSP, which is a slight increase from last quarter’s performance.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

Although the goal has been consistently met for the past four years, performance has been declining slightly over the last year, which reverses the trend of performance stability seen in previous years.

Trend data for each FGC are displayed below. As indicated, performance declined in the Central Oahu, Leeward Oahu, and Honolulu catchment areas.



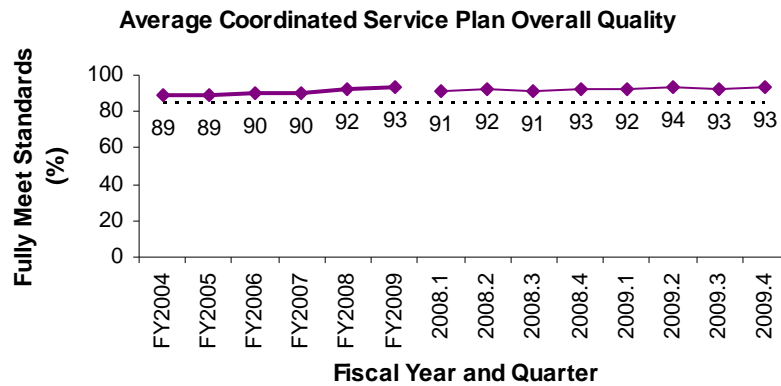
All of the FGCs met the goal. Maui’s performance increased significantly from the previous quarter, while Windward Oahu and Kauai experienced minor increases. As routine for any FGC measure not meeting a performance goal, COFGC, LOFGC, and Honolulu will implement improvement plans to address the timeliness of their plans.

“Current” is defined as having a plan newly developed or reviewed with the CSP team within the past six months. Quarterly reviews for timeliness are conducted by each FGC. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

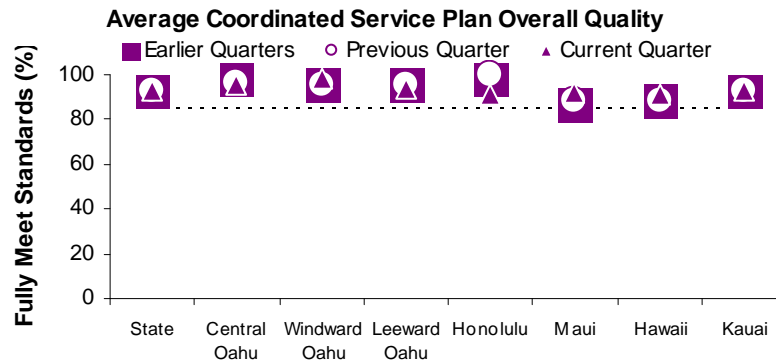
**Goal:**

⇒ **85% of Coordinated Service Plan review indicators meet quality standards.\***

The goal for this measure was met at the statewide level in the reporting quarter with 93% of CSPs sampled meeting overall standards for quality. This is consistent with last quarter’s performance results of 93% of plans meeting quality standards. The goal has been met for the past five years at the statewide level.



Individual FGC performance data are displayed below.



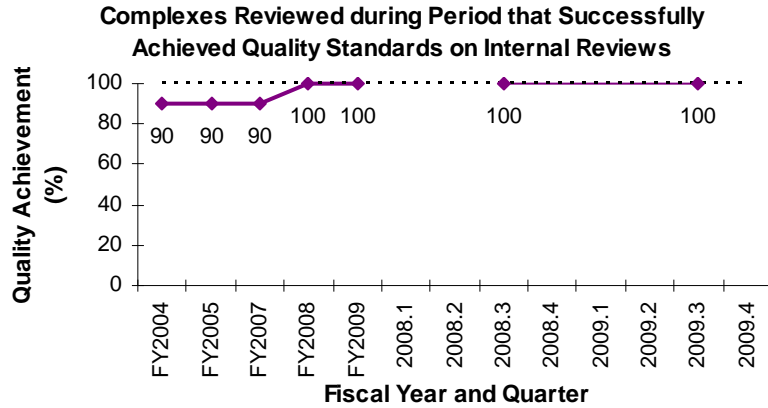
As indicated, the goal was met or exceeded by all of the FGCs. Continued improvement was seen by Maui, Windward Oahu, and Hawaii FGCs. Kauai’s performance remained the same from the previous quarter with 93% of plans meeting the goal. Honolulu experienced a decline this quarter after having showed improved performance the previous quarter.

CSPs are reviewed quarterly by the FGCs to determine if they meet the standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures.

**Goal:**

⇒ **100% of complexes will maintain acceptable scoring on internal/external reviews.\***

No complexes were reviewed in the reporting quarter. As indicated below, overall performance in External Reviews for the year showed continued improvement from previous years as 100% of complexes are meeting the performance target. Effective July 1, 2009, Internal/External Reviews will transition to General Support Services. As a result, this measure will no longer be reported.

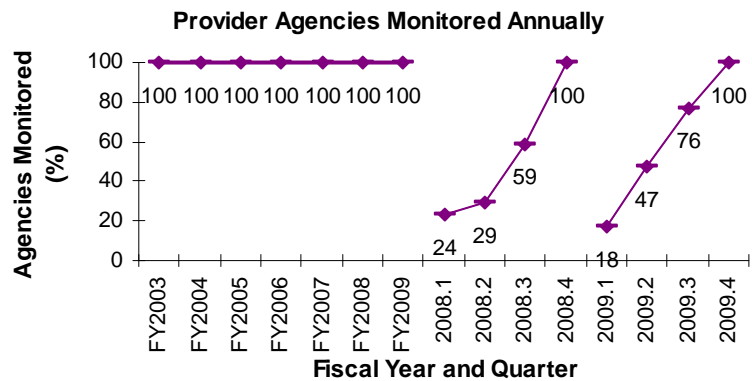


**Mental Health Services will be provided by an array of quality provider agencies**

**Goal:**

⇒ **100% of provider agencies are monitored annually.**

The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the quarter, all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Case-Based reviews were conducted for four agencies, representing nineteen contracts and seven levels of care in the fourth quarter. As the benchmark has been continuously met over the past fiscal years and this is an operational component of CAMHD’s Performance Management Office, this measure will no longer be reported on.

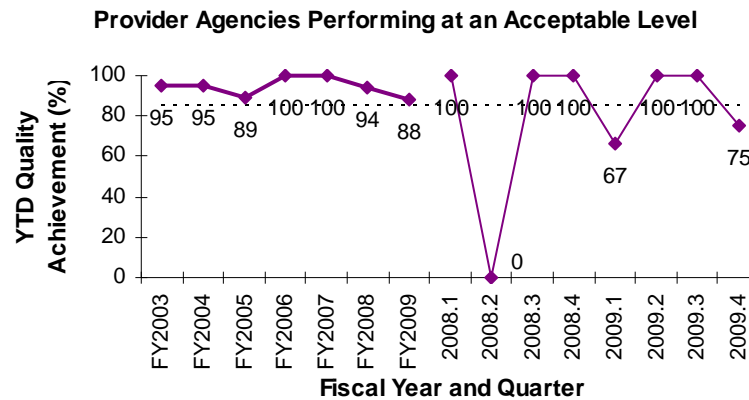


**Goal:**

⇒ **85% of provider agencies are rated as performing at an acceptable level.**

CAMHD monitors its contracted provider agencies across multiple dimensions of quality and effective practices. In the reporting quarter, three of the four provider agencies reviewed were determined to be performing at an acceptable level, which did not meet the performance goal for this measure. This is a decrease from the previous quarter in which 100% of the five agencies were found to be performing at an acceptable level. The programs that were not performing at an acceptable level are being closely monitored and remedial actions are being currently implemented and monitored.

For clarification purposes, in quarter two of fiscal year 2008 only one provider agency was monitored and they were found to have unacceptable performance. Corrective action plans were requested and have since been completed. The provider is currently performing at an acceptable level. A similar situation occurred in quarter one of this fiscal year, in which one of the three provider agencies was found to be performing at an unacceptable level. Improvement plans have been completed and the agency is being closely monitored.

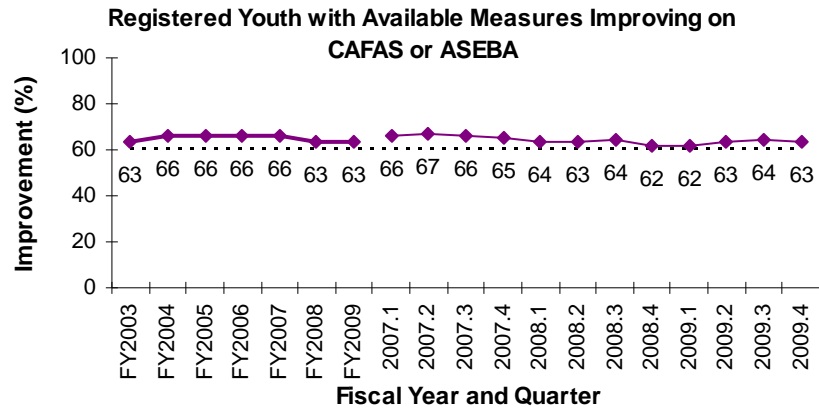


***CAMHD will demonstrate improvements in child status***

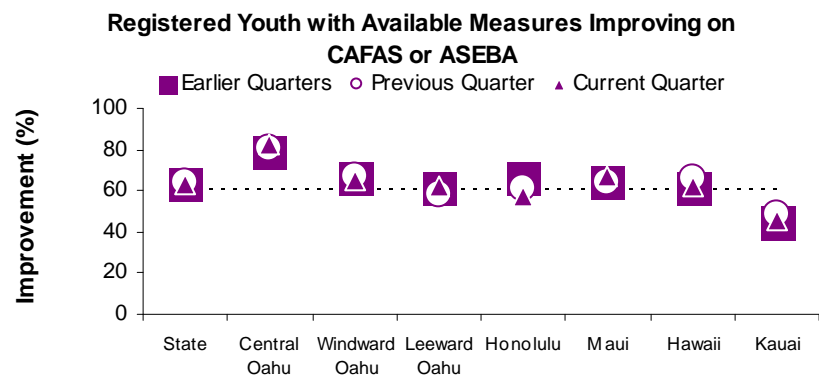
**Goal:**

⇒ **60% of youth sampled show 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).\***

To monitor performance of CAMHD’s goal of improving the functioning, competence and behavioral health of youth, care coordinators administer the CAFAS and/or ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.



In the reporting quarter, for youth with data for these measures, 63% showed improvements since entering the CAMHD system, which exceeds the performance goal. Child functioning demonstrated improvements from fiscal year 2002 to 2004, and plateaued with approximately two-thirds of youth showing improvement until last fiscal year. While the performance goal was met, there continues to be a concerning decline in child functioning for youth in the CAMHD system. There has been no increase from fiscal year 2008 to fiscal year 2009.



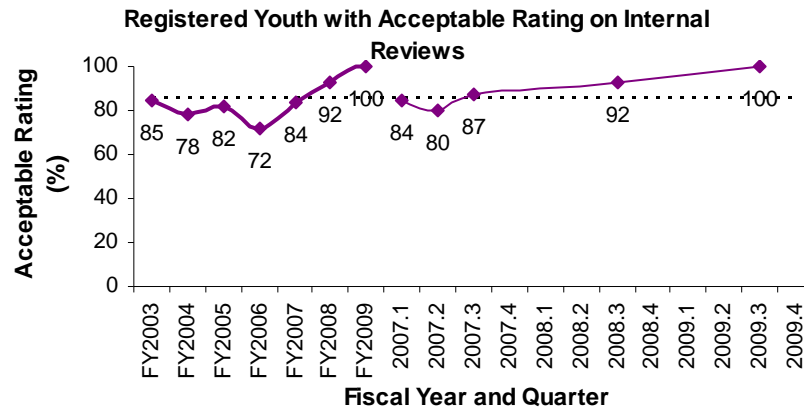
Almost all of the branches are performing near or above the state average with the exception of Honolulu and Kauai FGCs. Kauai has historically performed below the average. Kauai’s population differs from the other branches due to the Mokihana project, so the branch-to-branch results are not directly comparable. Windward Oahu, Honolulu, Hawaii, and Kauai’s performance decreased slightly from the previous quarter, while minor increases were experienced by Central Oahu, Leeward Oahu, and Maui.

**Goal:**

⇒ **85% of those with case-based reviews show acceptable child status.**

During fiscal year 2009, of youth receiving care coordination and services through CAMHD, 100% statewide were found to be doing acceptably well on measures of child well-being as measured through External Reviews, which met the performance goal for the year. Youth with unacceptable

child status or system performance are reviewed by the respective FGC clinical teams. Effective July 1, 2009, Internal/External Reviews will transition to General Support Services. As a result, this measure will no longer be reported.



**Families will be engaged as partners in the planning process**

**Goal:**

⇒ **85% of families surveyed report satisfaction with CAMHD services.**

CAMHD has historically conducted an annual consumer survey in the Spring of each year. This year, the survey has been contracted to SMS Research Group, a professional and independent survey company. Results from the survey are usually reported during the fourth quarter of the fiscal year, but data collection this Spring ran later than usual. Therefore, new data are not available for the current report.

The comprehensive report of the most recent results is posted on the CAMHD website at:

<http://hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/index.html>

**There will be a statewide community-based infrastructure to ensure quality service delivery in all communities**

**Goal:**

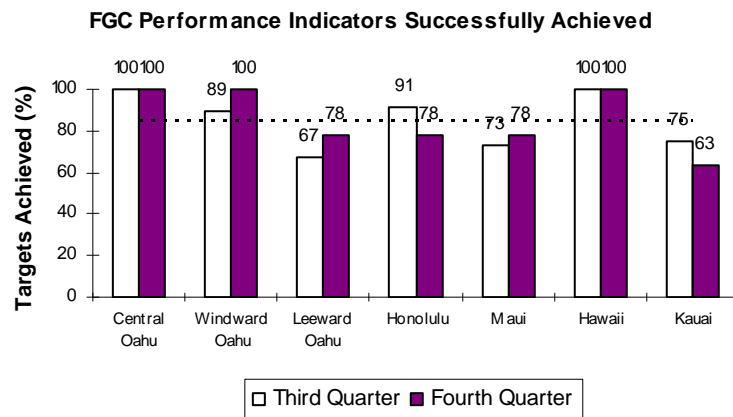
⇒ **85% of performance indicators are met for each Family Guidance Center\*.**

Among the CAMHD Branches, Central Oahu, Windward Oahu, and Hawaii Family Guidance Centers met their performance goals this quarter.

This indicator has been reconfigured to exclude reporting on the Family Court Liaison Branch (FCLB), which provides direct care and some case management services to youth who are incarcerated at the Hawaii Youth Correctional Facility or detained at the Oahu Detention Center. Due to its unique configuration, the FCLB is generally only evaluated for two indicators: expenditures within budget and percent of youth showing improvement on the CAFAS or ASEBA. As results were highly variable and not directly comparable to other branches, other means of reporting on performance of the FCLB are being developed.

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, grievances, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction.

Across all branches, 85.3% of all goals were met in the quarter, compared to 85.0% (excluding FCLB) in the last quarter, and 74.5% (inclusive of FLCB) over the same period last year. This trend showed improvement over previous quarters and met the performance goal.



Windward Oahu, Leeward Oahu, and Maui showed improvements, but only Central Oahu, Windward Oahu, and Hawaii met their goals. Central Oahu and Hawaii remained the same from the previous quarter, while Honolulu and Kauai FGCs experienced declines.

The branches did well on indicators of:

- documented complaints from consumers,
- serving youth in the State,
- timeliness of Coordinated Service Plans, and
- quality of Coordinated Service Plans.

One or two branches did not meet goals for:

- average caseloads,
- serving youth while they are living at home,
- youth showing improvements as measured by the CAFAS or ASEBA, and
- completing the CAFAS or ASEBA.

Several branches did not meet the goal for:

- filling care coordinator positions.
  - This has been impacted by the state budgetary situation.

The following indicators were not applicable for the reporting quarter:

- maintaining acceptable scoring on Internal Reviews,
- youth with acceptable child well-being in Internal Reviews, and
- service system satisfaction.
  - Data collection this Spring ran later than usual. Therefore, new data are not available for the current report.

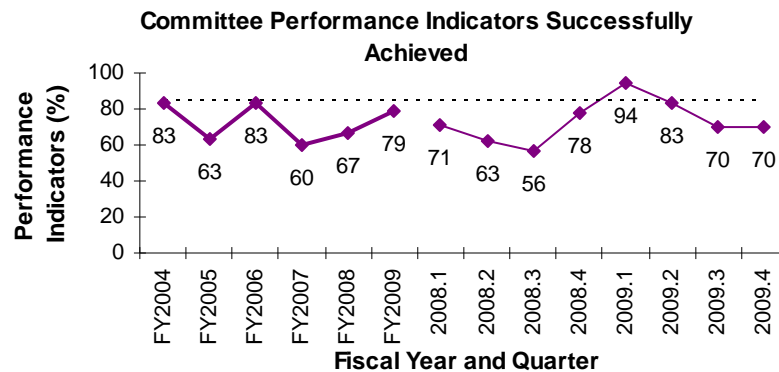
Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC Internal Quality Assurance Committee, and reported up through the CAMHD Quality Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

***There will be state-level quality performance that ensures effective infrastructure to support the system***

**Goal:**

⇒ **85% of CAMHD State Committees performance measures will be met.**

The CAMHD Quality Steering Committee (QSC) reviews quality issues and data reports from the following committees: Compliance, Safety & Risk Management, Grievance & Appeals, Credentialing, Evidence Based Services, and Utilization Management.



Currently, there are a total of 16 measures being tracked and reported. Results for each indicator are discussed in order to identify improvement strategies to be implemented under the leadership of respective CAMHD managers.

In the quarter, of the 10 measures with available data, 70% were successfully achieved through the work of the CAMHD Committees. Six measures did not have data available.

This quarter’s result does not meet the goal and it is the same as last quarter’s performance of 70% of measures met. There were two Credentialing measures and one Safety and Risk Management measure not meeting the benchmark. Committees not meeting their benchmark will present improvement strategies to the QSC.

## Summary

Sixty-five percent of performance goal benchmarks were met or exceeded in the fourth quarter of fiscal year 2009 (April 2009-June 2009), which is a decline over last quarter's overall performance of 72%.

For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "Sustainability" measures, all indicators met the performance goal in the reporting quarter with the exception of the following measures:

- Filled Care Coordinator Positions, which was 6% below targeted performance and the same as last quarter's result.
- Filled Central Administration Positions, which was 8% below the targeted performance goal, but a 2% increase over last quarter's performance.

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received\*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance\*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii\*
- CAMHD-enrolled youth receiving treatment while living in their home
- Coordinated Service Plan timeliness\*
- Coordinated Service Plan quality\*
- Performance Indicators met by the Central Family Guidance Center
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Monitoring of provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA\*

The following measures were below targeted performance, and will require implementation of improvement strategies developed by the appropriate monitoring bodies:

- Filled Care Coordinator positions\*
- Filled Central Administration positions\*
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Quality service provision by provider agencies
- State Committee performance indicators

The following measures were not completed this quarter, as they were not applicable for reporting. The satisfaction survey is an annual reporting indicator, which is usually reported during the fourth quarter. Due to data collection this Spring running later than usual, new data are not available for the current report. No Internal/External Reviews were conducted in the quarter.

- Complexes maintaining acceptable scoring on Internal Reviews\*
- Child Status as measured by Internal Review Results
- Overall satisfaction with services

Of the 26 performance measures completed during this quarter, 15 or 65% met or exceeded goals. This is a decline over last quarter's performance, but an improvement over the previous quarter's performance.

CAMHD seeks active collaboration on strategies for improvement that will allow Hawaii to provide quality and effective services for the children and families it serves.