ATTACHMENT A:
TARGETED TECHNICAL ASSISTANCE
PROJECT OVERVIEW

INTRODUCTION

There is much confusion about the targeted technical assistance project and as a consequence misstatements and misleading information is accepted as evidence of an improperly conceived or implemented effort. The reality is far from that. The targeted technical assistance initiative was much needed, properly conceived and openly developed. As the evidence demonstrates, it was an effective contributor to the efforts at implementing school-based and educationally oriented models of service delivery as well as progress towards compliance under the Felix Consent Decree. Unfortunately, without a clear understanding of exactly what was done and why. Many of the misstatements and selectively presented testimony prohibit careful or thoughtful examination. They must per force be accepted and in doing so, further the misperceptions.

Presented here is a brief overview of the whole of the initiative, its purpose, the manner in which it was conceived and organized, the history of its development, the reasons for choices made in doing so as well as its implementation and impact. There's no effort made here to rebut each or all of the misstatements, incomplete statements, insinuations or innuendoes. Rather, this description is intended only to provide a complete and accurate portrayal of the targeted technical assistance project.

1. What is the Targeted Technical Assistance initiative?

The targeted technical assistance (TTA) initiative was conceived as an effort to assist schools by providing an external technical assistance resource to complexes to aid in the planning for the transition to school based delivery of mental health services as well as preparation for service testing and compliance. It was observed in the winter and spring of 2000 that the State had long made a habit of instructing schools to plan for some transition and then left them all on their own to do so.

Two problems plagued such an approach that the TTA project was designed to address. First, many schools and complexes lacked the technical expertise to plan the transition to school based services necessary for compliance under service testing. The TTA was intended to provide such expertise and to create a bridge between the schools and other sources of relevant knowledge and information. Second, most school personnel did not have the time to plan, given the press of many other responsibilities and obligations. Even the simple logistics of planning (e.g. gathering information on possible designs and solutions; drafting options for consideration by school staff; drafting final plans based on decisions made by school staff; and organizing for implementation) were more than school staff could find the time to do well. These simple facts were reflected in the quality of planning as well as the lack of success of many complexes in achieving compliance.

The TTA project was intended to recruit and retain on a fixed short-term basis a number (as many as 15) of qualified individuals who could draw upon their education and experience as well as training and information provided by the Department to assist complexes with their "final push" towards compliance. A large number of individuals were sought because the TTA

project would put an individual in each complex on nearly a full-time basis to facilitate, inform, and materially support planning and implementation of the final requirements for compliance.

2. What is the relationship between the targeted technical assistance initiative and the Court's Orders to the State as of July 2000?

In June 2000, the State was found in contempt of court for not having completed all of what was required (full compliance for all complexes) by the original deadline of June 30, 2000. The Court was, however, impressed with recent progress: success in the schools, the quality of the plans, and the seriousness of effort in addressing them. As a result, instead of imposing punitive measures, the Court issued orders giving detailed instructions of what was to be done month by month over the next year and a half. Included amongst those orders were two contracts: the first for recruiting services to secure qualified teachers and other support professionals, and the second for contracts to provide targeted technical assistance to 15 complexes identified as having the greatest difficulty coming into compliance. These contracts were to be entered into by a date specified in the Orders, a date early enough that the contracts could not possibly be enacted under existing procurement law, a date which required, therefore, the State to move outside those procedures to enact the contracts. The TTA initiative then was ordered by the Court and the State was required to do so on a timeline that necessitated setting aside the usual procurement bid procedures. In its order, the Court provided the authority to do so.

3. Why contract outside for the TTA project?

We sought to contract outside the department for these technical services for two simple reasons. First, given the number of individuals required (as many as 15 serving at any one time), most with advanced degrees at the Masters and even Doctoral levels, there was no way that the system could mount the effort internally. We could not dedicate that level of resource without greatly debilitating the student support services unit and leaving it unable to address its already extensive workload. Frankly, the system already had too long a track record of promising to deliver without additional resource or outside support and then proving unable to do so. The suggestion that it is a sign of weakness to seek outside assistance is a trap that had time and again created the conditions for failure within the department. The second reason for going outside for the TTA services is even simpler. It is not work that would continue indefinitely. Therefore, it is not an in-house capacity that the system needed to have and maintain. Since it is work that was to be accomplished and finished, it is a service that the system should purchase, be done with, and move on from.

4. How was the project structured and why?

The contract was let to Pacific Resources for Education and Learning (PREL) and they were joined in the coordination and direction of the TTA by a sub-contractor, the Hilo-based firm of Na Laukoa. PREL is a well established firm, with a staff of over 100 providing program implementation and technical assistance services to educational entities throughout the Pacific region. In its 10 years of existence, it has held numerous contracts from the federal government as well as Pacific entities, including the State of Hawai'i. It has served for all of that time as the regional laboratory for the Pacific area providing assistance to education agencies throughout the region.

This educational and consulting expertise and experience needed to be augmented by mental

and behavioral health perspectives as well. Na Laukoa has been providing behavioral health services to children on the Big Island (close to 300 in all with billings exceeding $4 million) for over five years. The staff of Na Laukoa is highly qualified and credentialed. Over 41% had advanced degrees in their fields, with almost 20% holding doctorates. Finally, Na Laukoa is fully accredited by the Commission for Accreditation of Rehabilitation Facilities (CARF), an independent credentialing agency based on the mainland that conducts a rigorous examination process including on-site visits.

PREL is responsible for providing contract management as well as programmatic expertise and brokering access to other technical assistance as needed. Na Laukoa was responsible for project coordination, logistics, and for the time that the project director was an employee there, project direction. The direct providers of consultation to the complexes, the technical assistance coordinators (TAC's), were hired on a contractual basis for a fixed time by PREL. It is they (within the structure outlined above) who provided the technical assistance support directly to the complexes. Just over 20 individuals were involved over the course of the year to maintain a staff of 15.

5. Who served as technical assistance coordinators and what were the qualifications of those who served?

The technical assistance coordinators (TAC's) were hired on a contractual basis to serve the complexes through the TTA initiative. They were all hired from outside by PREL, with DOE and DOH retaining the final approval of the appointments. There were 19 professionals who worked on this project in all. Five (or 26%) had doctorates and 11 (or 58%) had at least a master's degree. Fully 84% had advanced degrees, all of them in education, counseling, or related fields. It is worth nothing that more than a few of these individuals (9 or 47%) were highly enough thought of that they have since been hired by either the Department of Education or the Department of Health to assume significant roles in school-based services. One more has been hired by the Center for Disabilities Studies at the University of Hawai'i. We expect that this trend will continue, and this serves as validation of their qualifications and contributions above and beyond even their degrees and credentialing.

6. How was the project developed and the contract let?

The need for targeted technical assistance services became evident to DOE leadership and many involved in the court case as early as February and March of 2000. The superintendent discussed the broad outlines of such an initiative with Dr. Douglas Houck and others in the Department of Education as well as the court monitor, Dr. Ivor Groves.

Given the desire to develop and distribute capacity throughout the islands as well as the fact that a considerable number of the most difficult complexes were located there, a partner and resource on the Big Island was an attractive goal. Given the absence of organizations that provided educational development and technical assistance, providers of mental health services and support to schools were considered and one, Na Laukoa, emerged as a possibility. I checked their track record and reputation with leaders in the Department of Health as well as the Department of Education on the Big Island and learned that while they were by no means perfect, their track record was solid, delivery of services strong and they had grown over the years into a solid and promising provider. Their internal qualifications in terms of licensure and education of staff (see Question 3 above), in terms of track record and experience with service delivery, and in terms of independent accreditation means that they were, in fact, qualified.

The two meetings that I had with them convinced me that they understood the goals of the project and how to craft an action plan to achieve them.

At that earliest point, however, I was concerned about being the only individual making these judgments defining the work. Consequently, in April of 2000, I asked Dr. Douglas Houck to attend a meeting to review their planning, inspect their qualifications, and advise me as to whether or not they could do what we were asking. I urged him to speak independently and freely as I do so often. His assessment was that they were a well qualified and good choice for the initiative.

Throughout May 2000, Dr. Houck continued with the development of the design for the initiative. In June 2000, the individual who had emerged as a leader in the development, Dr Kimo Alameida, and other Na Laukoa staff met with Dr. Ivor Groves, again to give him the opportunity to review the developing initiative and judge the suitability of these individuals to manage the undertaking. He indicated general satisfaction with how things were developing while suggesting some concerns about the capacity of the organization to manage the logistics and sub contracting to the numerous TAC's, etc.

On June 28, the Court issued Orders describing detailed and very specific actions that the State must enact over the ensuing 18 months. Included amongst them was contracting with an independent agency to provide targeted technical assistance to the 15 complexes exhibiting the greatest difficulty in coming into compliance. The date by which the contract was required was August 15, so at that point, there was grossly insufficient time to execute the contract under the usual procurement procedures. Clearly, the normal procedures, including competitive bidding, could not permit the State to fulfill its obligation.

Because the special authorities confirmed by the Court were to be used to enact the contract, there was a desire to ensure that the judgments made were prudent ones. To that end, a presentation was made by Dr. Alameida and Na Laukoa staff to a panel of four individuals: Mr. Robert Golden, Director of Student Support Services; Dr. Douglas Houck, Director of Felix Compliance; Ms. Paula Yoshioka, Assistant Superintendent for Administrative Services; and Dr. Paul LeMahieu, Superintendent. That presentation was held on July 7, 2000. Not counting the Superintendent, two of those present recommended going forward and one, Mr. Golden, recommended against. In debriefing the presentation, it was decided that Ms. Yoshioka would follow-up on concerns regarding the administrative capacity of the organization, and Dr. LeMahieu would follow up with Mr. Golden regarding his concerns.

The feedback from Ms. Yoshioka's investigation was that there were individuals at Na Laukoa who easily had the technical expertise to contribute meaningfully and one, in particular, Dr. Kimo Alameida had the wherewithall to direct the effort. There were substantial questions about their ability to handle the logistics of so large an effort (sub-contracting to the TAC's, etc.) that would have to be addressed in some fashion. A follow-up discussion with Mr. Golden revealed two primary concerns. The first had to do with possible difficulty of some Na Laukoa staff to work well with school personnel given incidents in which some of them had been very challenging of DOE's efforts in addressing children's needs.

The second concern revealed a substantial difference in conceptual orientation on the TAC project. Mr. Golden sought to establish the technical assistance effort as an in-house undertaking, reporting that it suggested a lack of confidence in staff to contract outside. He proposed using the resources to support consultants from the mainland who had been working with the Department for several years. On this, there was a true disagreement -- but not one that

focused on issues of quality or qualification, but rather on fundamental approaches. The strength of the TAC project was the provision of a constant resource, one invested in and contributing to day-to-day planning and implementation. Outside consultants from the mainland could do no more than visit three to four times a year and this had not produced the changes needed previously nor was it likely to do so in the immediate future. The difference, then, was that between mainland consultants and the extent to which they can contribute to and enact change as opposed to a local resource that could work with the complexes on an intense, ongoing, day-to-day basis.

Having understood these objections as expressed, we took action to accommodate them. We persisted with the general concept as both very needed and preferable to the alternative suggested. At the same time we did recognize the limitations of the proposed contractor and sought to establish a partnership that would allow the effort to capitalize on what Na Laukoa had to offer while strengthening the effort with the involvement of a well-established, educationally focused consulting firm with the managerial capacity to oversee the program. Hence the involvement of PREL. Na Laukoa was in no way a condition of the contract, a fact corroborated by PREL leadership, verified by the press, and reported there many months ago. This new formulation was presented to the Court Monitor in early August for his comment and feedback. Very soon after that, on August 15, the contract was executed as ordered by the Court.

7. Is it possible that a personal relationship influenced the award of this contract?

It has been admitted publicly that a personal relationship grew as a result of working together on this effort. But it was not of a sort to interfere as of the time of this contracting. Even more to the point, precautions were taken to involve others in the judgments and the decision making. While not everyone was in agreement, the majority were: Na Laukoa was a qualified prospect, and they had developed a concept that was valid and much needed. The individual there who was to oversee it, Dr. Kimo Alameida was highly qualified and capable of directing the effort. The remaining TAC's were yet to be hired by PREL and would be approved by DoE and DoH staff. Finally, when the introduction to PREL was made, it was made clear that there was no requirement of Na Laukoa involvement, a fact that confirmed by PREL leadership in published interviews many months ago.

8. Has the effort been successful? How has the TTA performed?

Of course, the best measure of the contribution of the TTA effort is its success in support of achievement of compliance. The means of demonstrating compliance under the Felix Consent Decree is to score 85 percent or higher on both the School-Based Services Results and the Coordinated Services Results of the service testing process. The TTA focused on 15 complexes. Of those 15, ten have undergone service testing. Of those ten, seven passed service testing completely and three others passed one of the two portions, falling close on the other. In other words, the ten complexes tested have yielded seven complete successes and three partial successes. A closer examination of the numbers gives a further sense of the gains in those complexes. When compared to previous testing done (most of it in the 1994-95 timeframe), the TTA complexes that were service tested increased their performance by 28.8 percentage points. A comparison to all other complexes not receiving TTA support but service tested twice within the same timeframe shows that the comparison group increased their performance by 19 percentage points. The comparison again is 28.8 percentage points improvement in the TTA complexes compared to 19 percentage points in all others. In other words, the TTA complexes not only dramatically increased their performance, they did so significantly better than complexes not receiving TTA support. In three-fourths of the cases, they achieved compliance level

performance; in the remaining cases, they achieved partial compliance; in no case did they fail completely. This was in the 15 most challenged complexes in this state.

SUMMARY

In conclusion, the TTA project was a much needed, properly conceived initiative. As the data amply demonstrate, it was a highly effective form of assistance. To date, 70% of the complexes tested have passed the performance requirement for compliance, all of the others have made it at least halfway. That is in effect, seven wins, three ties, and no losses, all accomplished in the most challenging complexes in the State. While no one claims all the credit to the TTA effort, it was an important part of the success mixture, with everyone pulling together to get the job done. A $2.3 million investment realizing that kind of contribution and success represents a very wise investment, one which arguably should have been made some time ago.

ATTACHMENT B:
TARGETED TECHNICAL ASSISTANCE
PERFORMANCE OF PARTICIPATING COMPLEXES
(As of 9 November, 2001)

COMPLEX	COMPOSITE SCORE		OUTCOME	IMPROVEMENT
	INITIAL TESTING	FOLLOW-UP TESTING		
Aiea	57	94.5	Complete Pass	37.5
Kahuku	70	94.2	Complete Pass	24.2
Kaiser	65	100.0	Complete Pass	35.0
Kapolei	46	83.0	Part Pass	37.0
Ka'u	57	To be tested		
Kealakehe	39	To be tested		
King Kekaulike	42	To be tested		
Kohala	53	To be tested		
Konawaena	65	84.1	Part Pass	19.1
Leilehua	66	93.5	Complete Pass	27.5
Maui	68	90.0	Complete Pass	22.0
Mililani	63	97.1	Complete Pass	34.1
Moloka'i	28	To be tested		
Waialua	61	96.1	Complete Pass	35.1
Wai'anae	67	83.0	Part Pass	16.0

Summary of Performance for TTA:

- Of 10 complexes tested, 7 passed completely; 3 passed one of two parts
- 28.8 points increase between initial and follow-up testing

Summary of Performance Statewide (without TTA)

- 19.0 points increase between initial and follow-up testing

July 2001

Child and Adolescent Mental Health Division

Performance Monitoring Plan Overview

Impacting the Quality and Effectiveness of Children's Mental Health Services in Hawaii

Performance Management Section
Fiscal Year 2001-2002

Performance Management

Monitoring Contracted Provider Performance

Overall Approach to Monitoring

In January 2000, a Division-wide planning retreat was conducted to evaluate the Child and Adolescent Mental Health Division's monitoring of contracted service provision. Basic design and development questions were formulated. What resulted was a clear definition of the purpose of monitoring and an articulation of the Division's role in providing oversight for children's mental health services in the State of Hawaii.

CAMHD's mandate is to guarantee access to safe, humane, appropriate, and effective services and supports for each child and family served. In order to provide proper stewardship of State funds, CAMHD must continually demonstrate positive results through the work of the Family Guidance Centers and our contracted providers of service.

The overall purpose of performance management is to:

- Assess CAMHD staff practices and performance,
- Monitor provider practice and performance,
- Determine what's working and what is not,
- Stimulate changes in practice and results,
- Detect fraud, waste and abuse, and
- Demonstrate accountability.

Staging of reviews. CAMHD manages the performance of intensive mental healthservices, and demonstrates results for the children and families it serves. Because of the scope and scale of monitoring that needs to occur, approaches to monitoring need to be carefully selected based on their efficiencies and ability to maximize accountabilty for performance. Monitoring methodologies are designed to focus on key data that informs decisions in multiple arenas, as well as programmatic improvements.

Another key approach to the staging of reviews is that not all agencies need the same level or intensity of monitoring. That is, agencies with a demonstrated pattern of effective results will, in all likelihood, need a less intensive monitoring approach than those agencies where performance data indicates a need for more intensive oversight and improvements.

> *A key assumption of performance management is that performance and results need to be carefully measured. A second key assumption is that feedback needs to be offered in order to make changes.*

The overall scope of monitoring is as follows:

Level of Care	Number of Agencies
Biopsychosocial	10
Intensive In-home	21
Therapeutic Aides*	17
Outpatient*	21
Crisis	2
Therapeutic Foster Homes	8
Therapeutic Group Homes	8
Community-Based Residential	10
Partial-Hospitalization	1
Hospital-based Residential	2
Block-Grantees	3

Table. CAMHD Services

**The primary population who utilize Therapeutic Aide and Outpatient Services are youth with Autism Spectrum Disorders and Pervasive Developmental Disabilities. The services for this population will move to DOE oversight in July 2003.*

Monitoring Components

Key components of monitoring of any agency:

1. Determination of performance in fiscal audits and adherence to contract standards.
2. Assessment of previous profile and past performance data.
3. Assessing acceptability of credentialing files.
4. Determination of accreditation standing.
5. Assessment of adequacy of treatment processes, including how the agency monitors client progress and outcomes.
6. Analysis of complaints and sentinel event data.
7. Assessment of integrity of quality assurance and performance improvement processes, including internal utilization of performance data.
8. Assessment of quality of supervision practices.
9. Assessment of the training model and training plan used by the agency to improve and strengthen practice.
10. Assessment of adequacy of policies and procedures.
11. Process for resolving complaints and responding to questions from youth, families, and teams.
12. Overall experiences around family engagement and expectations for staff.
13. Performance in case-based reviews and outcome data.
14. Adequacy of responding to required corrective actions and calls for improvement.

In addition, residential programs are monitored for:

1. Adequacy of physical plant.
2. Licensing status.

Licensing Reviews

The Licensing Specialist conducts ongoing reviews of the programmatic component of therapeutic living programs (group homes) and special treatment facilities (community-based residential programs). A specific protocol is used -in reviewing all aspects of the program to maintain compliance with Hawaii Administrative Rules Chapter 11-98.1, and recommendations for licensing are submitted to the Office of Health Care Assurance.

Fiscal Reviews

Fiscal Reviews are conducted at least annually of each contracted provider to determine compliance with Contract Management Standards. Progress notes are crosswalked with billings to determine legitimacy of encounters. Providers are able to submit proof of documentation during the review process, or are able to appeal review findings to the Grievance and Appeals Committee. Overall finding of fiscal solvency should be sought from Administrative Services.

Credentialing Reviews

Credentialing audits are conducted under the supervision of the Credentialing Specialist, who provides an analysis of performance. Each agency is expected to maintain credentialing files in conformance with CAMHD Contract Management Standards and policies and procedures.

Utilization Reviews

Utilization reviews are conducted by the Utilization Review Specialist, who provides an overall analysis of performance in the area of utilization. Areas examined include census, population served, length of stay and outcomes. Trends and patterns are identified and tracked over time individually, by level of care and by FGC.

Physical Plant Reviews

The review team conducts on-site inspection of the physical plant. The physical plant must conform to the measures of a safe, clean and therapeutic environment.

Treatment Processes Reviews

Effectiveness of treatment process is generally determined through case-based reviews. Identified agencies will implement a specific treatment processes/treatment plan audit tool, and data will be submitted per requirements of Individualized Monitoring Plans

Case-Based Reviews

Context-specific protocols are utilized to determine current child status across key indicators of well-being, and performance of key programmatic functions. Findings are used to inform overall program performance, and aggregate data is used to determine performance levels.

Outcome Data

The CAMHMIS outcome module tracks specific indicators of child functional outcomes for all children served by CAMHD. As well, coordinated services review data is tracked for all children reviewed in complex service testing. Both sources of performance data can be accessed and analyzed by provider agency through CR numbers.

Family Guidance Center Report on Provider Performance

Family Guidance Centers experience provider agency performance at the level of the transactions. Prior to each review, an analysis of Family Guidance Center findings is conducted using a designated set of survey questions and addresses:

- Complaints from the provider agency or individual
- All responses to complaints
- Provider participation in Coordinated Service Plans and Treatment team meetings.
- Provider and FGC collaboration activities
- Provider staff submission of reports to Mental Health Care Coordinators
- Information on staff competency and child-specific progress/outcomes

Administrative Reviews

Administrative reviews are performed by the CAMHD Performance Monitoring section. They include an analysis of the information provided from all of the review areas mentioned above. Stakeholder interviews are also included for agency reviews. Stakeholders may include CAMHD section staff, provider staff, parents and community representatives.

When indicated by concerns raised in other review areas, the Administrative review may include identifying targeted areas to examine more closely. An example would be concerns raised by the Fiscal review may prompt a review of a sample of client records to examine quality of documentation or targeted utilization review as to appropriateness of length of stay.

Provider Reporting

Providers are mandated to report on a full range of activities including occurrences of incidents and sentinel events, weekly census including length of stay, status of quality assurance activities, and child progress.

Readiness Reviews

Readiness reviews are conducted prior to the opening of any new program with the emphasis on the opening of residential programs. Reviews comprise of full review of licensing requirements, facilities check, review of trainings conducted, supervision structures, policies and procedures, staffing commitments and overall programmatic/ administrative capacity.

Self-Assessment by Providers

A self-assessment, information gathering tool is collected from each agency and individual provider of services. The agency is assessed across dimensions of:

- Quality of supervision, training and oversight,
- How child progress is measured,
- Measures to assure no fraud or abuse,
- How communication is managed within the program,
- How performance improvements are conducted, and
- The process for resolving complaints

The assessment will be mailed back to CAMHD and screened for the following:

- Adequacy in each of the assessment areas
- Needs for enhancements/corrections

Feedback will then be provided to the agency and any needed improvements in the measured areas will be requested. A database will be developed to capture the status of the measured areas, and a profile will be developed for each agency. Additional information that informs the profile is:

1. Accreditation status
2. Fiscal solvency determination
3. Credentialing status
4. Complaints and sentinel events data
5. Input from family guidance centers
6. Service Testing findings
7. Satisfaction data.

8. Submitted performance data.

The agency is then rated for a determination of overall status.

Monitoring Individual Providers

Each individual provider will be monitored to assess the quality of care and treatment to CAMHD clients within that provider's caseload.

Monitoring Higher Levels of Care

Establishing a Baseline

A team leader is responsible for gathering specific data about the program. Baselines will be determined through the assessment of all current data, as well as performance in initial reviews.

Determining Review Level

Level One Review

The agency is assessed to be performing at 80% or better in case-based review findings (Overall Agency Performance), and has an acceptable performance in key performance data areas. The agency is accredited and has no egregious findings in complaints, sentinel events, or fiscal/contract management audits. The agency has an acceptable system for measuring quality and actively engages in ongoing performance improvement activities, including periodic internal case-base reviews of small samples of youth. The program has demonstrated outcomes over time. Monitoring will consist of submittal of required performance data, continued monitoring of sentinel events and complaints and a periodic case based review.

Level Two Review

The agency is performing in the 65%-79% ranges in the case-based reviews for Overall Agency Performance, and needs to implement improvements in order to perform consistently. Case-based reviews will be conducted semi-annually to determine progress on their Improvement Plan and identify needed areas for continued improvement. Implementation of specific improvements and corrective actions will be monitored.

Level Three Review

The agency is performing below 65% in the case-based reviews in Overall Agency Performance. There is an acceptable pattern of performance in the areas of complaints and sentinel events. Physical plant may need improvements. There is a poorly functioning system of quality assurance and/or supervision functions. Monitoring may consist of any or all of the

following: intensive on-site monitoring, frequent case-based reviews, specific deliverables, contract modifications or action.

Data to be Gathered for each Review

Reference above plus Improvement Plan "probe" areas

Monitoring Tools

Case-based protocols will be used to review programs that provide the following services:

- Intensive home and community-based
- Therapeutic foster homes
- Therapeutic group homes
- Community-based residential
- Sub-acute Inpatient Hospitalization Services
- Autism Programs

Developing an Individualized Monitoring Plan

Once baseline data is gathered, analysis of performance is conducted, and key strengths and needed corrective actions are determined, the agency will be engaged to address areas of concern. When a corrective action plan is submitted and accepted, a monitoring plan designating specific deliverables and how on-site monitoring will occur is implemented.

Department of Justice (CARS) Monitoring

The Child and Adolescent Residential Services agencies (Kahi Mohala and Queen's Family Treatment Center) will be monitored, at a minimum, according to the terms of the Settlement Agreement and any subsequent stipulations.

Reports

Determination of Corrective Actions

Review team provides synthesis of findings of the review. See Individualized Monitoring Plan above.

Creating a Report

Report components will include a synopsis, including analysis and determination of acceptable performance, in each of the areas of monitoring. Key programmatic strengths, issues and concerns are determined through team debriefing and overall analysis of findings. The team leader and Provider Monitoring Supervisor determine strategic recommendations.

Providing Feedback to Agencies

Within 45 days of a monitoring review, a completed report and transmittal letter outlining overall agency status, as well as required corrective actions will be conveyed to the agency. Specific expectations must be clearly communicated, and format for improvement activities must be attached. If indicated, the team leader, the Provider Monitoring Supervisor and thePerformance Manager Supervisor will meet with the agency to explain findings and define improvement activities.

Brokering of Technical Assistance

Occasionally, CAMHD will use internal resources targeted at specific programmatic improvements. The team leader will consult with the Performance Monitoring Supervisor to address technical assistance needs.

Monitoring of Performance Data and Corrective Actions

The team leader will, for most agencies, be the ongoing monitor for tracking corrective action deliverables and overall progress of the agency's improvement processes. The team leader will be responsible for scheduling any needed site visits or subsequent reviews. They will be the single point of contact for agency inquiries regarding performance and requirements.

Adjusting of Individualized Monitoring Plan

The individualized monitoring plan will need to be adjusted as improvements are realized. The team leader is responsible for negotiating adjustments, revisions, or completion of plans.

Performance Management

Monitoring Family Guidance Center Performance

Introduction

The primary responsibility for monitoring of Family Guidance Centers rests with each FGC Quality Assurance Specialist and its Management Team. The Branch Chief makes quarterly presentations to stakeholders comprising of a multi-faceted report on current performance. As well, the Central Office monitors data on an ongoing basis, including utilization, status of Coordinated Service Plans (compliance with 100% benchmark and quality indicators), involvement of Child Protective Services and Family Court Probation Officers in planning, referrals to SSI, QUEST compliance, service testing data and analysis, and supervision structure implementation.

Measurement Components

Chart Audits.

- The FGC Quality Assurance Committee determines the internal process for monthly chart audits. FGC charts are audited using a consistent review tool that incorporates MedQuest and CAMHD record content requirements. Charts are audited for quality content as well as compliance. The FGC Quality Assurance Specialists gather, summarize, analyze and report on findings to the FGC QA Committee. The QAS tracks trends and patterns related to data over time. Recommendations are included in the FGC annual Quality Assurance Improvement Plan.

Self-assessment.

- The FGC conducts periodic self-assessments of its performance and practice. The management team identifies improvement areas and develops strategies that support practice development at all levels. Implementation, monitoring, evaluation and adapting are ongoing activities and are reflected in FGC plans, activities and daily practice.

Utilization Review.

- The FGC is responsible for ensuring that youth it serves are receiving services that are appropriate and reflect the CASSP principles. MHCCs review individual cases with their supervisors and examine length of stay,

discharge plans and as appropriate transition to a less restrictive environment (LRE).

Coordinated Service Plan Reviews.

- FGC QASs review all Coordinated Service Plans (CSP) using an audit tool that looks at areas of participation, use of appropriate supports, crisis and transition plans, and individualization for each youth. Quarterly data is collected and reported to the FGC Management Team and CAMHD. The QAS identifies trends, patterns and issues and works with the FGC Mentor to identify training needs.

Supervision Processes Reviews.

- The FGC Mental Health Supervisors provide individual and group supervision on a regular basis to MHCCs. The FGC Clinical Director participates in case review and offers clinical guidance and direction as well. The MHS and MHCC use the Case Assessment tool to review cases. The MHS and MHCC jointly develop an Individual Supervision Plan (ISP) that identifies strength and challenge areas. Quarterly reviews are conducted to update the plan.

Satisfaction and Performance/Outcome Data.

- FGC MHCCs submit client outcome data using the Achenbach, CAFAS and CALOCUS on a quarterly basis. Client satisfaction data is also entered into CAMHMIS. The FGC may also conduct independent client satisfaction surveys. Reports are used by the FGC Management Team to identify areas of progress and challenges and improve performance.

Case-based Reviews.

- The FGC, with the assistance of CAMHD Performance Monitoring staff may conduct child specific reviews in order to address complaints or safety concerns; to evaluate child status and/or system performance where concerns have been raised. Reports are used by the FGC Clinical and Management Teams to improve performance; address child specific concerns and promote best practice initiatives.

Reports and Feedback

Quarterly Presentations

- The FGC Branch Chief makes quarterly presentations to key community stakeholders that includes demographics of the FGC and population served, outcome data for youth served, FGC initiatives directed at improved practice, family engagement and partner collaboration. The presentation includes identification of trends and patterns as data is tracked over time.

Targeted Reviews

- When targeted reviews are conducted, the review team meets with key FGC staff to debrief each case, identify what is working, present areas of concern and provide recommendations for next steps. Follow up meetings are scheduled as appropriate.

Coordinated Services Reviews

- The FGC participates in all Coordinated Services Reviews of youth they serve. Reviews are conducted at the school complex level, using a team approach. The CSR evaluates child status and system performance. The FGC QAS and other staff are trained in the process and participate as appropriate.

Complex Service Testing Results and Content Analysis

- The FGC QAS participates in the debriefing session for all complexes served by the FGC. The QAS listens for trends and patterns in the areas of Complex and FGC strengths and challenges. The QAS then debriefs the FGC complex team on the preliminary findings. Upon receipt by CAMHD Performance Monitoring section of all narrative reports and roll-up sheets, the QAS conducts a content analysis at the CAMHD offices. The QAS reviews and summarizes all key issues, strengths and recommendations. The QAS presents findings to the FGC complex team and coordinates with the Complex Quality Assurance Team on developing an improvement plan and compliance presentation.

Interagency Quality Support Plans.

IQSPs are required of each school-complex and determine the interagency process for maintaining acceptable status on key indicators of system performance. See policy on IQSPs.

Performance Improvement Plan and Processes.

The QAS in collaboration with the FGC management Team develops a FGC Quality Assurance Plan that is updated annually. Components of that plan include complex specific plans, supervision, training, internal QA practices and review processes.

Each Family Guidance Center also tracks trend data on selected performance measures, and submits improvement plans targeted at improving quality in specific areas. Quarterly reports are provided on progress.

BENJAMIN J. CAYETANO
[redacted]
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D., M.P.H.
[redacted]
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

01 NOV 29 A8:57

HONOLULU HI

In reply, please refer to:
File:

November 27, 2001

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawai'I 96813-2917

Dear Ms. Higa:

Re: Child and Adolescent Mental Health Division (CAMHD) Provider

Enclosed, please find the "*Investigation of Statements by Marion Higa Regarding Allegations of Fraudulent Billing by CAMHD Provider.*"

Thank you for the opportunity to provide our information.

Please call me at 586-4410 or Anita Swanson, Deputy Director for Behavioral Health, at 586-4416 if you have any questions.

Sincerely,

Bruce S. Anderson, Ph.D., M.P.H.
Director of Health

DWM:mt

Enclosure

c: Chief, CAMHD

NOV 29

Child & Adolescent Mental Health Division
Department of Health

Investigation of Statements by Marion Higa
Regarding Allegations of Fraudulent Billing by CAMHD Provider

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During the Legislative Auditor's testimony to the Felix Legislative Investigative Committee on November 16, 2001 she identified that there was a clinician that billed the Department of Health (DOH), Child & Adolescent Mental Health Division (CAMHD) for 127 hours in one day. She went on to state that one therapist had billed 1765 hours or $60,000 in one month and in particular in one day 7 hours of individual therapy, 5 hours of group therapy and 115 hours of BPSR. Although the Committee's legal transcript has not yet been made available, our best memory of the Legislative Auditor's comments were in relation to her recommendations that the Department needed to develop a system to assure accountability.

A statement such as this in a public forum came as a surprise to the Department, as CAMHD staff had been working with staff of the Legislative Auditor's Office in recent months to specifically address these types of concerns. It is unusual that the Auditor's Office did not previously ask CAMHD to explain this specific situation. Since Ms. Higa's testimony, CAMHD staff had clarified the exact date and clinician mentioned by the Auditor. CAMHD had previously conducted an investigation of the billings by this clinician on this specific date and provides the following information about our findings.

History of the Agency

The agency that this clinician was subcontracted with was Child & Adolescent Resources for Education, Inc. (CARE). The CAMHD contract with this agency was effective July 1, 1999. August 1999 was the agency's second month of billing in accordance with CAMHD electronic billing requirement. The date of the alleged fraudulent billing, per Ms. Higa's office, was August 11, 1999.

During the month of August 1999, CARE provided a biopsychosocial rehabilitation (BPSR) program for children with Autism Spectrum Disorder. This program operated for 9 hours a day during that month. This was a month when school was not in session, so it would not be considered unusual to see a program of this type and duration during this time.

Review of August 11, 1999 billing

The specific clinician, DA5193, invoiced CAMHD – via CARE – for 127 billable hours on August 11, 1999. (See Attachment A – DA5193 Billing).

Details of that day's billing are as follows:

NAME OF SERVICE	LEVEL OF CARE	HOURS
Individual Therapy	7101	7 hours
Group Therapy	7102	5 hours
Therapeutic Aide – Level 3	15301	9 hours
BPSR	16101/201/301	106 hours
	TOTAL	127 hours

Previous Actions Taken by CAMHD

In January 2000, CAMHD conducted a review of this clinician's billing. The CAMHD reviewers identified concerns about the billing practice of this clinician and therefore, CAMHD sought corrective action from CARE (see Attachment B – Letter to Tina McLaughlin).

CARE investigated the billing of this clinician and provided CAMHD a response letter in March 2000 (see Attachment C – CARE's response letter to CAMHD).

CAMHD accepted CARE's corrective action letter at that time. CARE refunded CAMHD a total of $4189.88 for the billing errors detected at that time.

Explanation of August 11, 1999 Billing

The majority of the billing hours are for BPSR, level of care 16. The sub-levels of care within BPSR (evident as 16101, 16201, 16301) are levels of acuity for a specific child. (See Attachment D – CAMHD Clinical standards for this level of care).

1. There were 12 children with Autism Spectrum Disorder in the program. The program was in operation for 9 hours (8am – 5pm). The majority of children attended for 9 hours; however, a few attended for 8 hours. These 12 children attending for 8-9 hours results in the 106 hours billing for BPSR for that day. As previously explained, BPSR billing is completed under the leading clinician's billing code number. Therefore, clinician DA5193 had appropriately billed for these 106 hours.

2. Clinician DA5193 billed for individual therapy during the BPSR. This was acknowledged to be an error by CARE. As identified in Dr. McLaughlin's March 2000 letter, CARE acknowledged this error and reimbursed CAMHD.

3. Clinician DA5193 billed for therapeutic aide – level 3 services. As identified in Dr. McLaughlin's March 2000 letter, CARE acknowledged this billing error and reimbursed to CAMHD.

4. Clinician DA5193 billed for 5 hours of group therapy. There were 4 youth involved in group therapy on the identified date. One group was 1 ½ hours for 2 youth. One group was 1 hour for 2 youth. This was provided as a break out of the BPSR program. For children with Autistic Spectrum disorders, such groups would be used for specific skill building including targeted work on socialization and feedback reinforcement.

CONCLUSION

CAMHD conducted a review of the identified clinician's billing in January 2000. CAMHD issued a letter to the contracted provider agency in the same month. The contracted agency, CARE, provided a response letter to CAMHD's concerns in March 2000. CARE provided reimbursement to the state for those services that had been inappropriately billed.

CAMHD continues to review clinician billing. CAMHD is currently developing mechanisms for more regular and routine auditing of clinician billings. CAMHD is committed to providing appropriate fiscal oversight of contracted agencies billings.

In the particular case identified by the Legislative Auditor, there certainly were errors made in the billing process. However, CARE was a new agency at that time, and there were new requirements for electronic billing. CAMHD did not consider it unusual that some errors were made in the first few months of this billing process. These errors were pointed out to the agency and the agency took appropriate corrective action. All identified errors in billing were remedied through the reimbursement of funds in March 2000. While we are not denying the billings occurred, CAMHD provided oversight, investigation, and remediation of the occurrences, as evidenced in this review and attached correspondences.

Accepted Records FY 00 as of (11/2/00)

CLINICIAN	MonthYear	SERVICEDATE	SERVICECODE	Units	Hours	Total Cost
DA5193	199908	8/11/99	7101	84	7	630
DA5193	199908	8/11/99	7102	60	5	175.2
DA5193	199908	8/11/99	15301	108	9	261.36
DA5193	199908	8/11/99	16101	324	27	272.16
DA5193	199908	8/11/99	16201	327	27.25	408.75
DA5193	199908	8/11/99	16301	621	51.75	2074.14

9
8.625

Attachment "A"

Accepted Records FY 00 as of (11/2/00)

CLINICIAN	MonthYear	Date	Code	Units	Hours	Total Cost	CRNO	LASTNAME	FIRSTNAME	CTR
DA5193	199908	8/11/99	7101	12	1	90				
DA5193	199908	8/11/99	7101	24	2	180				
DA5193	199908	8/11/99	7101	12	1	90				
DA5193	199908	8/11/99	7101	12	1	90				
DA5193	199908	8/11/99	7101	12	1	90				
DA5193	199908	8/11/99	7101	12	1	90				
DA5193	199908	8/11/99	7102	12	1	35.04				
DA5193	199908	8/11/99	7102	12	1	35.04				
DA5193	199908	8/11/99	7102	18	1.5	52.56				
DA5193	199908	8/11/99	7102	18	1.5	52.56				
DA5193	199908	8/11/99	15301	108	9	261.36				
DA5193	199908	8/11/99	16101	108	9	90.72				
DA5193	199908	8/11/99	16101	108	9	90.72				
DA5193	199908	8/11/99	16101	108	9	90.72				
DA5193	199908	8/11/99	16201	108	9	135				
DA5193	199908	8/11/99	16201	108	9	135				
DA5193	199908	8/11/99	16201	111	9.25	138.75				
DA5193	199908	8/11/99	16301	96	8	320.64				
DA5193	199908	8/11/99	16301	96	8	320.64				
DA5193	199908	8/11/99	16301	108	9	360.72				
DA5193	199908	8/11/99	16301	111	9.25	370.74				
DA5193	199908	8/11/99	16301	99	8.25	330.66				
DA5193	199908	8/11/99	16301	111	9.25	370.74				
				1524	127	3821.61				

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVENUE, ROOM 101
HONOLULU, HAWAII 96816

In reply, please refer to
File

January 30, 2000

Tina McLaughlin, Ph.D.
Child and Adolescent Resources for Education
677 Ala Moana Blvd., Suite 1003
Honolulu, Hawaii 96813

Subject: Provider Review and Request for Reports

Dear Dr. McLaughlin:

The purpose of this communication is to notify your agency that during routine internal review of provider reimbursement processes, some discrepancies surfaced in a vast majority of claims billed, and paid, for . who is contracted provider with Child and Adolescent Resources for Education (CARE).

For example, the total billing for August 1999 amounted to 1301.33 hours and as submitted for 25 of the 31 days in the month. Thus, the average billing was slightly more than 52 hours per day. During this same time period, the clients were enrolled in your Biopsychosocial Rehabilitation Service (BPRS), and additional claims were received for individual and group services. By contract, these services are inclusive of the BPRS. The provider also billed for Therapeutic Aide Level III Service (15301) on five different occasions.

If these numbers are correct, we are concerned about the high volume of visits provided, the possibility of inadvertent duplicate billings and contractual compliance with regards to service and levels of care. If they are in error, we question the provider's billing practice and your agency's internal control to ensure appropriate claims processing. Under the Quality Assurance Terms of our contract, please investigate the items detailed below and provide us with a written report within **thirty calendar days.**

We request that your report take the following format for the months of **July through December, 1999**: For each month, the provider reports should be separated by the day of the month. Indicate the name of the child service was provided to, date of service, place of service/service code, begin and end time of each service and total time of hour(s) provided.on each day. An example of the report is below:

Client Name	Service Date	POS, Service Code	Begin Time	End Time	Hours Provided
Jane Doe	09/01/99	School, 07101	9:00 am	10:00 am	1
John Doe	09/01/99	Private Office, 12102	10:00 am	11:00 am	1

ATTACHMENT "B"

The reports may be mailed to my attention. If over billing occurred, please enclose a reimbursement check with your report and an assessment of the provider's fitness to continue as a member of your network.

It is our intent to work collaboratively with your agency, but to reiterate, we are very concerned about the matters mentioned above. Thank you in advance for your cooperation with this request and please feel free to contact me if I can be of assistance, or if you have additional questions.

Sincerely,

Dawn Mendiola
Provider Relations Officer

Cc: Clinical Service Office
Performance Management Office
Fiscal Office
Contract File

CHILD AND ADOLESCENT RESOURCES FOR EDUCATION, INC.
677 Ala Moana Blvd., Suite 1003
Honolulu, HI 96813

Phone: 808-533-3936
Fax: 808-533-3966

March 1, 2000

Ms. Dawn Mendiola
Provider Relations Officer
Child and Adolescent mental health Division
3627 Kilauea Avenue, Room 101
Honolulu, HI 96816

Dear Ms. Mendiola:

We have been carefully reviewing the billing and chart records for Dr. . so we can respond to the concerns raised in your letter of January 30, 2000. In your letter you raised the concern the Dr. billing hours were impossibly high. Our review has found the following:

1. Per instruction from CAMHD, billing for CARE's bio-psycho-social program were billed under Dr. while that program was under his direct supervision. As there are several clients in that program, this has dramatically inflated Dr. s billing for the month of August. When the bio-psycho-social hours are subtracted from Dr. s billing for this month, he billed a total of 206.167 hours. Of this, 59 hours were group therapy, which, with an average of 4 clients in a group means that Dr. physically provided approximately 15 hours of group therapy. Thus, Dr. actually provided 162.167 hours of therapy during the month of August (24 working days), which averages to 6.76 hours of therapy per day, which is not excessive.

2. Dr. conducts group therapy, which means that the total hours billed are higher, although of course he and CARE are being reimbursed at the group rate.

3. We did find that Dr. billed for individual therapy during the bio-psycho-social program. Those hours amounted to 15 hours and were reimbursed for a total of $1350. We are returning those funds to CAMHD. We regret this error on our part, which was a result of our initial misunderstanding of the billing structure for the bio-psycho-social program. We have not subsequently billed for individual services provided during the hours of the bio-psycho-social program.

4. We did find, as you mentioned, the we erroneously billed 44.5 hours under the 15301 code as Dr. ; hours. These should have been billed as 16301. We are returning the 15301 funds in the amount of $1292.28 to CAMHD.

5. We also discovered that 14.5 hours of 7101 were billed under Dr. erroneously. These hours should have been billed under ., a master's level provider with CARE. We are reimbursing CAMHD the difference between Dr. . s rate of $90/hour and Ms. rate of $70/hour for a total of $290.00.

6. It was also noticed that there are 12 hours of 07101 double billings and 2.5 hours of 07102 double billings for the month of July, and 1 hour of 07101 double billings for the month of August. We are returning the double billing funds in the amount of $1257.60.

7. We have reviewed all of Dr. , billing (see enclosure) and find that he averages 8.135 hours per day (1122.67 hours/138 days), which is well within the range of full-time practice. In our review we pulled start/end times only for those days in which the hours appeared to be excessive. Dr. . has provided over 1000 separate services during the July to August time frame, and to pull every start/end time would have been an excessive drain on our resources.

As a result of the above review, we are reimbursing a total of $4189.88 to CAMHD.

We believe that our review has answered the concerns raised in your letter. We are continuing to review our providers' billing on a number of issues so as to prevent incorrect billings or excessive workloads. We continue to be confident that Dr. is providing excellent services well within the scope of standard practices in the field. Should you have any further concerns, please contact me.

Sincerely,

Tina L. McLaughlin, Psy.D

Tina L. McLaughlin, Psy.D.
Program Director

LEVEL OF CARE 16101: BIOPSYCHOSOCIAL REHABILITATION I

Definition

A social skills building service which allows youth with serious emotional disturbance, developmental disabilities, behavioral disorders, or emotional disturbance to remain in or return to the community by providing after school, evening, weekend, and school vacation services.

Referrals

The FGC Care Coordinator faxes the provider a referral packet including a referral application, the current IEP and MHTP, and the current psychological evaluation. The provider has two days following receipt of the packet to contact the family to set up an intake interview. The intake interview occurs within one week. Within two days of the interview, the provider faxes a written acceptance or rejection letter to the FGC. The rejection letter must include the reason for the rejection.

Service Content

A. Program Description

1. The program offers educational, skill-building, and recreational activities designed to build upon the strengths of the youth and to improve overall functioning.
2. The program's structured schedule of therapeutic and educational activities and milieu promote the development of healthy life skills, self-understanding, self-management, and social, interpersonal, and recreational skills. Activities are appropriate to the age, behavioral levels, and emotional readiness of the youth.
3. A mental health professional (MHP) provides direct observation, supervision and assessment of the program's functioning at least weekly. The MHP assures that the program is individualized to meet the needs of the youth.
4. Appropriate staff as indicated in the MHTP performs daily interventions. The active treatment interventions focus on a) stabilization and/or alleviation of the behaviors and/or problems that necessitated admission or b) symptoms and/or problems that have emerged and/or have been identified since admission.

B. Treatment Planning and Documentation

1. For youth where it is anticipated that he/she will participate in this program for more than three months all of the following must be completed:
   a) At admission, a screening of the youth and family need for service is conducted. A written social history is placed in the youth's file at admission. It includes a summary of information about past and current services, an assessment of the youth and family strengths, and an assessment of psychosocial problems that are leading to placement. The social history includes a substance use history. It includes a risk assessment of the youth's suicide and runaway risk. A copy of the social history is provided to the Family Guidance Center within one week of admission.
   b) Within three days an initial treatment plan is developed by a mental health professional based on the strengths and reasons for placement. A copy is provided to the Family Guidance Center within two days of being developed.

c) Within 30 days a comprehensive treatment plan is developed and implemented by a multi-disciplinary team of mental health professionals, direct care staff, the Family Guidance Center Care Coordinator, and family. The plan is strengths-based, family-centered, and goal-oriented. It includes measurable objectives, which are clearly linked to the assessment and reason for placement. It provides an integrated program of daily activity designed to meet the therapeutic needs of youths served. To the extent possible, the youth participates in the development of the plan. Their participation is reflected in their signature on the plan. The plan must be placed in the youth's clinical record and sent to the Family Guidance Center within 10 days of completion of the plan.

d) The comprehensive treatment plan includes a discharge plan, which is updated as circumstances change. An updated written discharge plan is available at discharge.

e) The comprehensive treatment plan also includes a crisis plan for predictable crises that specifies what interventions will be used and who will be responsible for implementing them.

f) Treatment plans are reviewed and updated at least quarterly and more frequently if there are significant changes in the case. The entire treatment team is invited to these major reviews. The family, FGC and the home school personnel must be given five working days prior notification of a treatment review. Within 10 days of the treatment plan review, a copy of the treatment plan or any updates are placed in the youth's clinical record and sent to the Family Guidance Center.

g) Progress notes are written for each day and for specialized sessions as appropriate. The progress notes are placed in the clinical record within 24 hours.

2. For youth who will participate for less than three months:
   a) A mental health treatment plan that indicates the goals and objectives that will be addressed while the youth is in the program is developed.
   b) Progress notes for each day and for specialized sessions, as appropriate, are completed which meet standards (see Appendix B) and placed in the clinical record within 24 hours.

C. Behavior Management

1. The organization has clear procedures, which specify its approach to behavior management. These are safe, standardized methods for behavior management. The organization provides training for its personnel in alternative ways of dealing with aggressive or out of control behavior, methods of de-escalating volatile situations and of using non-physical techniques in such situations.
2. The organization prohibits <u>all</u> of the following forms of discipline:
   a) Degrading punishment;
   b) Corporal or other physical punishment;
   c) Forced physical exercise solely for the purpose of eliminating behavior rather than for instructive or athletic value;
   d) Punitive work assignments;
   e) Group punishment for one person's behavior;
   f) Medication for the purpose of punishment;

g) Extended isolation of the person;
h) Deprivation of the person's rights and needs (e.g., food, family visits);
i) Painful aversive stimuli used in behavior modification; and
j) Use of a seclusion room or mechanical restraints.

D. **Medication and Medical Emergencies**

1. The program is prepared to deal effectively with injuries, accidents, and illnesses, as follows:
   a) Procedures for handling such situations have been developed in consultation with a health professional to protect the persons served.
   b) Personnel involved in direct care are trained in basic first aid and retrained at least every three years.
   c) Personnel receive training in identification of abuse and neglect and in mandated reporting requirements.
   d) One person on duty is trained and currently certified in cardio-pulmonary resuscitation.
   e) Telephone, first aid supplies and manuals are readily available.
   f) Individual case records contain the names of the family physician, clinic or hospital used in emergencies, and written authorization from the parent/legal guardian for emergency care.
2. The organization has established emergency procedures and has either a licensed physician available on-call during its hours of operation or has formal arrangements for emergency services with a nearby primary health care facility.
3. The organization promptly reports to appropriate authorities any serious accident, emergency, or dangerous situation, including immediate reporting of instances of abuse, and reports to parents, other relatives, or legal guardians, any of the above which affect the youth served.
4. The organization which assists youth taking medication, establishes controls governing proper procedures and storage which include all of the following:
   a) Locked storage with supervision and access by only those persons trained and authorized;
   b) Proper labeling, with name of person served, dosage, administration interval, name of medication, and name of prescribing physician;
   c) Destruction of out-of-date medication; and,
   d) Proper disposal of unused medication, syringes, and medical waste.

E. Staffing

1. The organization has at least one MHP level mental health professional who participates in the development and implementation of the overall treatment program, in regular case reviews, and in direct services to person served as needed.
2. Adequate care and supervision of the youth served is provided at all times in accordance with the developmental and clinical needs of the youth served and includes:
   a) Staff providing continuous supervision at a youth/ staff ratio of 5 to 1;
   b) Program has the capacity for more intensive staffing during periods of greater activity as needed; and,
   c) Availability of additional personnel for emergencies or to meet the special needs of youth served at busier or more stressful periods.
3. The organization's direct service personnel include those with:

a) Educational and experiential backgrounds which enable them to participate in the overall treatment program and to meet the emotional and developmental needs of the youth served; and.
b) The personal characteristics and temperament suitable for working with youth with special needs.

Procurement Process and Time Frame for Length of Service

1. These services are recommended by the mental health treatment team and procured by the FGC Care Coordinator. The scope and nature of services are collaboratively determined by the mental health treatment team. Need for continuation of services is reviewed every three months.
2. Unit = 1 Hour (allows for increments with .25 units = 15 minutes)
3. Billable time is limited to time spent directly with youth. Internal program planning, treatment planning, and logistical planning/preparation is assumed in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.

Admission Criteria

All of the following criteria are met:

A. The identified youth meets at least one of the Service Eligibility criteria for CAMHD (as defined in Appendix A).

AND

B. The youth is registered with a Family Guidance Center (FGC), and has an assigned FGC Care Coordinator.

AND

C. The youth has a diagnosable DSM-IV psychiatric disorder.

AND

D. The youth has a total CAFAS score equal to or greater than 80, or it is determined by the treatment team that appropriate functioning depends on receiving a specific treatment and not receiving it would result in a significant deterioration in functioning.

AND

E. The youth needs a structured, skill building program outside of school hours to maintain the gains being achieved in school. The youth does not have the life, social or recreational skills to participate in a community recreation program.

AND

F. There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated.

AND

G. An adequate trial of active treatment at a less restrictive level has been unsuccessful or the youth is clearly inappropriate for a trial of less restrictive services.

AND

H. The youth is at significant risk for needing more restrictive levels of care and/or return to more restrictive levels of care due to the youth's moderate to severe and/or persistent maladaptive behavior in the home or community.

Continuation Criteria

Both of the following criteria must be met based on clinical review of the service documentation, and monthly treatment and progress summary every three months:

A. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.

AND

B. At least one of the following criteria are met:

1. The youth's symptoms or behaviors persist at a level of severity documented at the most recent procurement of this episode of care,

OR

2. Relevant youth and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3. No progress toward treatment goals at the most recent procurement of this episode of care have been documented but the treatment plan has been modified by the treatment provider and consumer and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4. The youth has manifested new symptoms or maladaptive behaviors which meet admission criteria and the treatment plan has been revised to incorporate new goals.

Discharge Criteria

The youth is no longer in need or eligible for this service due to at least one of the following:

A. The youth can be safely treated in a less restrictive environment,

OR

B. The youth no longer meets the admission or continuation criteria,

OR

C. The youth is in need of a more restrictive environment,

OR

D. Youth no longer meets the eligibility criteria for CAMHD.

Quality Indicators

A. Documentation in the youth's clinical record, personnel records and agency records indicate compliance with the Clinical Standards for this level of care.

B. Quarterly review of progress on youth's IEP/MHTP indicate that youth are receiving the services called for by the IEP/MHTP and 70% of objectives are being met.

Credentialling

CARF, COA or JCAHO accreditation required.

LEVEL OF CARE 16201: BIOPSYCHOSOCIAL REHABILITATION II

Definition

A social skill building service which allows youth with serious emotional disturbance, developmental disabilities, behavioral disorders, or emotional disturbance to remain in or return to the community by providing after school, evening, week-end, school vacation services. **This program is designed for youth who require a smaller child/staff ratio due to factors listed in the admission criteria.**

Referrals

Same as Biopsychosocial Rehabilitation I.

Service Content

Service content is the same as for Biopsychosocial Rehabilitation I with the following additional requirements:

Adequate care and supervision of the youth served is provided at all times in accordance with the developmental and clinical needs of the youth served and includes:

1. Staff providing continuous supervision at a youth/staff ratio of 3 to 1;
2. Higher staff/month ratios during periods of greater activity; and
3. Availability of additional personnel for emergencies or to meet the special needs of persons served at busier or more stressful periods.

Procurement Process and Time Frame for Length of Service

A. These services are recommended by the mental health treatment team and procured by the FGC Care Coordinator. The scope and nature of services are collaboratively determined by the mental health treatment team. Need for continuation of services is reviewed every three months.
B. 1 Unit = 1 Hour (allows for increments with .25 units = 15 minutes)
C. Billable time is limited to time spent directly with youth. Internal program planning, treatment planning, and logistical planning/preparation is assumed in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.

Admission Criteria

All of the following criteria are met:

A. The identified youth meets at least one of the Service Eligibility criteria for CAMHD (as defined in Appendix A).

AND

B. The youth is registered with a Family Guidance Center (FGC), and has an assigned FGC Care Coordinator.

AND

C. The youth has a diagnosable DSM-IV psychiatric disorder or is three to five years of age or younger and shows evidence of significantly atypical development.

AND

D. The youth has a total CAFAS score equal to or greater than 90 or it is determined by the treatment team that appropriate functioning depends on receiving a specific treatment and not receiving it would result in a significant deterioration in functioning.

AND

E. The youth is experiencing moderate to severe behavioral and/or emotional symptoms as indicated by one or more of the following behaviors:

1. More than five developmentally inappropriate emotional outbursts lasting more than five minutes each per week for two weeks in a 60 day period in a non-school setting.
2. Inappropriately removing self from supervision more than two times a week or for more than five hours a week for two weeks in a 60 day period.
3. Verbally aggressive (two of three behaviors must be present to constitute verbal aggression: 1) excessively loud voice, 2) closer than an arm's length, 3) use of threatening words or gestures, more than five times a week for two weeks in a 60 day period.
4. Physically aggressive (pushing, hitting, kicking, biting or throwing an object at a person) more than two times in a week for two weeks in a 60 day period or one incident causing significant bodily harm.
5. Property damage (deliberate damage to property of a value of greater than $50, does not include careless or accidental damage) more than two times in a 60 day period. These incidents would be reported by the primary care-takers, service providers and/or school.

AND

F. There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated.

AND

G. The youth needs a structured, skill building program outside of school hours to maintain the gains being achieved in school. The youth does not have the life, social or recreational skills to participate in a community recreation program.

AND

H. An adequate trial of active treatment at a less restrictive level has been unsuccessful or the youth is clearly inappropriate for a trial of less restrictive services.

AND

I. The youth is at significant risk for needing more restrictive levels of care and/or return to more restrictive levels of care due to the youth's moderate to severe and/or persistent maladaptive behavior in the home or community.

Continuation Criteria

Both of the following criteria must be met based on clinical review of the service documentation, and Mental Health Treatment Plans every three months:

A. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.

AND

B. At least one of the following criteria is met:

1. The youth's symptoms or behaviors persist at a level of severity documented at the most recent procurement of this episode of care.

OR

2. Relevant youth and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3. No progress toward treatment goals at the most recent procurement of this episode of care have been documented but the treatment plan has been modified by the treatment provider and consumer and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4. The youth has manifested new symptoms or maladaptive behaviors which meet initial procurement criteria and the treatment plan has been revised to incorporate new goals.

Discharge Criteria

The youth is no longer in need of or eligible for this service due to at least one of the following:

A. The youth can be safely treated in a less restrictive environment,

OR

B. The youth no longer meets the admission or continuation criteria,

OR

C. The youth is in need of a more restrictive environment,

OR

D. Youth no longer meets eligibility criteria for CAMHD.

Quality Indicators

Documentation in the youth's clinical record, personnel records and agency records indicate compliance with the clinical standards for this level of care.

Quarterly review of progress on youth's IEP/MHTP indicate that youth are receiving the services called for by the IEP/MHTP and 70% of objectives are being met.

Credentialling

CARF, COA or JCAHO accreditation required.

LEVEL OF CARE 16301: BIOPSYCHOSOCIAL REHABILITATION III

Definition

A social skill building service which allows youth with serious emotional disturbance, developmental disabilities, behavioral disorders, or emotional disturbance to remain in or return to the community by providing after school, evening, week-end, and school vacation services. Services typically extend from two to four hours and occur two to four times per week with focused programming including group sessions, behavioral management, social skills development, communication skills, and support groups. At least one session of group therapy and one session of individual therapy are provided to each client each day of the program. This is a **time-limited** program typically four to six weeks, focused on immediate stabilization to prevent placement in a more restrictive program.

Referrals

The FGC Care Coordinator faxes the provider a referral packet including a referral application, the current IEP and MHTP, the CSP, and the current psychological evaluation. The provider has two days following receipt of the packet to contact the family to set up an intake interview. The intake interview occurs within one week. Within two days of the interview, the provider faxes a written acceptance or rejection letter to the FGC. The rejection letter must include the reason for the rejection. The provider must begin contacting the youth/family within one week of procurement and be able to initiate service within two weeks of procurement unless otherwise indicated by the Family Guidance Center (FGC) Care Coordinator.

Service Content

A. Program Description

1. The program offers educational, skill-building, and therapeutic activities designed to build upon the strengths of the youth and to improve overall functioning.
2. The program's structured schedule of therapeutic and educational activities and milieu promote the development of healthy life skills, self-understanding, self-management, and social, interpersonal, and recreational skills. Activities are appropriate to the age, behavioral levels, and emotional readiness of the youth.
3. A mental health professional provides direct observation, supervision and assessment of the program's functioning at least weekly. The MHP assures that the program is individualized to meet the needs of the youth.
4. Appropriate staff as indicated in the MHTP performs daily interventions. The active treatment interventions focus on (a) stabilization and /or alleviation of the behaviors and/or problems that necessitated admission or (b) symptoms and/or problems that have emerged and/or have been identified since admission.
5. At least one session of group therapy and one session of individual therapy are provided to each client each day of the program.

B. Treatment Planning and Documentation

1. At admission, a screening of the youth and family need for service is conducted. A written social history is placed in the youth's file at admission. It includes a summary of information about past and current services, an assessment of the youth and family strengths, and an assessment of psychosocial problems that are leading to placement. The social history includes a substance use history. It includes a risk assessment of the youth's suicide and runaway risk. A copy of the social history is provided to the Family Guidance Center within one week of admission.
2. Within three treatment sessions an initial treatment plan is developed by a mental health professional based on the strengths and reasons for placement. A copy is provided to the Family Guidance Center within two days of being developed.
3. Within 14 treatment sessions a comprehensive treatment plan is developed and implemented by a multidisciplinary team of mental health professionals, direct care staff, the Family Guidance Center Care Coordinator, and family. The plan is strengths-based, family-centered, and goal-oriented. It includes measurable objectives, which are clearly linked to the assessment and reason for placement. It provides an integrated program of daily activity designed to meet the therapeutic needs of youth served. To the extent possible, the youth participates in the development of the plan. Their participation is reflected in their signature on the plan. The plan must be placed in the youth's clinical record and sent to the Family Guidance Center within 10 days of completion of the plan.
4. The comprehensive treatment plan includes a discharge plan, which is updated as circumstances change. An updated written discharge plan is available at discharge.
5. The comprehensive treatment plan also includes a crisis plan for predictable crises that specifies what interventions will be used and who will be responsible for implementing them.
6. Treatment plans are reviewed and updated at least monthly and more frequently if there are significant changes in the case. The entire treatment team is invited to these major reviews. The family, FGC Care Coordinator, and other treatment team members must be given five working days prior notification of a treatment review. Within 10 days of the treatment plan review, a copy of the treatment plan or any updates are placed in the youth's file and sent to the Family Guidance Center.
7. Many specialized services are provided to support this placement. Progress notes are written for each specialized services after every session. The progress notes are placed in the file within 24 hours.

C. **Behavior Management**

1. The organization has clear procedures which specify its approach to behavior management. These are safe, standardized methods for behavior management. The organization provides training for its personnel in alternative ways of dealing with aggressive or out of control behavior, methods of de-escalating volatile situations, and of using non-physical techniques in such situations.
2. The organization prohibits all of the following forms of discipline:
   a) Degrading punishment;
   b) Corporal or other physical punishment;

c) Forced physical exercise solely for the purpose of eliminating behavior rather than for instructive or athletic value;
d) Punitive work assignments;
e) Group punishment for one person's behavior;
f) Medication for purpose of punishment;
g) Extended isolation of the person;
h) Deprivation of the person's rights and needs (e.g., food, family visits);
i) Painful aversive stimuli used in behavior modification; and,
j) Use of a seclusion room or mechanical restraints.

3. The organization promptly reports to appropriate authorities any serious accident, emergency, or dangerous situation, including immediate reporting of instances of abuse, and reports to parents, other relatives, or legal guardians, any of the above which affect the youth served.

D. Staffing

1. The organization uses master's level mental health professionals who participate in the development and implementation of the overall treatment program, in regular case review, and in direct services to person served.
2. The organization's direct service personnel include those with:
   a) Educational and experiential backgrounds which enable them to participate in the overall treatment program and to meet the emotional and developmental needs of the youth served.
   b) The personal characteristics and temperament suitable for working with youth with special needs.

Level of Procurement And Time Frame for Length of Service

A. Biopsychosocial Rehabilitation III services can be of varying degrees of intensity and complexity depending upon the youth/family situation and needs. Regular sessions are scheduled per treatment plan and typically will decrease in frequency as needs are met and goals are reached. These services are intended to be time-limited, with services reduced and then discontinued as youth/family are able to function more effectively. The usual course of treatment is four to six weeks.
B. These services are recommended by the mental health treatment team and procured by the FGC Care Coordinator. The scope and nature of services are collaboratively determined by the mental health treatment team. Need for continuation of services is reviewed every month.
C. Unit = 1 Hour (allows for increments with .25 units = 15 minutes).
D. Billable time is limited to time spent in face-to-face programming with youth. Internal program planning, treatment planning, and logistical planning/preparation is assumed in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.

Admission Criteria

All of the following criteria must be met:

A. The identified youth meets at least one of the Service Eligibility criteria for CAMHD (as defined in Appendix A).

AND

B. The youth is registered with a Family Guidance Center (FGC), and has an assigned FGC Care Coordinator.

AND

C. The youth has a diagnosable DSM-IV psychiatric disorder.

AND

D. The youth has a total CAFAS score equal to or greater than 80, it is determined that appropriate functioning depends on receiving a specific treatment and not receiving it would result in a significant deterioration in functioning.

AND

E. There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated.

AND

F. An adequate trial of active treatment at a less restrictive level has been unsuccessful or the youth is clearly inappropriate for a trial of less restrictive services.

AND

G. The youth is at significant risk for needing more restrictive levels of care and/or return to more restrictive levels of care due to the youth's moderate to severe and/or persistent maladaptive behavior in the home or community.

Continuation Criteria

Both of the following criteria must be met every month, based on clinical review of the service documentation, Monthly Treatment and Progress Summary:

A. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.

AND

B. At least one of the following criteria is met:

1. The youth's symptoms or behaviors persist at a level of severity documented at the most recent procurement of this episode of care.

OR

2. Relevant youth and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached,

OR

3. No progress toward treatment goals at the most recent procurement of this episode of care have been documented but the treatment plan has been modified to introduce new therapeutic interventions,

OR

4. The youth has manifested new symptoms or maladaptive behaviors which meet admission criteria and the treatment plan has been revised to incorporate new goals.

Discharge Criteria

Youth is no longer in need of or eligible for services due to at least one of the following:

A. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the treatment plan,

OR

B. Youth has demonstrated minimal or no progress toward treatment goals for a two-month period and appropriate modification of plans have been made and implemented with no significant success, suggesting the youth is not benefiting from Biopsychosocial Rehabilitation III at this time,

OR

C. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this services,

OR

D. Youth no longer meets admission criteria for this level of care,

OR

E. Youth does not meet eligibility criteria for the CAMHD.

Quality Indicators

A. Documentation in the youth's clinical record, personnel records and agency records indicate compliance with the clinical standards for this level of care.

B. Monthly review of progress on youth's MHTP indicate that youth are receiving the services called for by the MHTP and 70% of objectives are being met.

Credentialling

A. Therapist(s) must meet one of the following requirements:

1. A Hawaii licensed, graduate level social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services,

OR

2. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, or behavioral science AND a minimum of two years of supervised training and experience in the provision of child and adolescent mental health services,

OR

3. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, or behavioral science, AND a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, AND work under the supervision of personnel meeting criteria A or B above.

B. CARF, COA and JCAHO accreditation is required.