I: State Information

State Information

Plan Year

Start Year:
2011

End Year:
2013

State DUNS Number

Number
80993567

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
Department of Health

Organizational Unit
Behavioral Health Administration

Mailing Address
1250 Punchbowl Street, 3rd Floor

City
Honolulu

Zip Code
96813

II. Contact Person for the Grantee of the Block Grant

First Name
Loretta J.

Last Name
Fuddy, A.C.S.W., M.P.H

Agency Name
Department of Health

Mailing Address
1250 Punchbowl Street, 3rd Floor

City
Honolulu

Zip Code
96813

Telephone
808-586-4410

Fax
808-586-4444

Email Address
loretta.fuddy@doh.hawaii.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2010

To
6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
Judith

Last Name
Clarke

Telephone
808-453-6946

Fax
808-453-6995

Email Address
judith.clarke@doh.hawaii.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Loretta J. Fuddy, A.C.S.W., M.P.H
Title	Director of Health
Organization	Department of Health

Signature: _____ Date: _____

Footnotes:

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Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Lorett J. Fuddy, A.C.S.W., M.P.H
Title	Director of Health
Organization	Department of Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Hawaii agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Loretta J. Fuddy, A.C.S.W., M.P.H.
Title	Director of Health
Organization	Department of Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Description of the State Service System

Hawai`i, the 50th State, is one of the most remote places in the country. Located in the middle of the North Pacific Ocean, Hawaii's closest neighbor is 2,400 miles away (California). The "Hawai`ian chain" is made up of hundreds of islands that stretch 1,600 miles across the Pacific. Collectively, these islands have a total landmass of 6,450+ square miles and are the only State in the U.S. that is continuously growing due to active lava flows. The eight main islands of the Hawaiian Archipelago include: Hawaii, Maui, Oahu, Kaua`i, Lanai, Ni`ihau and Kaho`olawe (listed in order of size). Seven of the eight most southerly islands in the chain are inhabited (Kaho`olawe is not).

The State's 1,360,301 population (U.S. Census Bureau, 2010[1]) is unevenly distributed among its four counties, with the majority (70.1%) of the residents in the City & County of Honolulu, 13.6 percent in Hawai`i County, 11.2 percent in the tri-island populated County of Maui (Maui, Molokai, and Lanai), and 4.9 percent in Kaua`i county (County (including Ni`ihau). Between 2000 and 2010, Hawai`i's population grew by 12.8 percent, with the Hawai`i and Maui counties experiencing the highest increases of 24.5 percent and 20.8 percent respectively. The islands of Moloka`i (7,345) and Lana`i (3,135) decreased in population.

Hawai`i is composed of a rich blend of races, ethnicities, languages and cultures-Native Hawaiians, Pacific Islanders, Japanese, Filipino, Chinese, Vietnamese, Caucasian, African American, American Indian, Alaska Native, Hispanic, Micronesians, and people of other heritages. Hawai`i's population consists of 50.5 percent males and 49.5 percent females. Hawai`i's largest ethnic population reported is Asian, which represents 38.6 percent of the population. The second largest ethnicity reported is Caucasian, which represents 24.7 percent of the population. Of the remaining ethnic groups, Native Hawaiians/Pacific Islanders represent 10.0 percent. Hawai`i also has the largest percentage of persons with two or more races, which constitutes 23.6 percent of the total population.

According to the 2010 U.S. Census, children under the age of five accounted for 6.9 percent of the population, and during the last ten years, the 18 years and older group has increased to seventy-eight percent. Approximately 63.2 percent are between the ages of 18 and 64. Nationally (due to the aging of the baby boomers) by the year 2030 one in four individuals will be an older adult. According to data provided by the University of Hawai`i Center on the Family 2007, during the decade of 1900 – 2000, the nation as a whole saw a 9 percent increase in older adults. By comparison during the same time period, Hawai`i's older adult population increased 19 percent (Center on the Family). By 2010, people 65 years and over, accounted for 14.5 percent of the total resident population in Hawai`i

Additionally, at 79 years, Hawai`i has the longest life expectancy in the county. While the total population has increased 26 percent over two decades the 85+ population has increased 216 percent, over eight times as fast as the total population and two-and-a-half times as fast as the older adult population as a whole. Among the four counties, Kaua`i County had the highest percentage of older population (65+) at 14.9 percent and Maui County had the lowest percentage at 12.2 percent.

The 2010 U.S. Census indicated that 10.4 percent of Hawai`i's families live below the poverty level. By county, Maui County had the lowest poverty rate at 6.8 percent, while Hawai`i County had the highest at 13.1 percent. The U.S Bureau of Labor Statistics[2] reported in July 2011 that Hawai`i's unemployment

[1] http://hawaii.gov/dbedt/info/censu/Census_2010/

[2] Source: Hawaii Department of Labor and Industrial Relations, August 2011.

rate stood at 6.1 percent. Despite the slow decline in Hawai`i's unemployment rate, it remained among the lowest in the nation, tied with Virginia at ninth best. According to thea State Department of Labor and Industrial Relations' report, the unemployment rate for Honolulu County fell to 5.4 percent in July from 5.7 percent in June; it fell to 9.5 percent from 10.6 percent in Hawai`i County, to 7.5 percent from 8.2 percent in Maui County, and to 8.5 percent from 9.2 percent in Kauai County.

Other characteristics about Hawai`i revealed in the 2010 U.S. Census are:

- Honolulu County ranked best for health insurance coverage for the uninsured (5.3%), while Hawaii County was worst in health care coverage for adults (9.5%).% uninsured).
- Compared to the other counties, Kaua`i County ranked last in havinghas the highest infant mortality rate and cancer deaths.
- Maui County ranked lowest in infant mortality, but had the highest diabetes death rate.

Hawai`i's unique geography, demography, and culture present special challenges in developing comprehensive treatment resources. Dependence upon air travel between geographically isolated islands presents a challenge to statewide project coordination, and lack of transportation in rural areas on all islands presents a challenge to accessibility of mental health services. Multiple languages, adherence to traditional Hawai`ian and other local cultures, and influences from the mainland majority culture result in unique situations that require appropriate, differentiated treatment processes and responses. Hawai`i's Governor, as the chief executive of the State of Hawai`i, is in charge of the Executive Branch State agencies and establishes the goals of the State and outlines ways to reach those goals.

Overview of Hawai`i's Public Behavioral Health System

The Hawai`i Department of Health is committed to protect and improve the health and environment for all people in Hawai`i. According to Hawai`i Revised Statutes[3], the departmentDepartment of healthHealth within the limits of available funds within the designated programs, shall promote and provide for the establishment and operation of a community-based mental health system responsive to the needs of persons of all ages, ethnic groups and geographical areas of the State, reflective of an appropriate distribution of resources and services, and monitored and evaluated in terms of standards, goal attainment, and outcomes. The elements of the system are defined by departmental rules recognizing the need for at least the following services:

- Informational and educational services to the general public and to lay and professional groups;
- Collaborative and cooperative services with public and private agencies and groups for the prevention and treatment of mental or emotional disorders and substance abuse and rehabilitation of patients;
- Consultation services to the judiciary, to educational institutions, and to health and welfare agencies;
- Case management, outreach, and follow-up services;
- Emergency crisis and non-crisis intervention services accessible to all residents;
- Community-based, relevant, and responsive outpatient services;

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[3] Hawaii Revised Statutes §334-3

- Community residential care comprising a comprehensive range of small, homelike, and appropriately staffed treatment and rehabilitation facilities;
- Short-term psychiatric treatment, preferably in facilities where access to other health and medical services are readily available;
- Intensive psychiatric treatment for patients in need of long-term highly structured or highly specialized care and treatment and provision of appropriate community resources;
- Training programs, activities, and staffing standards for the major mental health disciplines and ancillary services; and
- Rehabilitative services for hospital and community-based individuals who have experienced short- or long-term mental or emotional disorders and substance abuse.

The State's Adult Mental Health Division is considered the single mental health authority. The authority is within the State of Hawai`i, Department of Health (DOH) Behavioral Health Administration (BHA). Four Divisions comprise the BHA: the Alcohol and Drug Abuse Division (ADAD); the Adult Mental Health Division (AMHD); the Child and Adolescent Mental Health Division (CAMHD) and Developmental Disabilities Division (DDD). ADAD is the only division within the BHA that exclusively contracts for all services. AMHD provides services through the public Community Mental Health Centers (CMHCs), the Hawai`i State Hospital and contracts for services through thirty (30) Purchase of Service providers. CAMHD and DDD contract for all services provided beyond case coordination.

The four Divisions utilize a strong collaboration structure, which facilitates communication and the ongoing development of a solid community-based system of mental health care throughout the state. Under the BHA and its Deputy Director, the AMHD is closely aligned with the other three divisions comprising the BHA – ADAD, DDD, CAMHD and AMHD. The AMHD Chief meets with the BHA Deputy Director and other three BHA Chiefs on an ongoing basis. Recent and continuing collaboration between the AMHD and ADAD focused on substance abuse has been supported by the completed COSIG Grant; and between AMHD and CAMHD focused on youth to adult transition has been supported by the Data Infrastructure Grants (DIG). Receipt of a Mental Health State Transformation Incentive Grant (MHT SIG) has provided significant opportunities for increased BHA and interagency collaboration through five initiatives: community engagement; workforce development; systems integration; criminal justice, and consumer, family member and youth alliance. Finally, since CAMHD, DDD and AMHD have long term responsibility for individuals that span these agencies, the three Divisions meet regularly to increase collaboration.

<u>The Alcohol and Drug Abuse Division</u>

The Alcohol and Drug Abuse Division is responsible for the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of the State of Hawaii. ADAD aims to reduce the severity and disabling effects related to alcohol and other drug use by assuring access to an integrated, community-based system of prevention, strategies and treatment services designed to empower individuals and communities to make health-enhancing choices. ADAD is the primary and often sole source of public funds for substance abuse treatment. ADAD treatment efforts are designed to promote a statewide culturally appropriate, comprehensive system of services to meet the treatment and recovery needs of individuals and families. Treatment services have, as a requirement, priority admission for pregnant women and injection drug users.

<u>The Developmental Disabilities Division</u>

The DDD aims to prevent institutionalization of people with developmental disabilities through community-based services. The Division provides support through two branches, the Disability Supports Branch and the Case Management and Information Services Branch (CMISB). The CMISB develops, coordinates, monitors, and ensures the statewide delivery of individually appropriate services and supports to persons with developmental disabilities and/or mental retardation through the utilization of existing resources within the community, through coordination with supports and services provided under federal, state, or county acts, and through specific funding when no other resources are available. These functions are supported by the four organizational units of CMISB: Case Management Section, Fiscal Services, Program Supports, and Contracts and Resource Development Section

II. Planning Steps: Step 1: Assess the strengths and needs of the service system to address the specific populations

Child and Adolescent Mental Health Division (CAMHD)

The mission, vision, and guiding principles of the Child and Adolescent Mental Health Division (CAMHD) of the Hawai`i State Department of Health (DOH) are part of the CAMHD Strategic Plan (See Attachment CAMHD1: "CAMHD Strategic Plan"):

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

Vision
Happy and Healthy Children and Families Living in Caring Communities

Guiding Principles
CAMHD's guiding principles are reflected in the Hawai`i Child and Adolescent Service System Principles (CASSP) document (See Attachment CAMHD2: "CASSP Principles.")

Description of Agency
CAMHD is headed by a CAMHD Administrator and consists of both line and staff offices. The staff offices are maintained at the state level and consist of 82 positions, of which 48 are filled. The line offices are organized into seven (7) CAMHD branches consisting of six (6) Family Guidance Centers (FGCs) and one (1) Family Court Liaison Branch (FCLB), and include 145.5 positions, of which 99 are filled. A network of approximately 17 contracted provider agencies located throughout the State provides an array of home and community-based and residential treatment services.

The CAMHD state office includes the Research & Evaluation Office, Administrative Operations Office, Clinical Services Office, and the Performance Management Office. The Research & Evaluation Office is responsible for designing and overseeing a comprehensive, statewide evaluation and reporting system for the purpose of improving effectiveness and efficiency, improving clinical practice, and client outcomes. The Administrative Operations Office is responsible for budgeting, accounting, personnel resource management, and contracting. This section is also responsible for maximizing alternative funding sources, such as Title XIX, Title IV-E, and grants. The Clinical Services Office is responsible for

clinical practice issues, training, specialty case consultation, utilization review, and resource management. The Performance Management Office (PMO) develops, implements, and monitors a Division-wide, structured system for continuous improvement of mental health services delivery and youth outcomes. CAMHD's Management Information System (CAMHMIS) provides the organizational foundation for CAMHD's outcome tracking, utilization management, and accountability systems, as well as billing and general registration. MIS is the lead for CAMHD's two information technology initiatives—electronic health records, and Telehealth.

The community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGCs are strategically located in geographic areas that correspond with the Department of Education school districts. Three FGCs are located on Oahu, where close to 72% of the state's population resides. Also, there is one FGC each on the neighbor island counties--Kauai, Maui, and the Big Island. Most of the FGCs also have satellite offices. The placement of FGCs and their satellite offices help to address the needs of Hawai`i's ethnic and racial diversity, which differs by geographic location.

Each FGC is headed by a Branch Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide intensive case management. Services provided by the centers include facilitating access to care coordination (intensive case management), direct service provision, service procurement, and utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

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

*Intensive Case Management***.** Within 48 hours of registration, youth at CAMHD are assigned a Mental Health Care Coordinator (MHCC) from their regional Family Guidance Center to provide intensive case management. The care coordinator serves as the central point of contact for the delivery and coordination of mental health services to youth and the family. The care coordinator ensures that needed services, interventions, and strategies are identified and delivered in a coordinated manner and in partnership with the families. The MHCC is responsible for engaging the youth and family, referring the youth for appropriate services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuously monitoring the effectiveness of interventions. The youth's MHCC is responsible for convening an initial Coordinated Service Plan meeting within 30 days of eligibility determination, or immediately, if the youth has immediate needs and assuring service delivery within 30 days of identification for routine services. When appropriate, responsibilities also include coordination of care with Family Court, the Department of Human Services and other state and community agencies. The MHCC is responsible for facilitating the integration, coordination, and

monitoring of behavioral health services across programs and domains and to initiate necessary adjustments to services when needed through the team based process.

In order to assure youth-centered, culturally competent and effective services, care coordinators undergo internal training on engagement skills, intensive case management, coordinated service planning process, mental health assessments, Child and Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Level of Care Utilization System (CALOCUS), and Achenbach tools, evidence-based services and evidence-based practice elements, and interagency performance standards and practice guidelines.

Service Eligibility. The CAMHD provides timely, consistent, and responsive mental health services in the following categories:

Emergency Public Mental Health Services. These services are available to all children and youth in Hawai`i, ages 3-18 years, experiencing an imminent life threatening mental health crisis. Services include: 24-hour crisis telephone service, crisis mobile outreach, crisis therapeutic foster home, and community-based crisis group home.

Educationally Supportive (ES) Mental Health Services. ES Mental Health services are available for students with an educational disability who have been determined to be in need of intensive mental health services to benefit from their public education. The services are for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific support via their individualized education plan (IEP). The criteria for enrolling a youth in the ES program are Individuals with Disabilities Education Act (IDEA) eligibility, an IEP plan with recommendation for services from CAMHD, and an IEP meeting with CAMHD participation to determine the goals of mental health services to be provided. The available mental health services are: ancillary services, respite supports, psychosexual assessment, intensive case management, intensive in-home intervention, MultiSystemic Therapy, respite home, community mental health shelter, therapeutic foster home, Multidimensional Treatment Foster Care, therapeutic group homes, independent living program for 16-18 year olds, community-based residential levels III-I, and hospital-based residential.

Support for Emotional and Behavioral Development (SEBD) Program. SEBD is an acronym for the CAMHD's Support for Emotional and Behavioral Development program. CAMHD's unique SEBD designation was suggested by youth who rejected the previous stigmatizing labels. Formerly known as SED (Serious Emotional Disturbance) or Serious Emotional Behavioral Disturbance, CAMHD's SEBD program provides an array of services needed by families to support children and youth with high-end intensive mental health support. Children and youth are eligible if they are ages 3-20, are Hawai`i Medicaid QUEST or Fee-for-Service eligible and have a Child and Adolescent Functional Assessment Scale (CAFAS) or *Preschool And Early Childhood Functional Assessment Scale (*PECFAS) score of 80 or above and an eligible DSM-IV Axis I diagnosis of at least 6 months.

System Coordination

Three major state agencies - the Child and Adolescent Mental Health Division (CAMHD), the state Department of Education, and the Med-QUEST Division of the Department of Human Services - jointly provide for a comprehensive community-based system of care for children and adolescents in need of mental health services in Hawaii. Children and youth who have educational disabilities receive school-level supports and services through their home school. The school provides assessment and diagnostic

services whenever concerns arise that children or youth have a disability that might affect their education. If indicated, the school provides classroom strategies and specific mental health services. If more intensive services than those available at the home school arise, the school arranges access to the CAMHD services.

Children and youth who are having emotional challenges that are not affecting their education receive mental health services from their family private insurance or a Department of Human Services Med-QUEST provider. The Med-Quest Health Plans provide medically necessary services for assessment and mental health treatment. If more intensive services than those available through the Medicaid Health Plan arise, the youth is referred to the CAMHD system.

The Med-QUEST Division of the state's Medicaid Agency (Department of Human Services), contracts with health plans to provide health services to the Medicaid eligible population. The health plans provide medically necessary mental health assessments and treatment services to children and youth. Since 1994, CAMHD has had a Memorandum of Agreement with the Med-QUEST Division that provides that CAMHD serve the Medicaid eligible SEBD youth. In 1999, the Memorandum was modified to include services to all youth who are eligible under Hawai`i's Felix Consent Decree and who are Medicaid eligible. Med-QUEST identifies children and youth who are SEBD eligible and refer the youth to CAMHD for intensive care coordination and access to CAMHD's comprehensive array of community-based services. No youth are admitted to the Hawai`i State Hospital.

Co-occurring disorders. Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, intellectual or developmental disabilities, or medical impairments. Consequently, the presence of co-occurring disorders is assessed with all youth at the point of initial evaluation, as well as routinely during the course of on-going treatment. These efforts assure that youth receive the services appropriate to their strengths and needs. All of CAMHD's providers are required to provide integrated treatment for co-occurring disorders. Youth with a primary diagnosis of substance abuse can access services from our sister agency, the Alcohol and Drug Abuse Division (ADAD). When necessary, ADAD has some bed capacity available for residential treatment.

Employment Services. Employment services are not part of CAMHD's comprehensive service array of mental health services. However, on a case-by-case basis, CAMHD care coordinators will provide linkage to employment services if it has been identified in the youth's Coordinated Service Plan. If employment services have been identified in the youth's Individualized Education Plan, then CAMHD coordinates with the state department of education. CAMHD's Independent Living Program (ILP) develops transition plans for youth that include employment and financial independence. The ILP also provides vocational and employment opportunities to youth who are not in school. Linkage and referrals are made to the state's vocational rehabilitation services, the City & County of Honolulu's YouthBuild program, Community Action Programs, or other private agencies, such as Ola I Kahana.

Quality Assurance. As a result of the 1994 Felix Consent Decree, the Department of Education and Department of Health-CAMHD developed an interagency accountability system to monitor, evaluate, and improve the system of care. Around 2002, the Departments of Health and Education began meeting regularly to share information on the performance of their own systems as well as the interface between them. In 2004 the effort was expanded to other child-serving agencies. The monthly Interagency Quality Assurance and Accountability System meetings include representatives from Child Welfare Services, Family Court, Developmental Disabilities Division, Alcohol and Drug Abuse Division, Early Intervention Services, the Children's Coordinating Councils Office, and Hawai`i's statewide family

organization, Hawai`i Families as Allies. At the local level, district quality assurance teams meet monthly to review data and track improvement activities, while each "shared" child is reviewed at least quarterly. Annual case-based reviews are used to measure child status and system performance. Currently, work is in process to develop a Memorandum of Agreement that formalizes this interagency collaboration.

Related Behavioral Health Services and Resources

Department of Health (DOH)

In addition to mental health services for children and youth, the Hawai`i Department of Health provides a variety of health services for the children of Hawaii. The Family Health Services Division provides services through its Maternal & Child Health Branch (MCHB), Children with Special Health Needs Branch and WIC Services Branch. The Alcohol and Drug Abuse Division is responsible for the development and delivery of quality substance abuse prevention, intervention, and treatment services for the residents of the State of Hawaii. The Developmental Disabilities Division and the Public Health Nursing Branch may also serve youth.

DOH - Maternal & Child Health Branch (MCHB). The MCHB oversees contracts and collaborates with primary care health centers statewide to assure medical and dental services for children who do not have insurance. The MCHB-Child Wellness Program also collaborates with other state serving agencies to address children's dental health, ensuring that each child has access to a dentist for regular dental care, and to address childhood obesity. The MCHB-Healthy Start program provides home visiting to foster family functioning, promote child health/development, and enhance positive parenting skills for families. Backed by extensive research and evaluation, Hawai`i Healthy Start offers focused support services within a family's natural environment to reduce the likelihood of child maltreatment by reducing parental/environmental stressors. The MCHB-Adolescent Wellness Program promotes adolescent wellness, healthy youth development, and prevention of teen pregnancies. It also collaborates with other child serving agencies to implement the Centers for Disease Control's Youth Risk Behavior Survey, which includes questions on feeling sad, considering suicide, making suicide plans, number of suicide attempts, and seeking care as a result of a suicide attempt. Survey results indicating that Hawai`i has had higher-than-national rates of youth attempting suicide in the past month over 5 reporting periods (1993, 1995, 1997, 1999, 2001) were used to urge the Hawai`i State Legislature to authorize the establishment of a new Suicide Prevention Program in the Department of Health, Injury Prevention Program.

The MCHB-Parenting Support Programs include a statewide system of community-based parenting education and family support services, including:

- *The Parent Line* is a free, statewide telephone line that provides support, encouragement, informal counseling, information, and referral to callers experiencing concerns about their child's development and behavior or who have issues regarding family stresses or questions about community resources.
- *HomeReach* provides short-term home visitation services to resolve a parenting concern or family crisis.
- *Mobile Outreach (play and learn groups)* provides activities and programs to isolated or homeless families that promote age-appropriate parent-child interaction, communication, and positive discipline.
- *Respite Services* provides care giving relief, parent education, and support on Oahu to high risk families having crises or difficulties with parenting and family stress.

- *Services for Children who have Witnessed Violence* is intended to help children cope with their emotional responses to violence and by helping the family create a safe, stable, and nurturing environment for the child by teaching parents to have age-appropriate expectations and an awareness of the effects of violence on children.

DOH - The Children with Special Health Needs Branch (CSHNB). This branch provides care coordination, social work, nutrition, and other services for children with special health care needs age 0-21 years with chronic medical conditions. CSHNB follows the National Core Outcomes for Children & Youth with Special Health Care Needs. The Children with Special Health Needs Program serves children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. The CHSNB-Preschool Developmental Screening Program promotes the screening and follow-up for developmental/behavioral concerns in children age 3-5 years. The CSHNB Early Intervention Section provides early intervention services for children age 0-3 years old that are developmentally delayed, biologically at risk, or environmentally at risk. Care coordination is provided that assists the family in having the child evaluated, developing an Individualized Family Support Plan, linking the family to programs and services, providing family support, and supporting transition at age 3 to the Department of Education, Special Education.

*DOH - The Hawai`i WIC Services Branch*. This branch is part of the national WIC program, and they provide Hawai`i residents with nourishing supplemental foods, nutrition education, breastfeeding promotion and health and social service referrals.

DOH - Public Health Nursing Branch. The community-based Public Health Nurses facilitate access to medical home and health insurance programs, conduct immunization clinics, provide school health services, and provide care coordination services to infants and toddlers in early intervention programs and special needs populations.

Department of Education (DOE)

Hawai`i's Department of Education (DOE) incorporates a Comprehensive Student Support System (CSSS) to meet the academic, physical, social, and emotional development of all of its students. The CSSS responds to student needs that may correspond to one of five levels: 1) basic support for all children, 2) informal support through collaboration, 3) services through school-level and community programs, 4) specialized services from DOE and other agencies, and 5) intensive and multi-agency services. Students whose needs are at level 4 may receive special education services or services through the School-Based Behavioral Health (SBBH) program.

DOE - School-Based Behavioral Health (SBBH). SBBH program staff includes Behavioral Specialists, School Counselors, School Social Workers, Clinical Psychologists, and School Psychologists, who are located within schools/complexes. They assist school teams in understanding students' challenging behaviors and disabilities and in developing strategies and supports to help students benefit from their education. Parents, as members of the IEP/MP teams, participate in developing the IEP/MP goals and objectives, Functional Behavioral Assessment and Behavioral Support Plans. School teams (IEP and MP), work collaboratively with other SBBH program staff (School Psychologists, Clinical Psychologists, Mental Health Supervisors, School Social Workers, and Psychological Examiners) to properly address the student's functioning and develop classroom strategies as well as behavioral supports and interventions. CAMHD's geographically located Family Guidance Centers roughly correspond with the DOE districts.

DOE - Positive Behavior Supports Program. The Positive Behavior Supports Program develops local capacity at individual schools to:

- develop proactive behavioral practices,
- use school discipline as an instrument for student success,
- formalize team-based problem solving for addressing behavioral concerns and challenges,
- develop a continuum of procedures for acknowledging appropriate behaviors,
- develop a continuum of procedures for discouraging inappropriate behaviors,
- have on-going monitoring and evaluation procedures, and
- develop the local expertise and capacity of the school leadership team to address simple to complex behavioral challenges of students.

DOE - Primary School Adjustment Project (PSAP). The Primary School Adjustment Project is a school-based early identification and intervention program which seeks to enhance learning and adjustment skills to reduce social, emotional, and school adjustment difficulties for children in grades kindergarten through three. It is a preventative mental health project based on the belief that early intervention can prevent the development of more serious difficulties in later years

DOE- Community Children's Councils (CCC). The Community Children's Councils were created in the Felix Implementation Plan as one of the key partnerships in the development of a full array of services to special needs children and their families. The mission of the CCC is to provide local forums statewide for all community members to come together as equal partners to discuss and positively affect multiple systems issues for the benefit of all children, families, and communities. Full participation of families is a high priority for the CCCs. They are led by parent and professional co-chairs and include representation from public and private child serving agencies, private providers, and other community members such as recreational services, businesses, churches, and others. There are 17 CCCs in Hawai`i (8 on Oahu, 4 on Maui, 4 on Hawai`i Island, 1 on Kauai) who usually meet once a month. Parent support groups, workshops, and informational meetings on pertinent subjects are common local activities. Conferences and special events are offered throughout the year.

Department of Human Services (DHS)

DHS – MEDQUEST Division (MQD). QUEST is a program the Department of Human Services MQD developed for Medicaid clients who are under the age of 65 years and without a disabling diagnosis. QUEST is a statewide Section 1115 demonstration project that provides medical and behavioral health service through managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children's Health Insurance Program and offered benefits to citizens having incomes below 300 percent of the Federal Poverty Level (FPL). Low-income women, children, and adults who had been covered by the two "state-only" programs were enrolled into fully capitated managed care plans throughout the State. This program contributed substantially to closing the coverage gap in the State for low-income individuals. QUEST includes three primary programs: QUEST, QUEST-Net, and QUEST-ACE.

DHS Social Services Division (SSD). SSD provides protection from abuse and neglect for children and dependent adults. This program also provides safe living arrangements with the goal of reducing abuse, neglect and maltreatment. Within SSD, there are the Adult & Community Care Services and Child Welfare Services Programs (CWS). CWS programs include family strengthening and support, child

protection, foster care, adoption, independent living and licensing of resource family homes, group homes, and child-placing organizations. It administers the State's Title IV-E funding. Services are available on Oahu, Hawai`i, Kauai, Maui, Molokai, and Lanai with 36 units or sub-units and a staff of over 500.

DHS - Vocational Rehabilitation Program. The State Department of Human Services, Vocational Rehabilitation Program is a state-Federal partnership program that provides services to help people with physical or mental disabilities to achieve gainful employment and economic self-sufficiency. The VR program has developed a program specifically for youth and young adults. The Special Education-Vocational Rehabilitation Work-Study Program prepares students for transition from public school to employment and adult life.

DHS - Employment and Training (E & T) Program. The goal of the E & T program is to assist able-bodied persons receiving Food Stamp benefits to obtain employment and to become self-sufficient. E & T puts emphasis on employment, work experience, training, on-the-job training, and limited job search activities. E & T also provides supportive services in the form of a participant reimbursement to cover work-related expenses and child care.

DHS - Temporary Assistance to Needy Families (TANF) and Temporary Assistance to Other Needy Families (TAONF). TANF and TAONF are the time-limited welfare reform programs for adults with children. These programs are designed to protect those who cannot work and to require those who are able to work to do so. Unlike the old welfare program, which fostered dependence and low self-esteem, the TANF and TAONF programs require work and promote self-reliance, responsibility, and family stability. Both TANF and TAONF offer a package of strong incentives and penalties, child care support for working parents, and restructured welfare benefits so that it "pays to work." Households which include an adult, who is not exempt, are allowed to receive TANF or TAONF cash benefits for a maximum of five years in their lifetime. TANF and TAONF provide monthly cash benefits to families for food, clothing, shelter, and other essentials. The Department of Human Services implements dependency diversion and prevention programs and services with the goal of preventing people from needing welfare or keeping people off welfare.

*DHS - Hawai`i Public Housing Authority (HPHA).* The goals of the Housing and Community Development Corporation of Hawai`i, Hawai`i's Public Housing Authority, are to increase the availability of decent, safe, and affordable housing; improve community quality of life and economic vitality; promote self-sufficiency and asset development of families and individuals; and ensure equal opportunity in housing for all Americans. The Hawai`i Public Housing Authority contracts with approximately 26 nonprofit agencies to provide emergency and transitional housing coupled with health and social services, as well as provide outreach services to the unsheltered homeless.

The Department of Human Services has made TANF funds available to help low income families receive assistance in finding affordable rental units, mentoring on the responsibility of being renters, and assistance with first month's rent or rental deposit. Housing placement provides the linkage between landlords and Section-8 voucher holders and homeless persons transitioning to permanent housing.

The Rent Supplement Program is a State of Hawai`i funded program. The rental supplements help eligible families pay for part of their monthly rent. Families must pay at least 30% of their adjusted family income for rent. The difference between the family contributing rent payment and the total monthly rent, up to a maximum of $160.00 per month, is paid directly to the owner by HPHA.

DHS - Homeless Programs Branch. The Homeless Programs Branch provides persons who are homeless with shelter and supportive services, empowers the homeless to attain permanent housing, and implements homeless prevention programs. The program's objectives are to address comprehensively the needs of the homeless in Hawai`i and provide opportunity for homeless people to help themselves to achieve improved living situations.

DHS - Office of Youth Services (OYS). The OYS provides and coordinates a continuum of services and programs for youth-at-risk to prevent delinquency and reduce the incidence of recidivism. The OYS also strives to provide a clear sense of responsibility and accountably for all youth services in Hawaii. Although a core responsibility of the OYS is to manage and operate the Hawai`i Youth Correctional Facility (HYCF), the agency places great emphasis on providing and supporting "front end" prevention, diversion, and intervention services. The OYS focuses on programs that address youths' needs from prevention to incarceration and aftercare.

The OYS partially funds several Youth Service Centers (YSCs) across the State to provide services that enable youth at risk to develop positive personal attributes. The YSCs are a means to provide youth and families with direct access to a continuum of support, prevention programs, and intervention services as well as information and referral services to a variety of agencies and resources within a community-oriented family support environment. YSCs incorporate a community planning process that includes citizen and family involvement, a focus on accountability, encouragement of interagency collaboration to ensure that individuals receive help "under one roof but from several sources," and the creation of partnerships and joint ventures.

Conducting activities during after-school hours, weekends, school intercessions, and holidays so as to complement and not duplicate other youth services, the YSC agencies provide targeted community outreach services and case management and supportive counseling to youth and their families. Community outreach involves staff making direct contact with youth, school personnel, and community members and organizations in an identified community to actively seek out youth to have them participate in activities and programs and to link with services that could enable them to interact and participate more successfully in the school and/or community as violence-free and drug-free individuals. The positive activities and programs that youth may engage in at the YSCs include sports and physical fitness, performing, visual, and culturally-focused arts and crafts, and educational development and support services such as tutoring, service learning, and career exploration.

The Youth Gang Response System (YGRS) was created to address youth gang behavior and related issues through a comprehensive and coordinated effort. The YGRS builds and maintains partnerships between public and private sector organizations to provide meaningful and positive opportunities for youth engaging in emerging or more serious gang behavior.

As a result of this collaborative effort, youth, schools, and communities benefit from a range of YGRS services that include school-based gang/violence prevention programs, community-based mobilization projects, gang awareness presentations and campaigns, truancy intervention services, community-based gang/delinquency intervention programs, anti-gang law enforcement sweeps, gang prevention/intervention training, gang-related informational forums, and on-going research on youth gang and delinquency trends.

The OYS's Adolescent Diversion Program, *Ho`okala*, which means to "free or release," is a statewide diversion program that the Juvenile Justice State Advisory Council and the OYS began in 1993 to ensure that juveniles are not secured inappropriately in police lock-up. The program was implemented to maintain compliance with three of the four federal mandates of the Juvenile Justice and Delinquency Prevention (JJDP) Act of 1974, as amended.

Ho`okala provides status offenders and non-violent law violators who have been arrested and who would otherwise be securely confined in police lock-ups, with 24-hour access to immediate crisis intervention services, assessment services, referral services, and short-term case management services. The program provides one-to-one supervision (attendant care) for youth whose parents cannot be contacted, case management, and access to emergency shelter services. Through these services, the program aims to divert juveniles from further involvement with the juvenile justice system and to provide immediate intervention at the point of arrest.

OYS also provides Non-residential and In-community Services, which provide appropriate intervention and supportive services to youth who are experiencing behavioral, emotional, substance abuse, or adjustment problems while in the community. Youth who benefit from these services are those who may be at-risk for incarceration or further involvement in the juvenile justice system, or who are in transition from incarceration at the HYCF to the community. These services include assessment/diagnosis, intensive supervision, individual, group and family counseling, cognitive restructuring, anger management skill development, independent living, social skill building, self-concept development, alternative educational services, and substance abuse education. Family strengthening activities are also provided as part of an overall effort to maintain successfully the youth in their families. http://hawaii.gov/dhs/youth/oys/index_html - LIST

OYS's Community-Based Residential Services seek to ensure that youth who do not require secure confinement or institutional care are served in a less restrictive environment that can provide individual and intensive services that are conducive to their growth and development. Less restrictive programs are often more cost-effective and better suited in fostering positive change in at-risk youth. Community-based residential programs allow youth in transition a unique opportunity to experience, in a safe and nurturing environment, many challenges they will face when living within a community. The goal of residential services is to provide an environment in which youth are able to increase their resiliency and reduce their risk factors to the extent they are able to safely return to a more permanent living situation. Services are provided to assist youth by increasing their decision-making, social and independent living skills, and by increasing their commitment to learning and education as important factors in their lives. Residential programs are provided on all major islands and provide an opportunity for youth to remain on their respective island near family and other community support systems.

OYS also operates the Hawai`i Youth Correctional Facility (HYCF). The primary purpose of the HYCF is to provide safe and secure housing for the most violent and dangerous juvenile offenders who pose a threat to the community. The HYCF provides a variety of counseling, treatment, and educational services within the facility to aid in the redirection and rehabilitation of each ward. The programs conducted within the facility are intended to be a part of this effort to provide guidance and opportunities for positive changes in the behavior of the youth. HYCF improvements currently being implemented include:

- Improve parole/aftercare programs to reduce recidivism with greater focus on re-entry programs, employment, life skills, and character-building activities;
- Improve youth policy and grievance system to meet national juvenile corrections standards; and

- Improve due process system for parole revocation.

Hawai`i State Judiciary
Under the Hawai`i State Judiciary are the Family Courts. The Family Court's mission is to provide a fair, speedy, economical, and accessible forum for the resolution of matters involving families and children. The Family Court hears legal matters involving children, domestic relations, domestic violence, and other civil commitment cases, guardianships of adults, and adult abuse cases. Family Court has four Judicial Circuits statewide. The FC has exclusive, original jurisdiction over juveniles who have committed delinquent acts and status offenses. Hawai`i Girls Court is another initiative implemented by the FC to develop and expand gender-responsive approaches to service delivery and support, and is the first court of its kind in the nation. CAMHD provides Family Court with clinical support in the form of training, consultation, assessment, and psychiatric services through its Family Court Liaison Branch.

County Government
The City & County of Honolulu (C&C), on the island of Oahu, has a one-stop Youth Services Center which provides services to at-risk, disadvantaged, and offender youth and young adults through six youth development and employment training programs. These programs are designed to improve the economic, educational, and social well-being of young people. The six programs are:

C&C - Juvenile Justice Center - provides status offenders and first-time law violators, ages 14 - 17, with accountability-based sanctions to prevent them from further involvement in the justice system. Services include anger management classes, mediation, substance abuse counseling, leadership development, and pre-employment training.

C&C - Workforce Investment Act Youth Operator Program - coordinates comprehensive employment services for youth participants ages 14-21. Activities include occupational skills training, alternative education, and job readiness and placement services.

C&C - Youthbuild Honolulu - provides non-high school graduates, ages 16 - 24, with alternative education and job training services. Services include a high school diploma program, vocational and hands-on construction training, leadership development, and job readiness and placement services.

C&C - Youthbuild Honolulu Re-Entry Project - offers adjudicated, non-high school graduates, ages 16 - 24, the opportunity to prepare for employment and avoid further involvement in the justice system. Services include leadership development, a high school diploma/equivalency program, substance abuse counseling, hands on construction training, and employment services.

C&C - Youth Offender Demonstration Project - provides young offenders and those at-risk for court and gang involvement, ages 16 - 24, with the opportunity to attain educational and employment goals and avoid further involvement in the court system. Services include a high school diploma/equivalency program, occupational training, community service projects, mentoring, and therapeutic counseling.

C&C - Building for Stronger Tomorrows - provides all federal public housing residents the opportunity to gain skills that lead to employment and self-sufficiency. Services include basic skills and leadership development, vocational training, and job readiness training and placement services.

CAMHD Strengths

CAMHD has developed a comprehensive array of mental health services that are coordinated with other related children's services, and created a system of care that is:

- *Family Driven* – Family members participate in system-level decision making through the consumer-led State Council on Mental Health, the Community Children's Councils, the parent-controlled family network organization Hawai'i Families As Allies, and through consumer surveys, as well as participate in their child's treatment services through involvement in their Coordinated Services Plan and Mental Health Treatment Plan.
- *Individualized and Youth Guided* – Coordinated Service Plans and Mental Health Treatment Plans are individualized for each youth, and "youth-guided planning meetings" are being newly implemented at the Family Guidance Centers.
- *Culturally Competent* - CAMHD remains committed to ensuring that all services provided to the persons under our care are provided in a culturally and linguistically competent manner. As a result of the unique and diverse nature of Hawai`i's population, including over ten common non-English language-speaking subgroups, CAMHD staff and administration understand the importance of addressing cultural beliefs and differences and remain fully aware of the ways in which the quality and effectiveness of mental health services are inherently tied to those beliefs and differences. Cultural competency is addressed with all of the providers within the CAMHD network and with all Division staff and administrators through training opportunities in this area as well as the provisions for cultural competence included in relevant policy and procedures, contract management standards, and parental rights brochures. In CAMHD's 2011 Consumer Report, 88% of respondents reported that services were culturally sensitive (the highest agreement ratings of all areas measured). Also, Table CAMHD1 shows that CAMHD's registered population closely mirrors the general population, although Asian youth are underrepresented and Multiracial youth are slightly overrepresented.
- *Community Based* – Over the years, CAMHD has made substantial progress toward services being community based. In FY 2010, 73% of procured services were intensive home and community services, 14% were supportive services, and 16% were outpatient services, while 35% were out-of-home (youth can receive more than one service type). Even for out-of-home services, such as community-based residential services, youth are kept in their home community as much as possible. In addition, rates of out-of-home placement, especially out-of-state placement, continue to show reductions.
- *Least Restrictive* – CAMHD continues to follow its CASSP principle that "Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs." From 2005 to 2010, the annual number of youth receiving out-of-home services decreased from 706 to 486 (31% decrease), which includes decreases in hospital residential services, community based residential services, and group home services, reflecting CAMHD's priority in keeping youth in their home.

Table CAMHD1. Comparison of Race Proportions Between CAMHD Registered and Population Youth

Race	Percent of Population Less than 18	Percent Registered in CAMHD System *
White	15.3%	15.8%
Black or African American	1.6%	1.2%
American Indian and Alaskan Native	0.2%	0.6%
Asian	26.9%	9.3%
Native Hawaiian and Other Pacific Islander	13.4%	15.6%

Some other races	1.3%	0.9%
Multiracial	41.3%	56.7%

* - Includes youth 3-20.

In addition, CAMHD has made considerable progress in the area of Health Information Technology, especially with its implementation of Telehealth services. By providing Telehealth capability at each of the CAMHD's Family Guidance Centers and major providers across the state, CAMHD will be able to increase access to care in remote/shortage areas and increase family contact and family therapy for youth and their families who are physically separated. This will benefit youth in residential placement on one island that have family members living on another. Telehealth will allow the family to have some contact with the youth and will also provide an opportunity for the family to continue family therapy. The Telehealth system is on a secure system, adhering to HIPAA privacy requirements. Another goal is to integrate Telehealth functions with Electronic Health Record operations. Not only will operations be more efficient but cost savings will arise from reducing travel costs as well as pool professional services that can be accessed anywhere across the Telehealth network. The system will also allow more training to be conducted.

CAMHD's emphasis on data-driven decision making is another strength. This is evident through an extensive library of relevant technical reports ranging from Quality Assurance programs, quarterly Interagency Performance Monitoring and Utilization Management Reports, Annual Fact books, Provider Reports, and Consumer Survey Reports. Some of the data analyzed and presented in these reports have been published in peer-reviewed publications and presented at national conferences. Also, results from these reports are not only presented to CAMHD's various committees via hard copy and/or online, but are often presented to local stakeholders. Stakeholder interpretation of data often results in a different focus and priority, depending on the needs brought to light by the reports.

CAMHD Needs

It is clear that CAMHD, like similar authorities in other states, has many challenges in addressing its population of youth who are in need of and qualify for services for Serious Emotional Disturbances (SED). While a conservative estimate of the percentage of youth in Hawai`i with SED is about 5%, the proportion of CAMHD's registered youth is about 1% of the population of those aged 5-19 in Hawai`i and those who procure services are about 0.6% of this same population of youth. In addition, both the number of registered and served youth has been decreasing in the past 2 years (7.6% and 8.5%, respectively, from FY 2009 to FY 2010). A number of environmental factors are likely contributing to this, but CAMHD has determined that one important way we can make sure all appropriate youth are referred to CAMHD is to work more closely with referral agencies to ensure that youth in need have access to CAMHD's system of care.

Also related to access to care and early intervention is the need for CAMHD to work more closely with primary care providers. There has been little collaboration to date with primary care, and the national move toward integrating behavioral health with physical health makes this an imperative. This collaboration would seek to ensure that earlier mental health intervention takes place to prevent more severe problems in youth.

Another high priority in being responsive to health reform and the challenging fiscal climate is increasing Medicaid dollars in Hawai`i's children's mental health system. In order to serve the number of youth who need CAMHD services as the health system moves toward greater coverage for individuals, there is

a critical need to maximize Medicaid reimbursement for the youth that CAMHD serves. Expanding the list of Medicaid billable services through the State's MedQUEST division has been a challenge and is an area that must be addressed in the upcoming years.

While CAMHD is a highly data-driven organization, its data systems must be updated to become advanced enough to respond to the needs of the system. System of care stakeholders are demanding more timely and broader access to data, such as care coordinators being able to access their own and providers' progress ratings quickly (i.e., in real time). Data processes must also become more efficient and effective at providing the system with real time data on costs, service utilization, medication management, and so forth.

Better Health Information Technology will allow CAMHD to establish a system to monitor the quality of health information, establish a review schedule of quality measures and provide relevant and timely feedback, and establish a decision support system to enhance compliance with best clinical practice. CAMHD plans to enhance Electronic Health Record functions to gain efficiencies and effectiveness in such areas as cross-agency data sharing, automatic computer notifications for incomplete work or necessary review, patient alerts for identified problems, and the streamlining of operations as data flows seamlessly from one section to another.

CAMHD has also recognized the need to strengthen trauma services throughout the system of care. CAMHD was recently awarded a six-year multi-million dollar grant from SAMHSA. Project *Kealahou* is designed to increase the capacity of the Hawai`i system of care to provide effective mental health treatment to girls who have experienced significant trauma. The initiative will establish some new gender-specific, trauma-informed programs, and will work with existing CAMHD-contracted programs and agency partners to enhance the effectiveness of their interventions with traumatized girls. Once best practices regarding trauma-informed care is identified, CAMHD will develop a system to introduce, monitor and evaluate the effects of trauma-informed practice. Included will be training for providers in evidence-based trauma treatment.

Finally, there is also a gap in services for youth who are transitioning to adulthood. CAMHD previously had Independent Living Programs for youth ages 16-18 and for ages 18-21, which were offered by multiple providers. These programs are designed to assist residents in developing the skills necessary to live independently in the community upon discharge. It is responsible for linking young adults to educational, vocational, employment, health services and community resources. Currently only one provider exists that operates a 16-18 year old program. Other assistance in the community for these youth is limited.

Adult Mental Health Division (AMHD)

The AMHD seeks to provide a comprehensive, integrated mental health system supporting the recovery of adults with severe and persistent mental illness. Services include mental health education, treatment and rehabilitation through community-based mental health providers, and in-patient state psychiatric hospital care for persons with mental illness, including those referred through courts and the criminal justice system.

The AMHD includes clinical and administrative lines of authority and responsibility from the Division to the county level for State-funded and operated services, all under the AMHD Chief. The AMHD Medical

Director supervises the clinical lines through the Statewide Services Directors (SSDs), who have statewide responsibility for the development of services, program standards, and policies and procedures, according to evidence-based practices and professional standards. The SSDs also provide coordination with relevant agencies to their service specialty; determining contract scopes of services, and provision of training and technical assistance for the AMHD system of care. The specialty areas of the five SSDs are: 1) Crisis Services, ACCESS Line and Specialized Treatment Facilities; 2) Community-Based Case Management, Community Support Services and Psychosocial Rehabilitation/Clubhouses; 3) Community Housing; 4) Mental Illness/Substance Abuse (MISA) and Special Populations (including Transition-Age Youth, Trauma, Older Adults and Co-Occurring Cognitive Impairments) and; 5) Continuity of Care. In this organizational context, Utilization Management and Performance Improvement are also considered part of the clinical lines.

AMHD's Service Eligibility

The AMHD eligibility criteria are organized into the following three categories: Category I: Continuing Services; Category II: Time Limited Services (including, but not limited to, Homeless and Crisis Services); and Category III: Disaster Services. Formerly more inclusive, the primary focus of the current eligibility criteria became individuals who have been diagnosed with a severe and persistent mental illness, who may also have co-occurring mental and substance use disorders, and those who are legally encumbered. Individuals must continue to demonstrate significant functional impairment, one that seriously limits their ability to function independently in an appropriate and effective manner (Global Assessment of Functioning score of 50 or lower). Individuals must also: 1) live in Hawai`i and be a citizen of, or have permanent residency status in the U.S.A. 2) fall within similar assets/income requirement for Medicaid and 3) meet a delineated insurance status or continue to be without insurance coverage.

Continuum of Care

The AMHD offers a wide range of behavioral health services and the continuum of care spans from services that are more restrictive to those that are less restrictive. Services are provided to all eligible individuals including racial and ethnic minorities, the Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) community, native Hawaiians, and other historically underserved populations. Services provided are listed below.

CASE MANAGEMENT / SUPPORT SERVICES

1. **Community-Based Case Management (CBCM):** Community-Based Case Management services assist individuals with the provision of or linkage assistance to necessary medical, nursing, social, restorative and rehabilitative services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services include, but are not limited to, assessment of needs and goals for planning and implementing services, problem-solving and development of necessary skills to sustain recovery and achieve goals, contact with collaterals (family and agency) to mobilize services and provide support and education. Other services include advocacy on behalf of the individual, coordination of services specified in the plan, and direct therapeutic interventions such as medication management and crisis intervention. Additionally, there are a few specialty teams on O`ahu which have a focus on 1) Homelessness, 2) Borderline Personality Disorder 3) Community ReEntry and 4) Geriatric.
   • Islands served: O`ahu, Maui, Moloka`i, Lana`i, Kaua`i, Hawai`i

2. **Bi-Lingual Support Services:** Cultural and linguistic care coordination is provided in conjunction with a CMHC for consumers who speak little or no English to support them in their recovery and to better access formal mental health services. Outreach, education and consultation is also available to AMHD providers and the community.
   • Islands served: O`ahu

3. **Representative Payee:** Services are contracted by AMHD to community specialists who assume responsibility for being a representative payee for a person who is receiving SSI or SSDI. This time limited service is available for individuals who are currently unable to mange their finances and need assistance and skill building to resume responsible oversight for their own finances. The representative payee shall be directly responsible for receiving the entitlement, the payment of rent, utilities, transportation, food, and clothes for the consumer and the provision of a daily or weekly amount of money for the consumer's personal use from their entitlements. Assists with budgeting and offers opportunities for consumers to gain money management skills for increased independence as appropriate.
   • Islands served: O`ahu, Kaua`i, Hawai`i

4. **Homeless Outreach:** This service identifies and engages with homeless individuals with mental illness and provides the support necessary to link them with formal mental health and social services. Homeless Outreach workers interact with homeless persons suspected of having a mental illness and assist them to obtain an Eligibility Determination and appropriate linkage into services.
   • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

5. **Peer Coach:** Peer coach services provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and development and maintenance of community living skills. Peer coaching involves providing increased attention and supports to consumers when they are under high stress, beginning to decompensate, or returning to the community after a hospitalization.
   • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

<u>TREATMENT SERVICES</u>

6. **Hospitals (Inpatient, General, Non-Forensic):** The provision of inpatient care within a unit designed to service seriously mentally ill patients who have just been admitted or are experiencing an acute phase of their illness in the course of an extended hospitalization. Primary services are oriented toward developing a differential diagnosis, attending treatment plans to more fully respond to the acute needs of the stabilization of the patient's psychiatric condition and aggressive intervention.
   • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

7. **Specialty/State, Forensic:** The provision of secure or supervised care within a location designed to: 1) serve seriously mentally ill patients who require secure or supervised care beyond the acute phase of their illness. Primary services are oriented toward providing psychiatric rehabilitation services with the goal of achieving the highest level of functioning possible before returning to, or while residing in the community; 2) serve patients who are committed by a court to the unit to evaluate competency to stand trail, assess criminal responsibility, or provide recommendations for treatment. Services include clinical assessment, forensic evaluation, and short-or long-term treatment as appropriate based on the nature of the court commitment.
   • Island served: O`ahu (HSH)

8. **Intensive Outpatient (IOP) Hospital:** Outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. The goals of the service are clearly articulated in each consumer's individualized plan of care. Treatment is time-limited, ambulatory intensive, coordinated clinical service provided by a multi-disciplinary team.
   • Island served: O`ahu

9. **Specialized Residential Treatment:** This service provides intensive support and treatment on a 24-hour basis within a licensed treatment facility. The service provides Integrated Dual Diagnosis Treatment (IDDT) which is designed for those who may have a co-occurring serious and persistent mental illness/substance abuse disorder (MISA). Programs are comprehensive and have all-inclusive rehabilitative services to aid in developing skills that enable individuals with severe and persistent mental illness who may also have a substance use disorder, to manage symptoms and regain more independent functioning.
   • Island served: O`ahu, Maui

10. **Day Treatment:** This service is a structured day program for persons with a co -occurring disorder of mental illness and substance abuse (MISA) consisting of three hours to 25 hours of specialized treatment per week. The program is focused on treatment, relapse prevention and recovery.
   • Islands served: O`ahu, Maui, Kaua`i, Hawai`i.

11. **Aftercare**: This service is a program for persons with a co-occurring disorder of mental illness and substance abuse (MISA) consisting of up to five hours of specialized treatments per week for individuals who have completed Specialized Residential or Day Treatment. The program is focused on relapse prevention and recovery.
   • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

12. **Outpatient Treatment:** Outpatient Clinic Services are a series of services that are provided to the consumer in an outpatient clinic setting in combination with Community-Based Case Management. Interventions may include medication management, individual therapy, group therapy, and family therapy and education.
   • Islands served: O`ahu, Maui, Moloka`i, Lana`i, Kaua`i, Hawai`i

<u>CRISIS SERVICES</u>

13. **ACCESS Line:** This is a 24-7 Crisis and Suicide Hotline with membership in the National Suicide Prevention Lifeline. As the entry point to the AMHD system of care, ACCESS provides screening for eligibility; supportive listening and crisis counseling; dispatch and authorization of 24-Hour crisis services for all ages; and serves as the after hours link for oral *Ex-Parte* orders.
   • Islands served: Statewide

14. **Crisis Mobile Outreach (CMO):** CMO provides assessment and intervention services for adults in an active state of crisis. This community-based service is available twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the consumer's home, local emergency department, etc. This community-based service provides an opportunity for immediate crisis intervention and de-escalation, which includes a thorough assessment of risk, mental status and medical stability, and exploration of service options in the community.

• Islands served: O`ahu, Maui, Moloka`i, Lana`i, Kaua`i, Hawai`i

15. **Crisis Support Management (CSM):** CSM provides time-limited support and intervention services to individuals who are in crisis and not linked with services or who do not have a Division-assigned case manager. Services assist the individual in returning to a pre-crisis state and gaining access to necessary services.
    • Islands served: O`ahu, Maui, Moloka`i, Lana`i, Kaua`i, Hawai`i

16. **Licensed Crisis Residential Services (LCRS):** The LCRS offers short-term, focused interventions to individuals experiencing or recovering from a psychiatric or behavioral health crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS services are for individuals who are experiencing a period of significant distress which impairs the capacity to cope with normal life circumstances. The program provides services which address the psychiatric, psychological, and behavioral health needs of the individual.
    • Islands served: O`ahu, Maui, Hawai`i

17. **Pre-Booking Jail Diversion:** This program operates as a joint effort between AMHD and the Honolulu Police Department (HPD). When a person is suspected of mental illness at a crime scene, the HPD officer can request consultation from one of three HPD-employed psychologists who are on 24-hours a day. This program is designed to appropriately divert individuals with mental illness into treatment rather than incarceration.
    • Island served: O`ahu

<u>COMMUNITY HOUSING</u>

18. **Therapeutic Living Program**: The Therapeutic Living Program is a residential program designed to provide longer term support for individuals whose recovery is largely stable but who need ongoing support with medication management or to remain connected with services. On-site programming is available, including medication management, although individuals are encouraged to be actively involved in off site programming and activities in order to continue to foster recovery and independence.
    • Islands served: O`ahu

19. **24 Hour Supervised Group Home:** The 24-hour group home provides supervision twenty-four (24) hours a day, seven (7) days a week. Services are directed to consumers being discharged from the hospital and to those consumers who need twenty-four hour supervision to build community living skills. This is a time-limited rehabilitative program whose goal is to move consumers to more independent living options from a higher level of care. The service is designed to be individualized, integrated into the community, and the most normal and least restrictive possible consistent with the individual's needs.
    • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

20. **8-16 Hour Supervised Group Home:** This housing service is designed to be skill based, individualized, integrated into the community, and the most normal and least restrictive possible consistent with the individual's needs. Supportive staff is on site between eight (8) to sixteen (16) hours per day, seven (7) days per week.
    • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

21. **Semi-Independent Living:** This housing service provides group living with property management staff on site 8 hours per day, plus some weekend coverage. This service applies to individuals who are capable of handling non-crisis issues for a day or two until a scheduled staff visit. This program is designed to be individualized, integrated into the community and the most normal and least restrictive possible, consistent with the individual's needs. The service focuses on home and community integration and enhances the independence, dignity, privacy of the consumer and personal choice.
    • Islands served: O`ahu, Maui, Kaua`i, Hawai`i

22. **Supported Housing/Bridge Subsidy:** Supported housing provides consumers the option to live in permanent housing of their choice with support necessary to successfully assume the role of tenant and neighbor. This occurs in settings where an individual can live either alone, with a relative, or friends in a home or apartment without regularly structured supervision from supported housing and mental health staff. Supports provided by mental health staff are separated from the living arrangements but in-home support is encouraged as needed.
    • Islands served: O`ahu, Maui, Moloka`i, Kaua`i, Hawai`i

23. **Shelter Plus Care (S+C) for the Homeless:** This is a HUD rental subsidy program in which a Residential Specialist locates housing for homeless persons with severe and persistent mental illness. Housing is selected by consumers, has 24-hour housing support team available to landlords and consumers; and the rental subsidy allows consumers to pay no more than 30% of their entitlements for rent.
    • Islands served: O`ahu, Maui, Moloka`i, Kaua`i, Hawai`i

24. **Safe Haven:** This HUD-funded transitional Safe Haven housing program for homeless consumers provides 24-hour supervision, primary care and case management. It is a low demand setting aimed to engage the chronically mentally ill homeless population.
    • Islands served: O`ahu, Hawai`i, Maui

<u>PSYCHOSOCIAL REBHABILITATION SERVICES</u>

25. **Clubhouse:** A Clubhouse program is a voluntary program whose participants are members, not patients or clients. Members' strengths and needs are emphasized rather than their mental illness, symptoms or psychiatric history. The clubhouse community operates as an "*Ohana"*. Members and staff work side by side in the running of the Clubhouse and work as partners in the rehabilitation and recovery process. Clubhouse services include Transitional Employment (TE), Group Transitional Employment (GTE) Supported Employment (SE), Supported Education (SE), Social Support, Advocacy and Case Management.
    • Islands served: O`ahu, Maui, Moloka`i, Kaua`i, Hawai`i

    - **Transitional Employment/Supported Employment**: This Clubhouse service offers members the opportunity for paid employment various hours a day and lengths of time depending on individual needs. Clubhouse staff assumes the paid TE job in the event of a member's (temporary) absence.
      • Islands served: O`ahu, Maui, Moloka`i, Kaua`i, Hawai`i

    - **Supported Education:** This Clubhouse service provides consumers with a full range of educational services from basic literacy through gaining of a General Equivalency Diploma (GED)

to educational counseling for college, technical education or other courses. Necessary supports are provided such as study skills training and social skills training.
• Islands served: O`ahu, Maui, Moloka`i, Kaua`i, Hawai`i

26. **Supported Employment (SE):** Supported employment is an evidence-based model of: 1) "Individual Placement and Support (IPS)", a "place-train" approach, or, 2) "choose get, keep and leave (jobs)" as opposed to engaging in pre-vocational training. These services are intended for consumers for whom competitive employment has not traditionally occurred, or has been interrupted, or intermittent as a result of their disability. Elements include zero exclusion, consumer preference, rapid job search, integration with mental health services; and personalized benefits planning.
• Islands served: O`ahu

FORENSIC SERVICES

27. **Post-Booking Jail Diversion:** Post-Booking Jail Diversion is a supportive case management service provided for potential consumers in post-booking and pre/post arraignment situations. The intent of this service is to reduce criminal recidivism by diverting eligible, non-dangerous mentally ill arrestees and detainees from incarceration and into the appropriate level of community behavioral health services. This service strives to balance the individual service needs of the arrestee/detainee, the legal requirements of the courts, and the safety needs of the community.
• Islands served: O`ahu, Maui, Moloka`i, Lana`i, Kaua`i, Hawai`i

28. **Central Receiving Division Project**: The CRD Clinical Services Project is a collaborative endeavor between the Adult Mental Health Division (AMHD) and the Honolulu Police Department (HPD), which funds psychiatric Advance Practice Registered Nurses in the main cellblock of the HPD. The goals of this project include rapid identification of detainees with mental health issues, including those currently receiving services and those who have yet to be identified as needing services or those who had received services in the past but had been somehow dropped from services, and to provide mental health assessment, intervention, linking or re-linking with services, and recommendations to the court for disposition at their hearing. The CRD Clinical Services Project is a project affiliated with the Emergency Psychological Services and Jail Diversion Project (EPSJDP) spearheaded by the Honolulu Police Department with collaborative support from AMHD. The EPSJDP provides training for police officers on issues related to mental health, substance abuse and appropriate interventions and compliance with state law, as well as consultation for involuntary transportation for mental health evaluations when warranted.
• Island served: O`ahu

29. **Court Based Clinician:** Works with the Central Receiving Division of the Honolulu Police Department as well as District Court to provide technical assistance and clinical consultation to Criminal Justice providers on mental health issues. Collaborates with District Court to facilitate entry into community services to decrease or avoid criminalization of individuals whose criminal actions are a result of mental illness.
• Islands served: O`ahu

30. **Community Based Conditional Release Program- Hale Imua:** This program serves forensically encumbered consumers on Conditional Release status and its programming is based on Contingency Management theory and highlights forensic issues. Hale Imua offers a interdisciplinary approach to integrated treatment along with a 24-hour group home setting focusing on consumer strengths.

The program is tailored to meet the unique needs of each individual, including tightly wrapped linkages to community programs and resources, such as Clubhouses. This localized service is supported primarily by Windward Oahu CMHC Staff, Koolau Clubhouse and Steadfast Housing.
• Island served: O`ahu.

31. **Community-based Fitness Restoration-Kalihi-Palama Community Fitness Restoration Program (K-FIT):** This program provides fitness restoration in a community setting, after a defendant has been released on conditions to the community on a 704-406(1) (unfit to proceed with discharge to community) legal status. Along with other treatment, KFIT additionally provides a specific track aimed at restoring fitness. The residential and treatment model is similar to the Hale Imua program. This program allows for the safe discharge of court-ordered HSH patients who no longer need hospital level care. Like Hale Imua, the program is tailored to meet the unique needs of each individual, including linkages to community programs and resources, such as Clubhouses. This localized service is supported primarily by Kalihi-Palama CMHC, Hale O Honolulu Clubhouse and to a privately contracted housing service.
• Island served: O`ahu

32. **Community Re-Entry Program:** This program is a collaborative effort between AMHD and the Department of Public Safety, The Judiciary, and The Institute of Human Services (state's largest homeless shelter). This program starts with engagement and transition planning while the individual is still incarcerated and immediately upon release, provides shelter with treatment programming customized to address the unique needs of mentally ill individuals returning to the community following incarceration. The goal is to build on consumer strengths to develop new skills, coping strategies, and natural individual and community supports to achieve recovery and reduce recidivism.
• Island served: O`ahu

33. **Conditional Release (CR) Exit Support and Transition Program (CREST):** This program provides an avenue for consumers on CR to prepare for potential release from CR. It involves a multi-session group format with primary focus on identifying warning signs, triggers, crisis plans, available resources, and other issues related to stabilization community tenure and reducing recidivism. Additional supports and resources are provided to help the court take action on the case in a timely manner.
• Island served: O`ahu

34. **Mental Health Court:** It is an inter-disciplinary, cross agency collaboration between AMHD, the Judiciary, Prosecutors Office and Public Defenders to address public safety, reduce recidivism, and increase community tenure for individuals with severe and persistent mental illness.
• Islands served: Statewide

35. **Courts & Corrections**: Provides court ordered evaluations for fitness to stand trial, penal responsibility, dangerousness and conditional release. Also, conducts an annual training for all fitness evaluators statewide.
• Islands served: Statewide

36. **Forensic Specialty Consultation**: This service provides a highly specialized forensic psychologist to provide technical assistance, and with case consultation to increase community tenure for all AMHD individuals who are on conditional release or release on conditions

• Islands served: Statewide

OTHER SERVICES

37. **Transition Aged Youth Program**: Services youth starting at age 17 for potential eligibility with AMHD. For those who are identified to be eligible upon turning 18 years old transition planning can occur to support smoother transition for the youth to the adult system of care.
    • Islands served: Statewide

38. **Multi-Cultural Services**: This service provides cultural competency training with ongoing technical assistance and consultation to AMHD staff, providers, consumers and family members. Provision of culturally appropriate service is ensured and a mechanism is established for ongoing data collection and monitoring on cultural competency outcomes and overall system change.
    • Islands served: O`ahu, Maui, Moloka`i, Lana`i, Kaua`i, Hawai`i

39. **Expanded Adult Residential Care Home (E-ARCH):** This is a care home placement service supported by RN and psychiatric case managers. It serves to successfully discharge AMHD consumers who are currently residing in the hospital (HSH, Kahi Mohala and Queen's Medical Center), who meet the intermediate care facility (ICF) level of care, have enhanced behavioral challenges, and are currently appropriate for admission to an E-ARCH.
    • Island served: O`ahu

40. **Hawaii Certified Peer Specialist (HCPS) Program:** The HCPS program has consisted of intensive consumer training and an examination for obtaining this certification. In the next two years, through a collaboration between the Office of Consumer Affairs and the AMHD Trauma Informed Care Initiative (SAMHSA funded grant); a forensic specialty track will be added to the HCPS program.
    - Island served: O`ahu, Maui, Moloka`i, Lanai, Kaua`i, Hawai`i

Community Mental Health Centers

The AMHD publicly-funded and operated Community Mental Health Centers (CMHCs) are under the direction of the CMHC Systems Administrator, a member of the AMHD Executive Team. This position is responsible for the operation of the eight CMHCs and their respective satellite clinics as well as nine Clubhouses statewide. The administrator ensures that the standards, service definitions, reporting requirements, and policies and procedures are implemented and followed by each CMHC. The eight Center Managers are responsible for administration of the CMHCs day-to day activities. Beginning July 1, 2010, designated center managers from each county Hawai`i, Kaua`i, Maui (islands of Maui, Moloka`i and Lana`i), and O`ahu assumed certain service area administrator functions. These designated administrators provide leadership for each of the four county-level state-mandated Service Area Boards (SABs) on Mental Health and Substance Abuse. The SABs provide service input and suggest solutions for community needs and challenges.

The CMHCs are led clinically by Medical Directors, who report administratively to the Center Manager, but are clinically supervised by the AMHD Medical Director. Each CMHC also has a Case Management Coordinator, a Mental Illness/Substance Abuse (MISA) Coordinator, and a Forensic Coordinator. Together, these center-based clinicians make up the core of the clinical leadership at each center.

Hawai`i State Hospital

The only state hospital, the Hawai`i State Hospital (HSH), is a branch of the AMHD and is administered under the responsibility of the AMHD Chief. The HSH is led by an administrator. Clinical leadership is provided by a Medical Director, who both administratively and clinically oversees all of the clinical departments. The hospital is a Joint Commission on Accreditation of Healthcare Organizations-accredited facility with a current census of 182 filled beds as of August, 2011. The HSH's population is 95 percent forensic and provides short and long term, inpatient psychiatric and rehabilitative services statewide. Admission is generally by Court order, as is discharge. The facility is state-operated and served 413 individuals with average patient days of 192.28 in FY2010.

AMHD's Contractual Relationships

In addition to contracts with thirty Purchase of Service (POS) providers, the AMHD contracts with community hospitals, including Kahi Mohala Hospital, Queen's Medical Center and Castle Medical Center on O`ahu and with Hawai`i Health Systems Corporation for the neighboring islands. The latter operates four neighbor island community hospitals: Hilo Medical Center, Kona Community Hospital (Big Island), Maui Memorial Hospital and Samuel Mahelona Memorial Hospital (Kaua`i). To augment the formal, contractual relationships the AMHD Provider Relations Director holds monthly meetings with the Provider Community, oriented to both clinical concerns and administrative issues.

Mental Health Treatment in Jails and Prisons

Mental health treatment for inmates is provided through the Department of Public Safety (DPS) at all of the State's correctional facilities. Additional mental health staff are being hired and trained to assist in improving services to mentally ill inmates and expand mental health treatment programs for inmates, including coping skills and dealing with trauma. Multiple organizations, including the DPS Intake Service Center, the Health Administration of all state correctional facilities, and the Attorney General's office meet monthly to improve mental health treatment including transitioning out of facilities. The AMHD and MHT SIG are collaborating with the state's women's prison, Women's Community Correctional Center (WCCC), to expand trauma programming. The AMHD Forensics Service Director and the Mental Illness/Substance Abuse and Special Populations Service Director implemented a community reentry program for inmates leaving O`ahu Community Correctional Center (OCCC), WCCC and Halawa Correctional facilities. Additionally, AMHD conducts Trauma Treatment Groups in WCCC. AMHD is actively involved in the Justice Re-Investment Initiative which is a collaboration/grant between the Department of Public Safety and the Council on State Government-Justice Center.

Consumer Participation in Integration and Coordination

The AMHD is committed to ensuring the full participation of consumers at every level of the organization. AMHD consumers have multiple avenues for participation in the development, provision and oversight of AMHD services in assuring the provision of quality services. This occurs through a variety of organized mental health structures including the State Council on Mental Health, County Service Area Boards, Multicultural Advisory Committee, AMHD Office of Consumer Affairs (OCA), Statewide Clubhouse Coalition, Statewide Peer Coaching Program Statewide Certified Peer Specialist Program, and a number of other committees and groups. The monthly AMHD Chief's Roundtable provides an opportunity for consumers and family members to make their concerns and needs known to the Division Chief.

Consumers, including the Chief of AMHD OCA, played an integral role in AMHD's successful application to SAMHSA for a Mental Health Transformation Grant in 2010 and continue to play prominent roles throughout the planning, implementation and evaluation of the grant's trauma-informed care and trauma-informed peer support development activities. Consumers, including existing Peer Specialists, are consulting in every phase of the redesign and re-launching of AMHD's Certified Peer Specialist Training Program. Consumer representation is also present in the development of scopes of service, selection and awarding of state contracts. OCA is actively involved in the grievance and complaints process.

QUEST Behavioral Health

Public mental health services for adults with severe and persistent mental illness have been delivered through two major mechanisms in the State of Hawai`i. First, public services are funded and provided by the Department of Health's Adult Mental Health Division (AMHD). Second, government insurance programs for adults with severe and persistent mental illnesses are administered through the Department of Human Services (DHS). The DHS, which is the Medicaid intermediary, administers the QUEST program for the uninsured who meet the assets and income criteria. The DHS contracts for service provision through the QUEST managed care programs with three providers: 1) Kaiser Quest, 2) HMSA Quest and 3) Aloha Care Quest, which are responsible to provide both mental health services and primary care services. The intent of this integration of services is for an individual to receive physical and psychiatric care from the same organization in hope of improving overall health outcomes.

The AMHD system of care is only one part of the treatment system for adults with SPMI. Significant numbers of persons are also served through the private sector, Hawai`i's Pre-paid Health Insurance Act, and government insurance programs including Medicaid, Medicare, and Med-QUEST. Approximately 90% of the AMHD consumers have Medicaid coverage, and all of AMHD providers are required to enroll consumers in Medicaid with AMHD as the payor of last resort. Only 9.6% of Hawai`i residents lack health insurance – the 3rd lowest percentage in the United States (My Online Maps[4]). The preponderance of residency on O`ahu necessitates a larger proportion of services to be delivered within the City and County of Honolulu which must be balanced against provision of a comprehensive integrated system of care in all counties.

Dental Services

Historically, there has been poor participation by dentists in the State Medicaid program primarily due to the low reimbursement rates. Dental coverage for adults in Medicaid has been for emergency dental services only. As a result, consumers experience a lack of dental care which is further exacerbated by the side-effects to psychiatric medications that increase the risk of dental problems. On Kaua`i, dental health services are provided to Native Hawaiians and to all the under-served people of Kaua`i by Ho`ola Lahui Hawai`i at Waimea and Kapa`a.

The State of Hawai`i Hospital and Community Dental Services Branch provides dental evaluations and some treatment services to consumers residing in facilities operated by the DOH including Hawai`i State Hospital. The Branch also provides dental evaluation and emergency and comprehensive treatment for

[4] http://www.myonlinmaps.com/Hawai`i.php

eligible persons at community based DOH dental clinics located conterminously with the State Public Health Centers/CMHCs.

Since 1995, the Aloha Medical Mission's Honolulu Free Clinic has been providing 100% free medical and dental services at Palama Settlement, in Honolulu's low-income Kalihi district. Individuals who lack medical insurance are served, including many persons who are homeless. AMHD and the Community Dental Services Branch have collaborated to train dental staff in developing skills for working with individuals with SPMI.

Screening and treatment provided by volunteer physicians, dentists, nurses, and other health professionals and volunteers are provided during the hours from 4:00 p.m. to 7:00 p.m.
Provision of services, primarily for indigent, uninsured, disabled persons, is in high demand and has a long waiting period. Additionally, a *pro bono* group of dentists provides dental services. They offer free basic oral health dental services weekdays at Palama Settlement.

Veteran's Administration

The AMHD continues to collaborate with the Veteran's Administration (VA) on a regular basis. The availability of mental health services for veterans is becoming a higher profile issue with the increasing number of soldiers returning home from Iraq and Afghanistan. In an agreement between the DOH and the military, AMHD provides services to returning veterans. State funds are expended for services to veterans and the State does not bill the Federal government for these services. Although the VA has a robust mental health program, of special concern are the families of servicemen who may not take advantage of mental health services in the military hospitals due to stigma. Consequently, mental health services are also afforded this group when needed.

Services in Rural Areas

The AMHD definition of rural populations includes Hawai`i, Kaua`i and Maui counties. Maui County is comprised of three islands: Lana`i, Maui, and Moloka`i. Services are provided in these areas through the AMHD Community Mental Health Centers (CMHCs), satellite clinics, and the purchase of service provider network. Hawai`i's unique geography, demography and culture present special challenges in developing comprehensive treatment resources. Multiple languages, adherence to traditional Hawaiian culture, and influences from the mainland majority culture result in unique situations that require appropriate, differentiated treatment processes and responses. Rural areas consistently experience shortages of dentists, psychiatrists, psychologists, and social workers.

Transportation continues to be a major issue for consumers in rural areas, and in an attempt to address this service is generally more decentralized, and outreach is more evident. Lack of transportation in rural areas presents a challenge in not only to the accessing mental health services, but also in employment and educational opportunities for consumers. Consumer surveys and community forums consistently rate transportation as a major impediment to the receipt of mental health services.

Hawai`i County: Hawai`i County's land mass of 4,028 square miles is 1.8 times larger than all other Hawai`i counties combined. The "Big Island" aptly named is undergoing further population growth that continues to challenge public and private agencies. The total population for Hawai`i County is 175,784 based on Census Bureau data for July 1, 2010. The estimated total number of consumers currently being served in Hawai`i County is 3,623.

Kaua`i County: In FY2010, 702 persons received services from the AMHD. In addition to the services provided at the CMHC, Purchase of Service providers on Kaua`i also provided case management, day treatment, community housing including group home and supported housing services, homeless outreach and representative payee services.

Maui County: Maui has one CMHC, located in Kahului, and two clinics, one on Moloka`i and one on Lana`i. Maui County has been noted as a community with a strong, cohesive network of providers who meet on a regular basis to address community problems and develop a recovery-based system of care. 1,515 persons received AMHD services in FY2010.

Accessibility issues continue to be prominent in Maui County. Current capacity of a co-occurring substance abuse program is at 100%, which suggests that a needs assessment be performed for increased capacity and/or out-patient alternatives. Outreach workers for persons who are homeless have recently exceeded their targets and have registered 100 consumers with the AMHD.

Older Adults

Over the past year AMHD has assisted in the establishment of the Oahu Geriatric Mental Health Hui (OGMHH). Hui is a Hawaiian word meaning group. The Hui has applied for membership with the National Coalition on Mental Health and Aging. This group has regular representation from the following entities:

- Adult Mental Health Division
- Executive Office on Aging
- Elderly Affairs Division
- Alzheimer's Association
- Neuropsychologist/Brain Rehabilitation Specialist
- Institute for Human Services (Homeless Shelter)
- Consumer and Family Advocates

Activities include:

- The Hui is currently going to press in collaboration with the Executive Office on Aging, who publishes a quarterly newsletter, to dedicate the fall issue to Aging and Mental Health issues.
- The Hui provided the impetus for the Executive Office on Aging to develop the first statewide plan on Alzheimer's disease and Other Related Dementia. That project is currently underway.
- With the Newsletter and the Dementia plan underway, the Hui is now focusing its efforts on the issue of "elderly wanderers in the community" and trying to develop a coordinated community response. Information and community input was gathered on a possible "Silver Alert" but based on community input, this was discontinued and other avenues are now being considered.

LGBTQ Community

AMHD has obtained a SAMHSA grant for implementing Trauma Informed Care. As such, an Advisory Council is being formed. Developing strategies for increasing sensitivity to the LGBTQ community will be addressed in that forum.

At present, upon admission to services a new consumer is asked for their preferences, (i.e. how they would like to be addressed, gender they identify with, types of treatment approaches that are preferred, etc).

Strengths of the AMHD Service System

Partnerships

In order to improve service delivery and cut costs, the AMHD has formed numerous partnerships for joint service delivery with agencies such as the police department, hospital emergency rooms, the Judiciary Branch, Development Disabilities Division, the Child and Adolescent Mental Health Division, Vocational Rehabilitation and the Homeless Coalition. Likewise, a multi-agency partnership has increased the service system's understanding of and ability to provide trauma-informed care. Partners including AMHD, the MHT SIG, the University of Hawaii and the Office of Hawaiian Affairs, have implemented trauma-related activities. For example, trauma treatment has been advanced in various CMHCs, with contracted providers, including inpatient settings, the state's largest women's homeless shelter and the women's prison. The latter is an exemplary combination of screening, treatment and staff training that brought together all of the partners noted above and enjoys the active support of the National Center for Trauma Informed Care.

Trauma Informed Care

On of the strengths of AMHD is the Trauma Informed Care initiative (TIC IT). In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced that Hawai`i was among 22 states to have been awarded a competitive grant to enhance its public mental health services. The Mental Health Transformation Grant (MHTG) will focus on universal trauma screening for all service recipients within the Adult Mental Health Division service network. Individuals with a history of trauma will be provided with opportunities to receive trauma specific treatment services through the grant. Additionally, the grant will be collaborating with the AMHD Office of Consumer Affairs to train consumer advocates to partner in providing the trauma services and develop this into employment opportunities for peer providers.

TIC IT and four other SAMHSA funded projects have joined to develop the Trauma Alliance. The Trauma Alliance works to coordinate, share and learn from each other, to efficiently utilize resources, and decrease duplication of services. This has already resulted in a cross agency Trauma Training Collaborative, joint conference presentations, and resource sharing.

Through the TIC-IT initiative, many agencies have been trained in TIC, training resources have been provided, and statewide training opportunities have been offered.

Continuity of Care

The primary function of this new focus is to coordinate a statewide system of services for adults with serious and persistent mental illness and to address AMHD's enhanced mission to focus on "recovery into independence." It promotes continuity of care regardless of where the consumer enters into or intersects with the broader system including the criminal justice system Hawai`i State Hospital (HSH), the Community Mental Health Centers, and the private sector. This service addresses continuity within AMHD services, but develops and sustains positive alliances with key stakeholders from criminal justice,

judiciary, law enforcement agencies, community hospitals, Purchase of Service Providers (POS) and other medical and mental health agencies throughout the state.

It was found that case managers from the CMHCs as well as the POS community were discharging consumers without discharge plans from the hospital to the community. Compliance went from a low of 19% to a high of 84% compliance for case managers' attendance at recovery team meetings.

Emergency Room Usage/Criminal Justice Front Door Diversion/Collaboration

AMHD consumers are high utilizers of services in Emergency Rooms (ER). A significant number of these identified are also involved with criminal justice system. Previously, there were no consistent, routine expectations for the Honolulu Police Department (HPD) officers when engaging on duty with individuals exhibiting behavioral problems. Interventions used to resolve the issues were:

- Updated the Emergency Mental Health Worker (EMHW) policy and procedure according to statutes.
- The Director of Health designated three EMHWs to HPD.
- A Memorandum of Agreement was established between the Director of Health and the HPD.
- Monthly meetings with staff at Castle Medical Center(CMC), Queens' Medical Center (QMC), Tripler Army Medical Center (TAMC), HPD, AMHD Crisis Services, Emergency Medical Services, Crisis Mobile Outreach Team and Licensed Crisis Residential Services were convened.
- Formalized mental health training to all police officers were developed and implemented, the Emergency Psychological Services and Jail Diversion Program (EPSJD).
- New psychiatry residents and emergency room nurses at QMC, CMC and TAMC receive training in EPSJD.
- Advanced Practice Registered Nurses are now located in the HPD Central Receiving Division.

Forensic Program

The AMHD Forensics program continues to improve its capacity to provide services to its forensically encumbered consumers, including its Conditional Release Exit Support and Transition (CREST) program, Conditional Release (CR) program, Community-based Fitness Restoration (K-Fit) program, and Hale Imua program, particularly due to creative interventions used to divert appropriate individuals away from Hawai`i State Hospital. Recent developments include a court-based clinician at the Honolulu District Court to provide real-time assessments and consultation regarding mental health issues. Three landmark legislative bills were passed during the 2011 Legislative session that will have a positive impact on many forensically encumbered individuals.

- Act 53: Places a time limit of 60/120 days for fitness restoration for defendants charged with petty misdemeanor or misdemeanor charges; 40+ individuals are projected to be affected annually with significant reduction of time spent at the State Hospital.
- Act 99: Places a one-year time limit on Conditional Release misdemeanor charges; 30+ individuals are projected to be affected annually. Prior to this law, Hawaii had 100+ individuals on Conditional Release (CR) for misdemeanor charges with an average of eight months in a locked facility and 5-years on CR.
- Act 112: Requires the Department of Health to implement a community-based outpatient fitness restoration program, and for the Office of the Prosecuting Attorney to be the agency

that reports problematic behavior to the court. This should affect approximately 50+ individuals statewide.

Stakeholder Involvement in Projects

In 2010, the Adult Mental Health Division reviewed the data from our 2009 monitoring cycle and presented it to the following stakeholder groups:

- The Chief's Consumer Roundtable
- A Provider group (all providers invited)
- The Statewide Medical Executive Committee, a group of psychiatrists serving the Adult Mental Health Division population.

The stakeholder groups were tasked with selecting a small number of areas for improvement. In 2010, workgroups met and as a result, the items measured on supervision in the monitoring were condensed and training was provided to all providers on the changes and on supervision in general.

Preliminary results covering monitoring up to May 2011 show changes from 2010 monitoring:

- Adequate frequency of supervision rose from 45% in 2010 to 67% in 2011.
- Feedback on documentation such as progress notes, assessments, IRPs and reviews rose from 57% in 2010 to 71% in 2011.
- Inclusion of practical suggestions on the consumer case made during supervision rose from 16% in 2010 to 45% in 2011.

Provider Monitoring

AMHD monitors all service providers annually on such quality of care issues as the agencies' assessment of, planning for, and responsiveness to consumers' needs/interest in inclusion of family/natural supports in their treatment, as well as family/natural supports' need for psycho-education. Additionally, the medical needs of the Adult Mental Health Division consumers are examined through the monitoring process. The last full monitoring cycle showed the following:

- 65% of records had a detailed Axis III (medical) diagnosis listed
- 52% of records mentioned the consumer's medical provider by name. An additional 19% mentioned a clinic as the consumer's medical provider.
- 55% of records had progress notes that evidenced coordination with a medical provider other than a psychiatrist. Of those, in 67% of the cases reviewers felt that the coordination was adequate to address the medical needs of the consumer.

Suicides

The AMHD requires providers to submit a sentinel event report for every suicide and attempted suicide (using the World Health Organization definition). Secondary notification is required for questionable consumer deaths, for which the Division requests Medical Examiner reports to determine cause of death. The cases are reviewed individually and the data analyzed by age, gender, diagnosis, substance abuse, previous attempt, provider, last face-to-face service date, split care (psychiatrist is/is not co-located with the team), by staff ratio, proximity to inpatient discharge, association with Division funded housing, association with crisis outreach services, and association with utilization management limits.

For the State fiscal year ending in July 2010:

- Attempted suicides were lower than the previous year.
- Completed suicides were generally consistent with the previous year, with the exception of a spike of 4 cases in September 2010.
- Ages 50-69 were more likely to have a consumer death sentinel event when compared other age segments of the AMHD population. However, when compared with the Center for Disease Control mortality data, this age group was not significant. Nevertheless, in response to this, the Adult Mental Health Division made available to its providers "Healing the Spirit", a DVD produced by the Asian Pacific Fund about depression in the elderly Asian population.
- One provider had a higher percent of consumers with attempted suicides than would be expected, given the number served. This provider was given additional training on assessing for suicide in the SPMI population.
- No other associations were significant.

To begin addressing early mortality in the SPMI population, the Adult Mental Health Division partnered with the Office of Health Status Monitoring to look at causes of death in the entire Adult Mental Health Division population.

The causes of death within the Adult Mental Health Division population and the causes of death were compared with the nationwide data from the Centers for Disease Control, as well as prominent studies of mortality in the SPMI population (including the technical report produced by the National Association of State Mental Health Program Directors). The number of deaths for the following causes, given the number of people served by AMHD, is significant in comparison:

- Toxic effects of substances include both prescription medication and street drugs, particularly methamphetamines.
- Cardiovascular event or disease

To begin addressing these, the AMHD is engaged in a drill down study on deaths to examine how providers are addressing barriers to accessing health care.

Funding

Effective streamlining and sustainability efforts to provide services through the braiding of funding streams with programs such as: SAMHSA/CMHS Block Grant; the Division of Vocational Rehabilitation; the Mental Health Transformation State Incentive Grant; the University of Hawai`i; the Department of Labor Center for Disabilities Studies; and through the Social Security's Ticket to Work program. The braiding of funds currently supports the development of supported self-employment and self-sustaining micro-enterprise infrastructure and services, as well as supporting a collaborative effort to provide training and technical assistance for consumers' self-employment.

Hawaii State Hospital (HSH)

The commitment of staff and management at the Hawai`i State Hospital has resulted in reduction of the census. In the early part of 2010, the number of discharges had been very low compared to the number of admissions resulting in a chronic state of overcrowding. While discharges for this 95% forensic population occur largely through the Courts, analysis nevertheless indicated that emphasis on discharge planning held promise. The focus is on rehabilitative activities, and activities supplemented by

occupational therapy and Psychosocial Rehabilitation (PSR). The primary responsibilities for psychiatry, psychology, social workers are to stabilize patients who were having acute difficulties, with an enhanced emphasis on discharge planning from the beginning. Quality Improvement and Utilization Management are now collecting information on current "discharge ready" consumers and those at behavioral "baseline" where an expedited court hearing would be helpful in facilitating discharge.

Weaknesses of AMHD's Service System

Economic Issues

Deterioration of the state's budget because of the economic downturn has been the most challenging issue. A number of system weaknesses resulted and further reduction in state funds compounded existing issues such as affordable housing, homelessness, transportation, and dental services.

Overall, there is a lack of affordable housing for all AMHD consumers in local communities. Funds to leverage the development of new housing are limited. With limited residential space in Hawai`i to begin with this is a particular problem.

Homelessness

The homeless population grew 6.1 percent between 2010 and 2011 according to a new state Department of Human Services report in May 2011. The increase includes many who moved here from the Micronesian islands under the federal Compact of Free Association and many who have lost jobs and then apartments because of the recession. They joined many of the "chronically homeless" with problems complicated by substance abuse, mental illness or other health problems. Whatever the cause of the problem and despite a dire shortage of government funds currently, legislatures are determined to put together at least partial solutions as soon as possible. There are various strategies being pursued both privately and through bills in the Legislature. The governor has recently created a new position and appointed the state's first Homelessness Coordinator, who has set his sights on long-term development of an inventory of permanent rentals that the working poor can afford, as well as helping the chronically homeless through "housing first," a policy of getting these individuals stable shelter which then makes them more receptive to medical treatment and social assistance. The "housing first" idea is receiving support among state lawmakers; however, many community leaders believe a more realistic approach when money is limited lies in repurposing existing buildings rather than in new construction.

Homelessness Statistics

The following table shows the homelessness statistics for various regions of the state. The data presented below was collected on the night of January 5. The unsheltered count was taken from January 26, 2011 to January 31, 2011 and was based on the question, "Where did you sleep on the night of January 25?" The report is prepared by the state Department of Humans Services (DHS) Homeless Programs Branch and the Honolulu Department of Community Services in accordance with requirements for ongoing McKinney-Vento homeless assistance funding. A "point-in-time" count completed this year, found that there are more than 6,188[5] homeless people statewide (outreach

[5] Source: State Department of Human Services; annual point- in-time counts.

workers knew of people living in “mountains, caves and bushes” but did not count them due to safety concerns).

Number of Homeless People in Hawaii

County	2010	2011	Change
Oahu	4,171	4,234	+2%
Hawaii	599	566	-6%
Maui	791	1,052	+33%
Kauai	273	336	+23%
TOTAL	**5,834**	**6,188**	**+6%**

Oahu accounted for 2,912 of the 3,632, or approximately 80 percent, of the state’s total sheltered homeless population. Of this number, 514 were in households with children, 2,058 were people in families and 854 were individuals. The reported noted that there are much fewer shelter beds available to single individuals and persons in households without children. In Hawaii County the number of sheltered homes decreased for the third year in a row. There were 229 sheltered homeless on the island this year versus 286 in 2010 and 321 in 2009.

The counts of unsheltered homeless provided some noticeable movements. On Oahu the number of unsheltered homeless stood at 1,322 in 2011, down from 1,374 in 2010. There was a noticeable shift from the Waianae Coast to downtown Honolulu. In 2010, the Waianae Coast had the highest concentration of unsheltered homeless with 401 unsheltered individuals (29.8 percent of the island’s total unsheltered homeless population); while downtown Honolulu recorded 394 people (28.7 percent). This year the highest concentration of unsheltered homeless is in downtown Honolulu (448 people or 33.9 percent) with Waianae accounting for just 296 people (22.4 percent).

Kauai County’s overall homeless count increased 23 percent from 273 to 336, while Maui County’s overall homeless count jumped 33 percent to 1,052 this year from 791 in 2010, a statistical phenomenon. The author’s of the report attributed this to improved effort among outreach workers to get an accurate count. The change was especially evident in the island’s count of unsheltered homeless which totaled 658 this year compared with 399 in 2010.

Statewide there are approximately 508 chronically homeless people, of whom an estimated portion was persons with mental illness. A total of 505 (295 unsheltered, 210 sheltered) homeless people are veterans. The number of homeless people with serious mental illness reported for each county includes all people with serious mental illness who were in an Emergency Shelter, Transitional Housing, Safe Haven, or were unsheltered on the night of the DHS’ point-in-time count.

The data is a result of point-in-time analysis of the Homeless population in the state; therefore, the data is not without limitations. For instance, 1) the data is collected through a point- in-time count and does not reflect the total number of homeless individuals over the course of a year; 2) the data is based on HUD’s very specific definition of homeless – those living in emergency shelters, transitional housing for the homeless, safe havens for homeless individuals and in places not intended for human habitation (unsheltered), and 3) the data on the number of homeless who have serious mental illness is generally

self reported by the individuals being surveyed, or by shelter staff or outreach workers. This can result in inaccuracies and varying assumptions about the percent of homeless individuals with serious mental illness.

Projects for Assistance in Transition from Homelessness (PATH), created under the McKinney Act, is a federal formula grant that supports service delivery to individuals with serious mental illnesses, as well as individuals with co-occurring substance use disorders who are homeless or at risk of becoming homeless. AMHD contracts with local community providers to provide PATH services. The counties and contracted providers have developed innovative PATH programs to best serve the needs of the SMI homeless population in their geographical areas, with some of the recent awardees adopting evidence based practices such as Critical Time Intervention (CTI). In general, the services provided for PATH eligible individuals include: outreach; screening and diagnostic treatment; habilitation/rehabilitation; community mental health services, alcohol or drug treatment, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health, job training, educational services, and allowable housing services. Most of the PATH programs provide services to all PATH eligible adults.

Number of Homeless Persons with Severe and Persistent Mental Illness Served: Outreach services to persons who are "homeless"[6] are provided primarily by service contracts with POS providers jointly funded by the Center for Mental Health Services, "Projects for Assistance in Transition from Homelessness" (PATH) and the AMHD. It is anticipated that the numbers of homeless will increase statewide due to the overwhelming shortage of housing development and rentals. According to the Consolidated Plan for the State of Hawai`i, the state is currently experiencing a shortfall of approximately 34,000 affordable homes for purchase and 17,000 rental apartments.

In FY2011, based on the State's budget crisis, the AMHD began working on the following:

- Utilize only Project for Assistance in Transition from Homelessness (PATH) [7] Grant federal funds of $300,000 per year to provide outreach services to persons who are homeless statewide.

- Continue to work collaboratively with the Veteran Affairs Program Administrators, AMHD contracted providers, and the City and County of Honolulu to provide housing and services to homeless veterans who meet the eligibility criteria for services with AMHD, who prefer to receive services with community-based programs than with the Department of Veteran Affairs.

- In partnership with the Steadfast Housing Development Corporation increase the rental subsidy program and utilize the "Housing First" model in placing homeless person in housing of their choice.

- Continue to meet quarterly with case management service staff, State PATH coordinators, advocates, consumers, private and public providers and representatives from the religious

[6] AMHD definition of "homeless" is: "Homeless adults are 18 years of age and older with a severe and persistent mental illness or with a severe and persistent mental illness with co-occurring substance abuse disorder. These homeless individuals have no fixed place of residence or their primary residence during the night is a supervised public or private facility that provides temporary living accommodations and residence in transitional housing."
[7] PATH = Project for Assistance in Transition from Homelessness. Federal formula grants to states to provide outreach services to persons who are homeless.

community to discuss and develop plans concerning housing, homeless issues and service delivery.

- Workforce decline: Due to the state's economic situation, there have been hiring freezes on most state positions, leaving numerous positions unfilled over the past year.

- Service limitations: Due to fiscal constraints, case management hours were reduced to the mean of 3.5 hours per month for the average contracted case management. The limit on CBCM services has been seen as problematic by advocates and providers. There are exceptions for historical high utilizes and in cases of crisis.

Transportation

Travel in the rural areas of Hawai`i continues to be problematic. Ground transportation for rural consumers on the island of Hawai`i and air travel options for neighbor island air traffic are examples. Oahu has a good mass transit system, but the neighbor islands continue to lag in their development.

Shortage of Psychiatrists

Hawai`i has been experiencing an unprecedented shortage of psychiatrists in community mental health statewide. One contributing factor is the recruitment of the Veterans Affairs administration for psychiatrists to treat its returning veterans from the Iraqi and Afghanistan wars. With higher salaries and benefits in the private sector, psychiatrists are leaving the state's system.

Transition of Quest consumers to the Department of Human Services

Over the past year, the Department of Human Services (DHS) made a major decision to "put the head back on the body." The result of this decision was that approximately 1800 individuals with SPMI who where formerly served by AMHD were transitioned to DHS for their behavioral health needs. Since this is still a relatively new occurrence, January 2011, there still remain many systems challenges to ensure smooth continuity of care for the individual and reimbursement to community providers. AMHD and DHS continue regular meetings to refine this process. This poses a system's challenge for those individuals who continue to cycle in and out of insurance and other entitlements/benefits. During the time an individual with SPMI is uninsured, they are under the oversight of AMHD. Once they obtain insurance they often revert to DHS. If they lose their coverage they are back with AMHD.

Further complicating this cycle are those who experience a disruption in benefits due to incarceration. The Department of Public Safety destroys inmate property after 30 days, this includes identification. An interagency work group has been trying for years to change this policy but continually meets new challenges to this issue; including entities not wanting to incur the responsibility/liability for securing identifications especially in light of recent concerns over identify theft. Additionally, with more movement toward the electronic medical records, ability to store identification in charts is diminishing creating further challenges.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

II. Planning Steps: Step 2: Identify the unmet service needs and critical gaps within the current system.

Child and Adolescent Mental Health Division (CAMHD)

In 2010, CAMHD conducted a needs assessment with key stakeholders which led to CAMHD's Strategic Plan for 2011-2014 (See Attachment CAMHD1: "CAMHD Strategic Plan"). CAMHD's Strategic Plan goals align well with SAMHSA's new Strategic Initiative goals as can be seen in the Table showing the link between the two sets of goal that is provided in Table xx. (See Attachment CAMHD3: "Link Between SAMHSA and CAMHD goals"). However, a prioritization of the populations to be targeted was not part of this planning process, so under the requirements of this Block Grant application, a new key stakeholder meeting was convened with a focus on prioritizing the target population and specific strategies.

Needs Assessment Meeting with Key Stakeholders

The latest effort to collect stakeholder feedback was organized in a meeting CAMHD held with key stakeholders on August 11, 2011. Nine key stakeholders were identified and invited (five were able to join the meeting) to attend a two-hour planning session where they were asked to provide feedback based on their considerable knowledge in the area of children's mental health regarding the direction CAMHD should take with the next round of funding dollars to become available for FY2012.

The narrative below describes how CAMHD (with the help of an outside facilitator hired by CAMHD) organized a meeting of key stakeholders and worked with participants to help guide CAMHD on the set of priorities related to the mental health needs (and corresponding potential services and activities) of the children and families living on all of the islands of Hawai`i.

The key stakeholders who were able to participate in this meeting represented the family partner organization, Catholic Charities, the Family Court, the Department of Education, and finally a representative from Hawai`i's Mental Health Transformation State Incentive Grant (MHT-SIG). (See Attachment CAMHD4: "Needs Assessment Meeting Attendees" for a complete list of invitees and attendees.)

The initial activity that took place in the meeting was, first, to prioritize the goals created by SAMHSA according to the mental health needs of children in Hawai`i.[1] The stakeholder group was then asked to prioritize each of the initiatives that were part of each goal, in order of importance *within each goal*. The group therefore developed a prioritized list of initiatives based on the most important SAMHSA goals that could better address the mental health needs of Hawai`i's children.

At the end of the meeting a ranking of two types of initiatives was created that demonstrated the most important initiatives that needed to be funded using SAMHSA BG funding.[2] Meeting participants were informed that the list produced in this one meeting could be utilized as a starting point for another

[1] We also matched up the goals of SAMHSA with those stated in the CAMHD Strategic Plan. There was a great deal of overlap and agreement between the goals set forth by SAMHSA and those in the CAMHD Strategic Plan.

[2] A discussion of the populations served was not required, because they were prioritized automatically by prioritizing the initiatives. The gaps and populations discussion may happen again in the year and that could also be another discussion of these issues.

discussion which could occur in the following months. See Attachment CAMHD5: "Priority Ranking Score Sheet" for the tool that was used by the participants to prioritize the list of initiatives.

A description of the 12 identified needs in Hawai`i's child and adolescent mental health system that will be addressed through upcoming and future grant periods will now be presented. Step 3 of this application reports on the priority initiatives that were identified by stakeholders.

In addition, with ongoing changes in the health care environment and SAMHSA's priorities, it is also necessary to use this upcoming grant period as a transitional phase for the programs currently being supported by the Block Grant. CAMHD will assist current Block Grant funded programs e.g., the parent partner organization) in maximizing other funding sources and minimizing disruption to services while CAMHD redirects funds to address new needs and priorities. By the 2013-2014 application, CAMHD expects to be fully transitioned to a new set of strategies that tackle the new system needs as described below.

Hawai`i's Identified Needs

1. Increased Access to System

Prevalence Estimate. Research has shown prevalence rates of youth with Serious Emotional Disturbances (SED) to range anywhere from 5% to 20%. However, there is some agreement in the 5% - 10% range for SED (Earls, 1980; Friedman et al., 1996; 1998; Gould et al., 1980; Vikan, 1985). Using the most conservative 5% estimate of the prevalence of SED by counties in Hawai`i for individuals aged 5-19 (from the 2010 census), Table CAMHD2 below shows there to be about 12,545 SED youth in the state of Hawai'i.

Table CAMHD2. Estimate of Number of SED Youth Aged 5-19 Years by County *

County	Number of Youth	Number of SED Youth (using 5%)
Hawai'i	35,088	1,754
Honolulu	174,309	8,715
Kauai	12,380	619
Maui	29,117	1,456
STATE TOTAL	250,894	12,545

* - (Based on 2010 U.S. Census)

While the Department of Education's School-Based Behavioral Health (SBBH) program serves about 8,300 youth per year, they primarily serve youth with less intense needs while CAMHD serves the youth who are SED. The distribution of youth who were registered with and received procured services through CAMHD in 2010 is:

Geographic Region	Registered Youth	Served Youth
Honolulu	224	161
Central Oahu	162	139
Windward Oahu	156	121
Leeward Oahu	354	239
Hawai`i	724	482
Maui	223	145
Kauai High End	143	77

Statewide TOTALS	**2,661**	**1,389**

CAMHD has not yet been able to determine how many youth with SED are being served in the private sector, but it is not likely that number will fill the gap to reach the conservative 5% estimate of need.

Reduction in Registration and Services. CAMHD's internal analyses reveal that there have been consistent decreases in the number of youth registered in and served by the system in recent years. From FY 2009 to 2010, there was a 7.6% decrease in youth registrations and over that same year there was an 8.5% decrease in the number of youth served. A more recent quarter by quarter trend reveals a 20.1% decrease in youth registered in the two year period from FY 2009 quarter 3 to FY 2011 quarter 2 and a 24.2% decrease in youth served in the same time period. This decrease has occurred in a system with an already low penetration rate. The analysis provided by SAMHSA's Data Infrastructure Grant (DIG) using their Uniform Reporting System (URS) data reveals that the SED population penetration rates for CAMHD are well below the national average. For 0-12 years, CAMHD's rate was 4.1 per 1000 while the national average was 11.2. For those aged 13-17 years, the rates were 19.6 for CAMHD and 25.8 nationally.

In addition, results of CAMHD's 2011 Consumer Survey showed that the second most frequent theme offered in the open-ended responses regarding what to improve in CAMHD's services was related to access to children's mental health services, with many parents suggesting more funding, facilities, and transportation (12% of responses).

Stigma against mental illness continues to be an important challenge in Hawai`i, particularly where there are strong cultural beliefs about the disclosure of mental illnesses in the family. In addition, the awareness of CAMHD services throughout the child-serving system seems to be decreasing. This could be due to reductions/turnover in state agency staff and reduced staff trainings. New strategies must include efforts to reduce the stigma related to mental health while simultaneously increasing access to mental health services through greater interagency collaboration and public awareness.

2. Earlier Intervention

CAMHD's population's age distribution is heavily skewed, with the largest proportion of youth served being older (average being 14.1 years of age). According to A. Kathryn Power, Director of the Center for Mental Health Services at SAMHSA, half of all diagnosable lifetime cases of mental illness begin by age 14, and three-fourths of all lifetime cases start by age 24. The first symptoms occur 2 to 4 years prior to development of a diagnosable disorder. Dr. Power asserts that mental health policy makers have an important window of opportunity to identify early or even prevent some mental illness. Interventions that are delivered before a disorder manifests itself offer the best opportunity to preventing a mental illness from becoming a more severe problem later on in the life of a child.

3. Strengthen Multiagency Collaborations.

Many youth with SED who qualify for CAMHD services may be involved in other systems, such as the Department of Education, Juvenile Justice System, and Primary Care. Despite this, the lack of knowledge of CAMHD services within other systems may be preventing appropriate referrals to CAMHD. CAMHD is currently working on initiatives to strengthen collaboration across agencies. Coordinating with primary care, however, has been a neglected area and will be a major priority for the Block Grant.

4. Increase Use of Medicaid

In the SAMHSA report, "Funding and Characteristics of State Mental Health Agencies, 2007," (based on 2005 data), Hawai`i mental health revenues (for adults and youths) from the state's general funds accounted for 95% of total mental health revenues, while total Medicaid revenues (state and federal) accounted for only 2%. Corresponding national percentages were 47% and 42%, respectively. More recent data for CAMHD, specifically from the FY 2010 annual analysis, show that state general funds accounted for 60% of CAMHD's revenues, while total Medicaid funds accounted for 30% of revenues. While there has been increased use of Medicaid funding, greater efforts need to be made to access these funds to ensure greater sustainability of services provided by CAMHD.

5. Support Transition-Age Youth

As noted by federal monitors several years ago, Hawaii does not have a good support system for youth who transition out of the child-serving system. According to CAMHD's Family Guidance Centers, it is estimated that approximately 45400 youth age out of CAMHD's services CAMHD each year. However, thereDue to eligibility criteria, only 1%-2% will transition to the adult mental health system. There are very limited services for these youth and. CAMHD currently has only onerecently closed two Independent Living Program to assist this population. The number of transition age youthPrograms at the providers' request due to low enrollment. In the upcoming Request for Proposals, CAMHD will be trying a new paraprofessional program to connect the youth to community resources that CAMHD serves per quarter has declined over the past two years from 21 to only 8 youth. The decrease in services for transition-age youth has reinforced the need for the will enable their transition to independence. Meanwhile, Block Grant towill continue supporting the educational and, employment, housing and life-skills needs of this population.

CAMHD's care coordinators work with youth to develop transition plans for all youth age 17 and older. Block grant funds will continue to be made available to secure the resources that youth need to achieve the goals in their transition plans. Transition age youth planning and implementation is documented in the Coordinated Service Plan for all youth age 17 and older. Youth will be able to access assistance for their educational, vocational, medical/health care needs, housing, and other life goal needs. Examples of assistance include: tuition for GED or college; transportation resources such as bus passes or bicycles; housing assistance such as rental deposits, household goods, and career wardrobe; or art classes and supplies for an aspiring artist. CAMHD's Family Guidance Center staff will assure that the purchases are appropriate to the goals in the transition plan before accompanying the youth to purchase the items or pay the fees. Although CAMHD supports the empowerment of youth, in these instances, the youth will not be allowed to handle the financial transactions, as the federal law prohibits cash payments to recipients.

6. Improve Outcomes and Quality

Higher Quality Data Through HIT. In the New Freedom Commission Report, Goal 6.2 calls for the development and integration of Electronic Health Records and personal health information systems. Electronic Health Records and Telehealth were also identified as key initiatives in CAMHD's current strategic plan. CAMHD staff and providers have been demanding a system with the ability to provide real-time data that shows youth progress on outcome measures over time. Currently, CAMHD's care coordinators have limited access to data that easily summarizes their clients' progress over time, with many still relying on hard copy documents; also, providers only get summary data from CAMHD twice per year on the services, characteristics, and outcomes of their youth. There is also a lack of data sharing among these and other treatment team members. Factors such as these often contribute to a disconnection between initial service plans and ongoing treatment strategies.

The ability to be highly responsive to changes in fiscal and service utilization matters also requires an efficient, streamlined EHR system. There is a need to integrate various data on a centralized system so authorized users can analyze data on an as-needed basis. While CAMHD has already developed some basic infrastructure for an Electronic Health Record system, further development is needed to create a system that is fully functional and meets the needs of CAMHD and the population it serves.

The Block Grant has supported the development of CAMHD's Telehealth system, which is now almost fully operational. Due to the complexity of this statewide video conferencing system and the need to coordinate conferencing between multiple internal and external systems, the next phase of implementation is to recruit a Telehealth Coordinator who will coordinate and monitor use of the system as well as assist in its integration with EHRs.

Increase Evidence-Based Clinical Involvement. Another CAMHD goal is to take more advantage of the clinical expertise among staff. Staff psychiatrists and psychologists can lend greater assistance to improving the quality of client care by being more directly involved in individual cases and encouraging more use of evidence based services. The Block Grant has provided and is still needed to support these clinical staff in ongoing clinical training. In addition, the statewide Evidence Based Services Committee which has multidisciplinary and cross-agency membership, needs continued support in its initiatives to 1) provide supervisor and therapist training in evidence-based practices, 2) provide evidence-based practices resources and educational opportunities for Hawai`i State graduate programs, 3) and increase consumer and parent knowledge of and demand for youth best practices by collaborating with parent and consumer partners for developing and maintaining a consumer-friendly information website.

7. Support Parents in Directing Care

According to CAMHD's 2011 Consumer Survey findings, participation in their child's mental health treatment was the second most predictive factor in consumer satisfaction.[3] Also, CAMHD's CASSP principles uphold the value of the family's full participation in services. However, there is still much to be done toward fully achieving participant-directed care.

Continued funding is needed in the short-term to support CAMHD's family partner organization that represents families in the mental health system and whose parent partners engage parents in advocacy and participation in treatment. However, during the transition period, CAMHD will need to assist the organization in maximizing alternative funding streams so they can remain viable and continue their critical function in the system of care. The goal will be for the parent organization to be self-sustaining by the beginning of the next Block Grant cycle. The family partner organization will also need support during this transition period in developing better accountability and evaluation systems, especially as they increase Medicaid funding and need to fulfill those requirements.

The parent partners will also be responsible for directing parents to information on child and adolescent mental health diagnoses, services provided in Hawaii, and the level of evidence that exists in support of the different types of services. This information will be available on a local, culturally-sensitive, and family-friendly website that is already being developed, but there is still a need to support ongoing maintenance and updates to the site. Mental health information needs to be provided through brochures (for those who do not have access to the internet). Also, parent partners need to make sure that parents can understand and use all of the information that is available.[4]

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[3] Positive outcomes for a parent's/guardian's child was the most predictive factor.

[4] These brochures will also be available in languages other than English.

As part of efforts to reduce stigma and increase knowledge of mental health in the community, CAMHD will also need to continue support of the Community Children's Councils and children's mental health public awareness activities.

8. Homeless Outreach Services

A May 26, 2009, Honolulu Star Advertiser article reported that a city-commissioned point-in-time count of homeless people found an increase of 30 percent more homeless people in the urban core since 2007. A more recent article on November 17, 2010 reported that the number of homeless people accessing services statewide increased 3 percent, with increases of 5 percent on Oahu, 6 percent on Maui and the Big Island, and 7 percent on Kauai. Also, in the 2009-10 school year, the state Department of Education found a 71% increase from the year before in school children identified as homeless.

The 2010 article reported on a study by the University of Hawai`i Center on the Family that also examined homeless children. They found that homeless children make up more than one-third of those in shelters and one-tenth of those served through outreach services. They found:

- 9 percent of homeless children from 6 to 17 years old were not attending school.
- 24 percent of 12th-graders and 47 percent of kindergarten-age children who were homeless were not going to school.
- One quarter of children who experienced homelessness had one or more physical, mental, behavioral, or developmental problems. The most prevalent was asthma, followed by speech, vision or hearing issues, allergies, and learning disabilities.
- Children from birth to age 5 made up 56 percent of all minors served through shelter or outreach services.

The experience of homelessness results in a loss of community, routines, possessions, privacy, and security. For children, homelessness can create a loss of stability, disruption in education, increased food insecurity, and increased exposure to disease, violence, and substance abuse. Anxiety, loss of sleep, frequent illness, and hunger can contribute to learning disabilities. These conditions can trigger or exacerbate emotional problems in children. Homelessness affects children's mental health, and causes emotional and behavioral problems.

Older youth who live on the streets are at risk for high rates of violence, with rates ranging from 17-35% for sexual abuse and 40-60% for physical abuse and neglect. Two studies conducted for the U.S. Department of Human Services found 46% of runaway and homeless youth reported being physically abused, 17% reported being sexually exploited, and 38% reported being emotionally abused. Another survey found that 25% of youth in shelters and 32% of those on the street had attempted suicide. The stresses associated with homelessness can exacerbate other trauma-related difficulties and interfere with trauma recovery.

CAMHD will dedicate resources to support homeless youth and families. Block grant funds will be made available to support the mental health needs of homeless youth and homeless families. CAMHD currently has a provider who offers homeless youth outreach services in the Waikiki area and recently contracted with another provider to provide mental health services to homeless families on the Waianae Coast of the island of Oahu.

9. Suicide Prevention

For the past several years, CAMHD has partnered with its sister Department of Health agency, the Emergency Medical Services and Injury Prevention System Branch, in the implementation of its Statewide Suicide Prevention Plan and support of the Suicide Prevention Task Force. Through the use of block grant funds, the EMSIPS Branch will be able to continue to provide suicide gatekeeper trainings across the state on every island. The gatekeeper training teaches those who work with youth to identify warning signs, administer suicide first aid, and refer youth to the appropriate community resource.

10. Trauma and Justice

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

Table CAMHD3. Psychiatric Disorders Among Youth in Juvenile Detention		
	Females	Males
Major Depressive Episode	22%	13%
Psychotic Disorders	1%	1%
Anxiety Disorder	31%	21%
ADHD	21%	17%
Disruptive Behavior Disorder	46%	41%
Substance Abuse Disorder	47%	51%
ANY DISORDER	74%	66%

Source: Teplin, L. A., et al. (2002).

In a study that examined Hawai`i's 2004 Juvenile Justice Information System data and Family Court case files of incarcerated juveniles and juveniles on probation, about 70% of both boys and girls in the juvenile justice system have an Axis I psychological diagnosis. Just over one-quarter (28%) of girls' and 14% of boys' case files contained records of depression; 19% of boys' and 13% of girls' case files had records of conduct disorder; and 23% of boys' and 7% of girls' case files had records of ADHD[5].

In an analysis of the 2004 Juvenile Justice Information System offense data and Family Court cases, Table CAMHD4 shows the following evidence of trauma was found in the youth's case records.

Table CAMHD4. Hawai`i Juvenile Offenders - Abuse and Mental Health		
	Females	Males
Physically abused	50%	41%
Witnessed domestic violence	58%	42%
Sexually abused	38%	8%
Self-injury	28%	5%
At least one prior Suicide attempt	35%	12%

Source: Pasko, L. (2007).

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

CAMHD plans to continue its collaboration with the Judiciary to support the provision of Court-ordered mental health assessments. CAMHD has a Memorandum of Understanding with the Family Court that allows it to secure a qualified clinical psychologist to provide the mental health assessments when requested by the Court. Additional MOUs assist the Juvenile Drug Court and Girls Court to secure the services of qualified mental health professionals to provide therapeutic services to its special populations.

11. Coordination with Military Family Services

To date, there has been little coordination with Military family services. CAMHD will seek to re-establish relationships with DOD institutions through assisting the military with Telehealth equipment and services, particularly at Tripler Army Medical Hospital and on neighbor islands, and examining possible co-programming opportunities.

12. Services for LGBTQ Youth

There are no current services for LGBTQ youth. An initial examination of CAMHD's Annual Factbook 2010 data on youth treatment targets reported by providers found only 0.9% of youth having "gender identity problems" as a target in their treatment and 0% of youth having "sexual orientation" as a target. This may be due to a greater acceptance of LGBTQ youth in Polynesian cultures, but it is also possible that providers do not know how to address LGBTQ issues and do not include them as part of treatment targets. CAMHD plans to examine this issue further and determine whether a need exists for LGBTQ youth. At this point in time, however, this was not discussed as a high priority need, at least within the stakeholder group assembled to prioritize initiatives for CAMHD funding.

Adult Mental Health Division (AMHD)

Unmet Service Needs and Critical Gaps in Service

In the Mental Health Transformation State Incentive Grant (MHT SIG), a 2008 Needs Assessment and Resource Inventory (NARI) provided insight into the needs and resources across the State related to behavioral health for AMHD consumers. Many of the recommendations and findings identified in 2008 appear to need ongoing attention because they were again raised during the AMHD Chief's Community Forums as areas of concern. The Community Forums were held statewide during March and April of 2011, which were attended by consumers, providers, community and family members.

Unmet needs across the AMHD System of Care identified were:

1. Reducing stigma
2. Improve access to quality care in rural and geographically remote areas.
3. Increase the number of psychiatrists on all islands.
4. Develop more hospital psychiatric bed availability for non-forensic consumers.
5. Transportation
6. Too many calls go unanswered at ACCESS Line.
7. Mental health disparities continue for indigenous individuals.
8. Consumers with private insurance don't have access to Clubhouses.
9. Inconsistent quality of skills and experience among case managers.
10. More homeless outreach and homeless shelters.
11. Develop, train and sustain peer specialists in the workforce.

12. Need more 24-hour group homes statewide.
13. Need integrated mental health services.
14. Strengthen the community mental health centers as a way to address the integration of behavioral health with primary care.
15. Not enough time allotted to case management.
16. As youth age-out of the CAMHD system, there is an insufficient service array in AMHD to meet their needs.
17. Implement internet/online resource where family, friends and the community can get information regarding obtaining an assessment.
18. PSR program is needed in the community to support consumers.

Estimated SMI and SPMI Prevalence among Adults by County, FY2010

Hawai`i does not formally collect estimates of prevalence of serious mental illness (SMI), or of serious and persistent mental illness (SPMI) for the state. Thus, the following information is based upon the established prevalence percentages provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's recommended estimated national prevalence rate of severe and persistent mental illness (SPMI) is 2.6% of the adult population (June 24, 1999 Federal Register, Vol. 64, No. 121, pages 33890-33897). Application of the 2.6% percentage to Hawai`i's Severe and Persistent Mental Illness (SPMI) adult population is shown in the table below. Application of a 5.4% prevalence percentage to Hawai`i's Serious Mental Illness (SMI) population is also shown. The 2.6% of SPMI is included within the 5.4% of SMI.

State of Hawai`i's Treated Prevalence: The state of Hawai`i's resident population comprised 1,360,301[6] persons in 2010. Of these, 1,056,483 persons were 18 years of age and above. Application of the SPMI rate of 2.6% to 1,056,483 adults yields 27,469 adults. Of the 27,469 adults with serious and persistent mental illness, the AMHD served 14,633 adults (unduplicated) in FY2010. Thus, 53.3 percent of those expected to demonstrate serious and persistent mental illness were served by the AMHD. Although not all these individuals have serious mental illness, it is likely that the Medicaid data would include additional individuals with severe mental illness in addition to those served by the county system.

County Prevalence: Honolulu County is predominately urban and the counties of Hawai`i, Kaua`i and Maui while designated as rural are demonstrating increased population growth. Since 2010, the Big Island (Hawai`i County) has seen a 24.5 percent population increase which is stretching government resources. Similar increases are occurring in Maui County, 20.9 percent; Kaua`i County, 14.8 percent; Honolulu County at 8.8%.

Kaua`i County: This is the fourth most populated county in the State of Hawai`i with 4.9% (67,091) of the state's population. Since 2010, the island of Kaua`i has shown a 4.9% population increase (*op cit*). There are 51,868 persons or 4.9% of the adult population that are in the category of 18 years and older. The

[6] 18 years and above, Hawai`i State Department of Business, Economic Development and Tourism. The State of Hawai`i Data Book. Table 1 - Resident Population by Selected Age Groups by County: 2010.

number of persons served in FY2010 by the AMHD in Kaua`i County was 702 persons or 52% (1,349 adults) of the estimated prevalence of serious and persistent mental illness on Kaua`i.

Maui County: Maui County includes three (3) inhabited islands (Maui, Moloka`i and Lana`i) and one uninhabited island (Kaho`olawe). Maui County is the third most populated county in the State of Hawai`i with 11.4% (154,924) of the State's population. Since 2010, the island has shown a population increase of 20.9%. There are 119,109 persons (11.3%) in the category of 18 years and older. The number of persons served in FY2010 by the AMHD in Maui County was 1,515 persons or 53% (3,097 adults) of the estimated prevalence of serious and persistent mental illness on Maui.

Hawai`i County: Hawai`i County known as the "Big Island" is the second most populated county with 13.6% (185,079) of the State's population (2010). There are 142,799 persons comprising 13.5 percent of the adult population that are 18 years and older. When compared to other counties, residents of Hawai`i County experience some of the highest rates of negative social indicators.

The table on the next page shows that Hawai`i County (the Big Island) provided services to 3,623 persons. In FY2010, Hawai`i County served 3,623 persons or 97.6% of the estimated prevalence (3,713) of persons with serious and persistent mental illness on Hawai`i.

ADULT POPULATION BY COUNTY, PREVALENCE AND TREATED PREVALENCE - FY 2010

COUNTY	ADULT POPULATION 2010		ESTIMATED ADULT Number of *SMI*[7] (5.4%)	ESTIMATED ADULT Number of *SPMI*[8] (2.6%)	NUMBER SPMI SERVED FY2010[9]	PERCENT SPMI SERVED OF SPMI PREVALENCE[10] (Treated Prevalence)
	Number	Percent	Number	Number	Number	Percent
O`AHU	742,707	70.3	40,106	19,310	8,793	45.5
HAWAI`I	142,799	13.5	7,711	3,713	3,623	97.6
KAUA`I	51,868	4.9	2,801	1,349	702	52.0
MAUI	119,109	11.3	6,432	3,097	1,515	48.9
STATEWIDE ADULT TOTAL	**1,056,483**	**100.0**	**57,050**	**27,469**	**14,633**	**53.3**

Honolulu County: The Island of O`ahu is also designated as the City and County of Honolulu. It is the most populated county with 70.1% (953,207) of the State's population. Honolulu was the only county to

[7] Federal definitions are utilized for Serious Mental Illness and Serious and Persistent Mental Illness (A portion of Serious Mental Illness) and applied to Hawai`i's population estimates.
[8] Federal definitions are utilized for Serious Mental Illness and Serious and Persistent Mental Illness (A portion of Serious Mental Illness) and applied to Hawai`i's population estimates.
[9] URS Table 2A, Profile of Persons Served; Statewide and by County.
[10] E.g., 8,793/19,310

recently demonstrate a net loss in migration and the only county to gain more of its population from a natural increase. There are 742,707 persons in the 18 year and older range, which is 70.3 percent of the adult population. The number of persons served in FY2010 by the AMHD in Honolulu (O`ahu) County was 8,793 persons or 45.5% (19,310 adults) of the estimated prevalence of serious and persistent mental illness on O`ahu.

State's Priorities and Plans to Address Unmet Needs: Reference is provided to identify which unmet need listed at the top of this document is being addressed

Crisis Services

- The shortage of staff, furloughs and a current hiring freeze, has contributed to an increase in the abandonment rate of calls.
- The workforce is no longer under furloughs and efforts are being made for staff to get an exception to the hiring freeze for these critical positions in ACCESS.
- There is a statewide training initiative for police officers statewide.

Case Management and Community Support/Treatment Services

- The case management contract will be re-issued this year.
    1. Peer services have been strengthened to support and clarify the role of the peer specialist. Additionally, more flexibility has been added to this contract to allow a broader array of psychosocial interventions.
    2. Need for increased units of service (case management hours) is being addressed by requiring providers to track and report consumer acuity levels in order to justify increased case management units/hours.

- AMHD is working with the State Medicaid Administration's revision to the Medicaid Rehabilitation Option in the State Plan to include reimbursement for Hawai`i Certified Peer Specialist, Supported Employment and Clubhouse services.

Community Housing Services

- Implementation of new housing admission and continuing stay criteria will create movement of consumers through the service array toward more independent long term community housing.
- Re-visit long term strategy to ensure adequate movement of consumer through AMHD's housing continuum.
- Decrease lengths of stay in 24-hour group homes statewide, and encourage greater movement to least restrictive and non-AMHD funded housing.
- Improve AMHD's management of housing resources and promote increased presence in 24-hour group homes via on-site chart reviews and discharge planning attendance.
- Develop tools/processes necessary to more accurately track current vacancies in 24-hour group homes as well as to assist providers with maintaining candidate waitlists which are reflective of AMHD priorities.

Psychosocial Rehabilitation

- Psychosocial rehabilitation programming will be included in the new case management RFP to increase rehabilitative capacity statewide. (See above section on Case Management and Community Supports).

Special Populations and Other

- AMHD has been working on implementation of it's newly awarded Trauma grant. This grant will increase case management units to provide trauma screening and treatment opportunities.
- Speakers Bureau has been created in collaboration with the Mental Health Transformation Systems Incentive Grant to increase public awareness and reduce stigma.
- A Locum Tenums contract has been implemented to ease the psychiatry shortage.
- A pool of qualified professionals has been expanded to include APRN-RXs to work in rural areas.
- A new Bi-lingual Support Service contract was implemented a year ago which includes outreach and education to underserved culture groups to increase awareness and access to mental health services.
- Efforts are underway to improve workforce development for current staff.
- Hawaii Certified Peer Specialist training has been scheduled for late in the year with the addition of a forensic specialty track.
- Consumers are and will continue to be trained to provide trauma support services thru the Trauma Grant (TIC IT) and will partner with Supported Employment for creating sustainability of this practice.
- Newsletter on mental health and healthy aging will be published in fall 2011.
- In response to Hawaii's growing older adult population and co-morbidity of serious/chronic medical need of parts of the AMHD population, AMHD is working to offer Adult Residential Care Homes (ARCH) and Expanded Adult Residential Care Homes (eARCH), who are specifically trained and mentored to address the needs of the fragile, and/or elderly individuals with SPMI.
- During the last monitoring cycle and continuing into the next cycle, AMHD is specifically reviewing actions taken to address primary care needs of consumers.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

2011

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	CAMHD 1: Implement Primary Care Collaboration *	Develop collaborations with FQHCs and other primary care entities
2	CAMHD 2: Support Youth Homeless Outreach Programs	Support homeless programs
3	CAMHD 3: Support Suicide Prevention Programs	Support Suicide Prevention Programs
4	CAMHD 4: Conduct Mental Health Assessments, Screening, Consultation and Services for Juvenile Justice Youth	Conduct Mental Health Assessments, Screening, Consultatin and Services for Juvenile Justice Youth.
5	CAMHD 5: Fund Transition Age Youth (TAY) Services	Fund Transition Age Youth (TAY) Services.
6	CAMHD 6: Support Department of Defense Collaborations *	Support Department of Defense Collaborations.
7	CAMHD 7: Support Evidence Based Services Committee and Initiatives	Support Evidence Based Services Committee and Initiatives.

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8	CAMHD 8: Develop Centralized and Real-Time Data Outcome Reporting System *	Develop Centralized and Real-Time Data Outcome Reporting System.
9	CAMHD 9: Support Clinical Staff Training	Support Clinical Staff Training.
10	CAMHD 10: Hire Programmer/Developer for New EHR System *	Hire Programmer/Developer for New Electronic Health Record (EHR) System.
11	CAMHD 11: Fund Annual Consumer Survey	Fund Annual Consumer Survey.
12	CAMHD 12: Support Family Partner Organization	Support Family Partner Organization.
13	CAMHD 13: Promote Children's Mental Health Public Awareness Activities	Promote Children's Mental Health Public Awareness Activities.
14	CAMHD 14: Assist Family Partner Organization in Meeting New Requirements *	Assist Family Partner Organization in Meeting New Requirements.
15	CAMHD 15: Maintain and Update Information Website *	Maintain and Update Information Website.
16	CAMHD 16: Hire Telehealth Coordinator *	Hire Telehealth Coordinator
17	CAMHD 17: Updgrade Data Repository/System *	Upgrade Data Repository/System
18	CAMHD 18: Increase Medicaid Reimbursement *	Increase Medicaid Reimbursement.
19	AMHD 19: Trauma	Integrate the Trauma Informed Care philosophy for AMHD consumers, providers and staff.
20	AMHD 20: Health Integration	Strengthen the CMHC system primary care knowledge base, and incerase the integration of behavioral health and primary care.

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21	AMHD 21: Public Awareness and Support	Increase public awareness and reduce stigma in the community.
22	AMHD 22: Health Information Technology	Increase the use of Interactive Communication Technology to promote recovery.
23	AMHD 23: Housing	Promote independent living for consumers.
24	AMHD 24: Peer Specialists	Develop, train and sustain peer specialists in the workforce.

Footnotes:

* - Designates “New Initiative”

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

2011

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
CAMHD 1: Implement Primary Care Collaboration *	Prevention of Substance Abuse and Mental Illness	Develop “primary care coordinator” position responsible for: a) Developing joint primary and behavioral care EPSDT program at Federally Qualified Community Health Center, b) Coordinating consultation with primary care providers, and c) Collaborate with Family Health Services Division’s early intervention efforts.	Number of interactions with primary care providers; # of meetings and recorded minutes of meetings with FHS	PCC will track interactions with primary care providers; PCC will track meetings and record minutes of meetings with FHS
CAMHD 2: Support Youth Homeless Outreach Programs	Prevention of Substance Abuse and Mental Illness	Continue support of current Youth Homeless Programs	Number of youth served	Homeless Outreach Program will collect data on # of youth served
CAMHD 3: Support Suicide Prevention Programs	Prevention of Substance Abuse and Mental Illness	Continue support of current Suicide Prevention Programs	Number and types of conferences and workshops provided	Youth suicide prevention providers will document conferences & workshops provided

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CAMHD 4: Conduct Mental Health Assessments, Screening, Consultation and Services for Juvenile Justice Youth	Trauma and Justice	Continue to conduct current battery of assessments, screening, and consultation services	Number of MH assessments conducted for youth	Agencies contracted to do mental health assessments will track the number of assessments conducted
CAMHD 5: Fund Transition Age Youth (TAY) Services	Recovery Support	Continue to fund current Transition Age Youth (TAY) services	Number of 'successfully discharged' youth from CAMHD	CAMHD Family Guidance Centers will track youth served through this program
CAMHD 6: Support Department of Defense Collaborations *	Military Families	Reestablish relationships with DOD institutions through: a) o Assisting military with Telehealth equipment and services, particularly at Tripler Army Medical and on neighbor islands and b) o Examination of possible co-programming opportunities	Number of trainings on Telehealth equipment to Tripler staff	CAMHD will keep records of trainings provided and summarize results of those meetings
CAMHD 7: Support Evidence Based Services Committee and Initiatives	Data, Outcomes, and Quality	Continue to support current Evidence Based Services (EBS) Committee and its initiatives	Evidence Based Services Committee will meet every month	CAMHD will track these meetings and summarize the topics discussed
CAMHD 8: Develop Centralized and Real-Time Data Outcome Reporting System *	Data, Outcomes, and Quality	Develop streamlined and real-time data entry and outcome reporting system	Plan for all data to be entered into central data system; Develop reports for FGC staff to use in case planning	CAMHMIS staff will report quarterly on development of central data system; CAMHMIS staff will track report creation on new central data system
CAMHD 9: Support Clinical Staff Training	Data, Outcomes, and Quality	Continue to support clinical staff training initiatives	80% of all Care Coordinators will participate in an agency-wide training	CAMHD will compile attendance list report how many CAMHD staff attend agency-wide trainings

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CAMHD 10: Hire Programmer/Developer for New EHR System *	Data, Outcomes, and Quality	Develop programmer/developer position to facilitate upgrade to new EHR system	A new Access programmer will be hired w/in 90 days of new funding	HR will notify when this position will be hired
CAMHD 11: Fund Annual Consumer Survey	Data, Outcomes, and Quality	Continue to support Annual Consumer Survey	SMS will complete final report to RET's satisfaction	Contract with SMS Research, Inc. to create final report on 2012 Consumer Survey
CAMHD 12: Support Family Partner Organization	Public Awareness and Support	Support Family Partner organization (Hawaii Families As Allies - HFAA) in representing families in Mental Health system and engaging parents in advocacy and participation in treatment	Number of families served	HFAA will track families provided services
CAMHD 13: Promote Children's Mental Health Public Awareness Activities	Public Awareness and Support	Increase marketing and public education on children's mental health	Coverage on local media and the public re: children's mental health will occur	CAMHD will monitor coverage of mental health public awareness activities
CAMHD 14: Assist Family Partner Organization in Meeting New Requirements *	Public Awareness and Support	Increase support to Family Partners (Hawaii Family As Allies - HFAA) in developing better accountability/ evaluation system	Number of trainings offered re: criteria for Medicaid reimbursement procedures	CAMHD will offer and summarize results of trainings offered to HFAA
CAMHD 15: Maintain and Update Information Website *	Public Awareness and Support	Maintain and update local mental health diagnoses and services information website	Maintain and update agency website	CAMHD will report on any improvements made to the agency website
CAMHD 16: Hire Telehealth Coordinator *	Health Information Technology	Develop new position to coordinate training and use of Telehealth system	A new Telehealth Coordinator will be hired w/in 90 days of funding	CAMHD HR will report when the Telehealth position is hired
		Develop central data		

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CAMHD 18: Increase Medicaid Reimbursement *	Health Information Technology	repository/system for better integrating health information between CAMHD and providers	Plans for a new data depository will be developed w/in 90 days of funding	CAMHD will unveil plans for new data depository and reports to be generated from the system
CAMHD 18: Increase Medicaid Reimbursement *	Health Reform	Recruit consultants to assist with maximizing Medicaid reimbursements for CAMHD as well as Hawaii Families As Allies (HFAA) services	Number of trainings/meetings conducted to discuss ways to utilize Medicaid reimbursement	CAMHD will track and summarize the results of trainings offered to Hawaii Families As Allies (HFAA)
AMHD 19: Trauma	Integrate the Trauma Informed Care philosopy for AMHD consumers, providers and staff.	Provide training and education on trauma informed care for AMHD staff and stakeholders. Expand the TIC initiative to military members and their dependents specifically in the area of PTSD and TBI.	Train 50% of consumers in trauma suport services. Train 70% providers in trauma informed care. Increase the number of military announcements re: trauma trainings by 100%.	MISA Service Director will track the number of trainings and analyze the Pre and Post test survey results.
AMHD 20: Health Integration	Strengthen the CMHC system primary care knowledge base, and increase the integration of behavioral health and primary care.	Provide training for CMHC clinical staff to ensure the integration of behavioral health and primary care.	85% of consumer charts will contain documentation on assessment of primary care health needs and integration with primary care.	The Community Mental Health Center System Administration will track outcomes based on record review monitoring.
		Reduce stigma within the different role groups: indigenous		

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AMHD 21: Public Awareness and Support	Increase public awareness to reduce stigma in the community.	groups, LBGTQ group and the law enforcement community. Implement internet/online resources where family, friends and community members can get information to obtain an assessment, etc. Advertise the benefits of using the Network of Care online website.	Educate 50% of law enforcement personnel statewide on mental health issues. Increase the number of consumers involved in the Speakers Bureau to increase public awareness and reduce stigma by 50%.	Provider Surveys MHSIP Surveys Track the number of people trained in the Speakers Bureau program. Track the number of speaking engagements. Track the number of community members reached through speaking engagements. Track the number of CFY Hui members by county who attended and spoke at Health Fairs. Track the number of hits that the Network of Care receives in Hawaii. Collect feedback from the Chief's Consumer Roundtable on a quarterly basis.
AMHD 22: Health Information Technology	Increase the use of Interactive Technology to promote recovery.	Increase the number of consumers using Telepsychiatry technology in rural areas. Increase the number of providers using web-based applications for authorization of services by 90%.	Establish technology and resources in rural areas. Establish baseline for utilization for 6 month period. Develop plan to increase utilization. Increase the number of providers using web-based applications by 80%.	Provider Survey Results Track the number of consumers using Telepsychiatry technology in rural areas. Track the number of providers using web-based application for authorization of services. Collect feedback from the Chief's Consumer Roundtables.
AMHD 23: Housing	Promote independent living for consumers.	Decrease the length of stay in 24-hour group homes statewide. Improve AMHD's management of housing resources by ensuring consumers transition through the housing continuum of care. Develop appropriate step-down services from 24-hour group homes.	Increase the number of consumers served in semi-independent housing by 50%. Increase the number of eARCH beds by 20%. Ensure charts have consumers in appropriate level of housing by 50%.	Tally the number of UM chart reviews quarterly. Tally the number of eARCH beds quarterly. Track the number of chronically homeless consumers transitioned into housing within 6 months. URS Tables - Living Situation
		Strengthen the sustainability of the certified peer specialists by receiving reimbursements from Medicaid Rehab	Increase the number of	

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AMHD 24: Peer Specialists	Develop, train, and sustain peer specialists in the workforce.	Option (MRO). Provide supports for certified peer specialists while they are employed. Educate staff (CMHC and POS providers) on the educational curriculum and role of a certified peer specialists before internship placement and hiring into permanent positions.	working peer specialists by 100%. Place 75% of newly certified peer specialists in the workforce. 100% of potential employers will be trained on the role of certified peer specialists.	Office of Consumer Affairs (OCA)to track the number of trainings for peer specialists. OCA to track the number of staff and provider trainings. OCA to track the number of certified peer specialists placed in jobs. URS Tables - Supported Employment.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	CAMHD: Mental health screening, mental health assessments, and case consultations for youth in the juvenile justice system. AMHD: Evaluation and surveys; Tobacco prevention and education; Medication for consumers in CRD; Residential services for forensics.
Grant/contract reimbursement	CAMHD: Homeless youth outreach services, Homeless family mental health supports, mental health supports for youth in the Girls Court program, Suicide Prevention, consumer survey, family support services. AMHD: Forensic System Development; Mental Health Court Project; CRD Pharmacy Project; CRD Clinical Services Project; Release on Recognizance Pilot Project; Forensic ACT Team; Sequential Intercept Model Research Project; Legislation Transition Project.
Other reimbursement strategy (please describe)	CAMHD: Health information technology – personnel costs; data quality – personnel costs; primary care integration – personnel costs; transition-age youth program – services and products; public awareness – products; evidence based practice – personnel costs; professional development – training fees. AMHD: Administrative Costs - Consumer conferences; State Council - trainings and conference fees; Forensic Examiner travel and trainings;

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2011

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	10-25% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	10-25% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	<10% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	26-50% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	10-25% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	N/A 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		10-25% 6
Other		N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year: 2011

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$5,000	$	$	$	$
Information Dissemination	Selective	$240,000	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$245,000	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$286,750	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$16,000	$	$	$	$
Education	Total	$302,750	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$20,000	$	$	$	$
Problem Identification and Referral	Selective	$80,000	$	$	$	$
Problem Identification and Referral	Indicated	$45,000	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$145,000	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$309,800	$	$	$	$
Community-Based Process	Indicated	$571,239	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$881,039	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$12,000	$	$	$	$
Other	Selective	$232,300	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$134,776	$	$	$	$
Other	Total	$379,076	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year: 2011

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$14,342,716	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$7,984,865	$	$
8. Administration (Excluding Program and Provider Level)	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$22,327,581	$	$
11. Total	$	$	$	$22,327,581	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

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Start Year: 2011

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$ 301,000		$			$301,000
2. Quality Assurance	$ 100,000		$			$100,000
3. Training (Post-Employment)	$ 63,776		$			$63,776
4. Education (Pre-Employment)	$ 15,000		$			$15,000
5. Program Development	$ 805,359		$			$805,359
6. Research and Evaluation	$ 507,730		$			$507,730
7. Information Systems	$ 160,000		$			$160,000
8. Total	$1,952,865	$	$	$	$	$1,952,865

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

IV. Narrative Plan

D: Activities that Support Individuals in Directing the Services

Child and Adolescent Mental Health Division

Current Activities

Participant-directed services are instituted in CAMHD's policies through Hawai`i's Child and Adolescent Service System Program (CASSP) principles (See Attachment CAMHD2: "CASSP principles") The CASSP principles relevant to ensuring parent and youth participation in directing care from among a comprehensive array of services include:

- The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided;
- Access will be to a comprehensive array of services that address the child's physical, emotional, educational, recreational, and developmental needs;
- Families or surrogate families will be full participants in all aspects of the planning and delivery of services;
- As children reach maturity, they will be full participants in all aspects of the planning and delivery of services;
- The rights of children will be protected, and effective advocacy efforts for children will be promoted.

To ensure that these CASSP principles are put into practice throughout the system, CAMHD has adopted various procedures at the system and the individual level. At the system level, the State Council on Mental Health (SCMH) is a consumer-led state advisory council that is required to review state mental health plans and submit recommendations for modification, and monitor and review annually the allocation and adequacy of mental health services in the State. The SCMH is also required to review the implementation of the State Plan.

There are 17 Community Children's Councils (CCCs) throughout the State of Hawai`i. Each CCC provides a forum for families, local communities, and state and private agencies to partner in maintaining the quality of educational, social and emotional programs available for youth with special needs in their community. The CCCs collaborate with State Departments and service providers to improve system delivery at school complex levels. More specifically, CCCs:

- Provide a focus of strong family participation in planning and decision-making
- Provide a vehicle for community-wide involvement
- Collaboratively create a shared vision for an integrated system of care
- Implement ongoing community needs assessments and strategic planning process
- Participate in quality assurance and improvement in the development of the system of care

Hawai`i Families As Allies (HFAA) is a statewide parent-controlled family network organization, recognized in Hawai`i and nationally as a voice on behalf of families of children and youth with emotional and/or behavioral challenges. HFAA's mission is to support families whose children and youth have emotional and/or behavioral challenges through education, technical assistance and advocacy. As parents become involved in the children's mental health system, an HFAA partner will team up with the parents to assist them in making educated choices around their child's mental health needs. HFAA representatives are also involved in multiple areas of the CAMHD system, such as management teams,

quality assurance committees, and staff meetings and they are also provided co-located office space at regional Family Guidance Centers. HFAA also has a youth council for children's mental health, Hawai`i Youth Helping Youth (HYHY). HYHY is comprised of youth ages 14-25 who have first-hand experience with special education, mental health, foster care, and the juvenile justice system. The council meets monthly to share their experiences and ideas in an effort to make things better for other children, youth and young adults in Hawaii.

In addition, CAMHD conducts an annual consumer survey which attempts to acquire feedback from all parents registered in the CAMHD system in that year. The survey gathers data on consumer satisfaction with services, perceptions of outcomes, and suggestions for improving the system, among other things. Data from this survey is reported to CAMHD's Quality Steering Committee where changes can be recommended to improve services.

At the individual level, CAMHD has developed or is in the process of developing ways to increase parent involvement in directing care. As part of CAMHD's current Interagency Performance Standards and Practice Guidelines, CAMHD's Mental Health Care Coordinators (MHCC) are responsible for engaging youth and families in the process of coordinating services, and a Coordinated Service Plan is developed with full engagement and involvement of youth and family/guardians. When youth are being served by a contracted service provider, a Mental Health Treatment Plan is developed, which is individualized for each youth and is an ongoing collaborative process driven by the family/guardian and youth that includes the Contractor, family, and MHCC. Also, a website and brochure are being developed that will provide information about child mental health diagnoses and services that are available, including research on the evidence of service effectiveness, all in family-friendly, culturally appropriate language. HFAA parent partners will be responsible for ensuring that parents have access to this information and is able to make educated decisions about their child's care.

Recently, to strengthen further the youth voice in the individualized service planning process, core components of a successful "youth-guided planning meeting" were defined and are being implemented at the Family Guidance Centers.

In summary, all services offered to youth (with the exception of emergency services) include requirements that the treatment plans be youth and family driven, with family encouraged to direct care at the youth service planning level as well as provide feedback to the system as a whole.

Future Activities

Despite these efforts, engaging families continues to be a challenge. With additional support provided through the Block Grant, CAMHD will continue to strengthen efforts to support families in directing their services. In addition to continuing the current activities previously mentioned to facilitate participant directed care, CAMHD will provide support to the contracted family organization to develop greater evaluation and accountability mechanisms, with the goal of strengthening the role of their Parent Partners within CAMHD's community-based branches, and ensuring that all families are provided with adequate resources to be able to direct their services. Assistance will also be provided to the family organization to develop their capacity to capitalize on Medicaid reimbursable peer support services and increase their organization's sustainability.

CAMHD will also use Block Grant support to maintain and update the local mental health diagnoses and services information website. Parent Partners will be responsible for referring parents to this information (whether in website or brochure form) and supporting parents in being able to fully

participate in treatment. To further aid families to be more involved in decision making, CAMHD will develop resources, such as clinical decision-making trees, to share with families so that they can be aware of the options available and the pros and cons of each option.

Adult Mental Health Division (AMHD)

Consumers are afforded the opportunity to be actively involved in planning, quality improvement, system transformation, program implementation and service delivery in the Adult Mental Health system. This occurs through a variety of organized mental health structures including the State Council on Mental Health, County Service Area Boards, Multicultural Advisory Committee, AMHD Office of Consumer Affairs (OCA), Clubhouse Coalition, and the newly created Consumer, Family and Youth Alliances.

The monthly Chief's Roundtable, provides an opportunity for consumers and family members to make their concerns and needs known to the Division Chief. The OCA actively participates in the AMHD Action Plan tasks for Recovery/Treatment Planning, which is transforming the way in which recovery/ treatment planning practices occur, including improved accountability and functioning of the Interdisciplinary Teams throughout the system. Consumer representation is also present in the development of scopes of service, selection and awarding of state contracts. AMHD consumer staff is the entry for grievance and complaints to ensure that individuals have support in expressing their concerns.

The Mental Health Transformation State Incentive Grant (MHT SIG) has fostered the Consumer, Family and Youth Alliances (CFY Hui) across the state. There are affiliates in each county and CFY conferences have been held in each county rather than one large state annual conference for consumers. The goal of the Hui's is to increase networking, facilitate collaboration, identify and accomplish shared goals, and strengthen local communities. These groups are actively involved in advocating for needed services, promoting recovery and wellness, and involved in meaningful discussions, which have impacted decision making at the state level. Over the past three years, MHT SIG has provided various trainings, expert consultations, administrative supports and meetings supports to assure that expertise input and guidance is available at local community and state levels. MHT SIG has also made a commitment to secure continued involvement of Hui members to serve on boards, committees and in the workforce of various state agencies to improve clinical and business outcomes once the grant ends.

In an effort to reach a larger audience of consumers, family members, the MHT SIG has initiated the Speakers Bureau in which consumers and family members play a significant role in speaking to communities. Community engagement activities have sought agreement with county and city mayors to allow greater mental health information in county facilities. This allows consumers to share their story with the hope of reducing stigma while changing attitudes about mental illness.

The introduction of the Network of Care (NOC) is also a medium that engages consumers, family members and the community. The NOC is a dynamic interactive website designed to assist individuals to be involved in community services. The website is designed to provide information about each county program and all of its providers, support efforts of consumers and families toward successful recovery, link to extensive resources about mental health, track bills in the Hawai`i legislature, and make contact with legislators. The NOC system is housed within the Community Mental Health Centers

statewide to be more accessible for consumers and families. Although the startup of the program has not been without its challenges, the system is currently working effectively.

Another of MHT SIG's initiatives is the Wellness Recovery Action Planning (WRAP) program. MHT SIG has trained numerous AMHD consumers on how to construct their personalized wellness plans as well as these consumers in turn facilitating other individuals in developing their own plans.

NAMI, United Self Help, and Mental Health America have also played an integral role in providing supports to families through educational programs, advocacy, understanding evidence-based practices, stigma reduction, support groups and community forums. In these settings, individual and families have the opportunity to share and connect with other families who are experiencing similar challenges, and have access to more information to understand mental illness.

IV: Narrative Plan

E. Data and Information Technology

Page 42 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

IV. Narrative Plan

E: Data and Information Technology

Child and Adolescent Mental Health Division (CAMHD)

CAMHD's information system is completely separate from AMHD's system and systems of other divisions and departments. The CAMHD system is supported by an array of centralized databases and Family Guidance Center (FGC)-specific manual tracking systems. The centralized EHR is based on the VA Open Vista and serves as the cornerstone for electronic information processing. The plan is to eventually upgrade this system to the RPMS system. CAMHD maintains a statewide network of personal computers (PCs) throughout the seven (7) FGCs and their 19 offices, which are spread among the six major islands of the state. Multiple autonomous special purpose Excel and Access databases are maintained by these separate operational units of CAMHD.

The CAMHD data network provides user connectivity statewide via fiber or frame-relay connections. CAMHD supports a PC base of 235 workstations that provide applications, email, and Internet connectivity. In 2003, CAMHD updated its workstations statewide to provide increased security and infrastructure in support of the Health Insurance Portability and Accountability Act (HIPAA) implementation. This upgrade produced a high capacity of distributed computing power to front-end users throughout the system. When autonomous data systems are maintained on PCs, they are generally based in the Microsoft Office environment.

The overall Child and Adolescent Mental Health Management Information System (CAMHMIS) is an Oracle based solution running within a Microsoft Windows environment that is housed at the CAMHD central office facilities. CAMHMIS is a cluster of multiple Oracle applications supporting core CAMHD operations, purchase of service (POS) functions, data center billing operations, and Medicaid reporting functions. All applications as well as data external to CAMHMIS operations are replicated in real-time to the CAMHD data warehouse. The data warehouse then feeds other operations that have the need for information as well as historical information.

Block Grant funds will primarily be used for infrastructure developments and not be used to directly support client services through CAMHD. For example, one program to be funded is a youth homeless outreach program that provides information and referrals for homeless youth without collecting information about the youth; another program is for suicide prevention training which also does not collect youth data. Therefore, it will not be necessary to collect and report on unique client-level encounter data for the Block Grant. However, universal prevention and other non-service-based activities can be reported describing the numbers and types of individuals impacted by those activities. In addition, CAMHD's information system is able to provide expenditures for each service identified in the matrix. The following information can be provided through CAMHMIS:

- Provider characteristics
- Client enrollment, demographics, and characteristics
- Admission, assessment, and discharge
- Services provided, including type, amount, and individual service provider
- Prescription drug utilization

CAMHMIS is also able to collect and record national provider identifiers, which providers are required to obtain, as well as other unique provider IDs that indicate their geographic location and allows linkage with Medicaid. The system also uses a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client. Client-level data is in the form of encounters that

include information on individual date of service, type of service, service quantity, and identity of individual provider. The system complies with Federal data standards for CPT/HCPCS codes. CAMHMIS also incorporates a unique identifier to allow linkage with Medicaid identifiers, which provides the ability to aggregate Medicaid and non-Medicaid information.

Reports based on Medicaid data are not currently being produced. The system for identifying Medicaid eligible clients and obtaining Medicaid reimbursement is an area of improvement for CAMHD which will be supported by the Block Grant. The State's IT division does participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues. Hawai`i has a grant to create a statewide health information exchange, and CAMHD's chief administrator sits on the policy committee of the Hawai`i Information Exchange group.

Recently, there has been an increase in collaboration among state agencies, including the State Medicaid agency that has been striving to improve its IT system. The collaborations, which include CAMHD, include IT-related issues.

In addition, as CAMHD develops and fully integrates the systems data into the Open Vista/RPMS system, providers will be able to access client data and reports.

Adult Mental Health Division (AMHD)

The Adult Mental Health Division (AMHD) utilizes Netsmart's Avatar EMR solution for its state operated Community Mental Health Centers and the Hawaii State Hospital. It captures provider characteristics, client enrollment, demographics, and characteristics, admission, assessment, and discharge, services provided, including type, amount, and individual service provider. Currently prescription drug utilization is captured only for patients at the HSH but ePrescribing at outpatient clinics is funded for implementation in 2011.

This system captures both NPI number as well as a system generated provider identification number. It facilitates the aggregation of service and other information by provider or client. The system collects encounter and claim information with date of service, procedure code, quantity, rendering provider as well as up to two co-practitioners.

Administrative Services

AMHD utilizes InfoMC's eCura application with contracted providers of service (POS). It captures provider characteristics, client enrollment, demographics, and characteristics, admission, assessment, and discharge, services provided, including type, amount, and provider agency. Implementation of rendering provider level data using NPI is funded for this year. AMHD does not pay for prescription drugs and has no plans to capture prescription orders from POS physicians at this time

This system captures both agency National Provider Identification (NPI) number as well as a system generated provider ID number. It facilitates the aggregation of service and other information by provider agency or client. The system collects encounter and claim information with date of service, procedure code, and quantity. As stated above, capture of rendering provider is funded for implementation this year.

For both of these systems:

- **For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?**
  Yes, as described above.

- **Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?**
  Yes, as described above.

- **Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?**
  Yes

- **Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?** *Yes*
- **Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?**
  Yes

As applicable, please answer the following:

- **Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?**
  No

- **Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?**
  No

- **Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?**
  Not at the agency level for IT.

- **Does your State have a grant to create a statewide health information exchange and does your agency participate**
  No

- **Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?**
  If planning is in process, our agency has not been asked to participate.

The Chief of the Health Information Systems Office participates on the Hawai`i Health Information Exchange which focuses on data exchange between Hawai`i Health Partners. The Chief also is part of

the Public Health Data Standards Committee that provides comments and input to proposed future HIT policy and standards. Public health conformance to HIT is driven by CDC standards.

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

IV. Narrative Plan

G: Consultation with Tribes

There are no Native-American tribes located within the Hawai`ian Islands.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

IV. Narrative Plan

H: Service Management Strategies

Child and Adolescent Mental Health Division (CAMHD)

Most of CAMHD's block grant funded projects are conducted via Purchase of Service (POS) contracts managed by other purchasers and are not the type of direct services that are amenable to client-based utilization management. CAMHD tracks the progress of the projects through desk reviews of aggregated quarterly and annual reports. These desk reviews allow CAMHD to monitor progress to ensure that the services provided adhere to the scope specified in the contracts and that quarterly progress on outcomes are achieved.

Adult Mental Health Division (AMHD)

The AMHD Division currently contracts Mental Health Block Grant projects with Purchase of Services providers with the Statewide Services Directors having oversight of each project. The Clinical Operations Team reviews each project for use of Block Grant funds to ensure they are clinically appropriate and effectively utilized. The Block Grant Oversight Committee reviews each project in light of State procurement and federal guidelines. On a quarterly basis, the Block Grant Oversight committee reviews the expenditure report to ensure that financially the funds are being spent on a timely basis.

Next steps:

- Statewide Service Directors (SSD) work with providers on the implementation and evaluation for each project.
- Where indicated Performance Improvement staff may be requested to complete case-based reviews to their provider monitoring tools. Findings will be reviewed with the SSDs.
- The SSDs are responsible for reporting data/findings to the appropriate Quality Committee or other designated review body (i.e. Clinical Operations Team, State Council, etc.)

All projects with the exception to the "Mental Health Court Project" are not amenable to utilization management (UM) because they are not service dose related in design. The Mental Health Court Project will be subject to identical Utilization Management as all of our other group homes. Any participant exceeding the length of stay established by UM will be reviewed to determine extended care. Additionally, the SSD associated with this project will participate and obtain monthly reports on consumer progress in this project to identify any concerning utilization trends.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2011

Priority	Performance Indicator	Selected
CAMHD 1: Implement Primary Care Collaboration *	Number of interactions with primary care providers; # of meetings and recorded minutes of meetings with FHS	
CAMHD 2: Support Youth Homeless Outreach Programs	Number of youth served	
CAMHD 3: Support Suicide Prevention Programs	Number and types of conferences and workshops provided	
CAMHD 4: Conduct Mental Health Assessments, Screening, Consultation and Services for Juvenile Justice Youth	Number of MH assessments conducted for youth	
CAMHD 5: Fund Transition Age Youth (TAY) Services	Number of 'successfully discharged' youth from CAMHD	
CAMHD 6: Support Department of Defense Collaborations *	Number of trainings on Telehealth equipment to Tripler staff	
CAMHD 7: Support Evidence Based Services Committee and Initiatives	Evidence Based Services Committee will meet every month	
CAMHD 8: Develop Centralized and Real-Time Data Outcome Reporting System *	Plan for all data to be entered into central data system; Develop reports for FGC staff to use in case planning	
CAMHD 9: Support Clinical Staff Training	80% of all Care Coordinators will participate in an agency-wide training	
CAMHD 10: Hire Programmer/Developer for New EHR System *	A new Access programmer will be hired w/in 90 days of new funding	
CAMHD 11: Fund Annual Consumer Survey	SMS will complete final report to RET's satisfaction	
CAMHD 12: Support Family Partner Organization	Number of families served	
CAMHD 13: Promote Children's Mental Health Public Awareness Activities	Coverage on local media and the public re: children's mental health will occur	
CAMHD 14: Assist Family Partner Organization in Meeting New Requirements *	Number of trainings offered re: criteria for Medicaid reimbursement procedures	

CAMHD 15: Maintain and Update Information Website *	Maintain and update agency website	
CAMHD 16: Hire Telehealth Coordinator *	A new Telehealth Coordinator will be hired w/in 90 days of funding	
CAMHD 18: Increase Medicaid Reimbursement *	Plans for a new data depository will be developed w/in 90 days of funding	
CAMHD 18: Increase Medicaid Reimbursement *	Number of trainings/meetings conducted to discuss ways to utilize Medicaid reimbursement	
AMHD 19: Trauma	Train 50% of consumers in trauma suport services. Train 70% providers in trauma informed care. Increase the number of military announcements re: trauma trainings by 100%.	
AMHD 20: Health Integration	85% of consumer charts will contain documentation on assessment of primary care health needs and integration with primary care.	
AMHD 21: Public Awareness and Support	Educate 50% of law enforcement personnel statewide on mental health issues. Increase the number of consumers involved in the Speakers Bureau to increase public awareness and reduce stigma by 50%.	
AMHD 22: Health Information Technology	Establish technology and resources in rural areas. Establish baseline for utilization for 6 month period. Develop plan to increase utilization. Increase the number of providers using web-based applications by 80%.	
AMHD 23: Housing	Increase the number of consumers served in semi-independent housing by 50%. Increase the number of eARCH beds by 20%. Ensure charts have consumers in appropriate level of housing by 50%.	
AMHD 24: Peer Specialists	Increase the number of working peer specialists by 100%. Place 75% of newly certified peer specialists in the workforce. 100% of potential employers will be trained on the role of certified peer specialists.	

Footnotes:

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America?s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

IV. Narrative Plan

K: Technical Assistance Needs

Child and Adolescent Mental Health Division (CAMHD)

With the advent of the global economic crisis as well as passage of the Affordable Care Act, it is incumbent upon programs to look at long term financial sustainability. CAMHD is proceeding with a re-engineering of operations, shifting from an administrative role to placing more emphasis on provision of some direct services from therapists and clinicians within CAMHD's own staff. Long-term viability is tied more to service provision and leveraging service provision, either through our direct contractors or from our own clinical staff. This necessitates a clear, reliable linkage between CAMHD and Medicaid reimbursements. CAMHD's greatest need for technical assistance then is not with guidance for how to construct a system of care, as in the past, but with how to structure the agency's long-term sustainability, intimately linked with Medicaid reimbursements. Recently SAMHSA has encouraged states to look at the 1915 (i) waiver program as the appropriate vehicle for statewide service support. Because this option is so new, there are few who are able to advise us on how to get approval for one of these waivers. Another similar financial issue is how to go about enabling our parent support organization to be reimbursed for some of their services. Thus, technical assistance that can advise us in such matters as state plan amendments is greatly needed at this time.

Adult Mental Health Division (AMHD)

Technical assistance for the State Mental Health Council has been planned for September 13, 14, 2011. At that time, members will be trained on understanding data and to better utilize data in their role in reviewing the Mental Health Block Grant application. Members will also be educated on the fundamental changes accompanying the new guidance of the FY2012 Block Grant Reporting Section.

The State Mental Health Authority is creating and disseminating best practices, particularly in the form of toolkits and manualized treatments for the administration and provision of integrated behavioral health and primary care models, for high at-risk population of persons with co-morbid mental and physical health problems. Assistance with standards and creation of consumer portals would be helpful. Other resources that would be helpful including sponsoring opportunities for information technology staff to meet to share ideas and solve problems. An example of where this would work well is the Western States Decision Support Group that meets quarterly.

Technical assistance and information exchange with other states would be helpful about how the eligibility for services, and services offered to individuals by the SMHA, could be standardized or determined by benchmarking to national standards. Technical assistance and information exchange with other states regarding outcome measures used to assess the effect of expenditures would also be helpful.

AMHD is relying on the technical assistance through the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI) to aid in advancing the accurate reporting of client level data in FY2012.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

IV. Narrative Plan

L: Involvement of Individuals and Families

Child and Adolescent Mental Health Division (CAMHD)

CAMHD has instituted measures to ensure family member involvement in the system of care. CAMHD partners with the statewide family organization, Hawai`i Families as Allies (HFAA) to ensure the involvement of the family voice in many aspects of its system of care. CAMHD incorporates the family voice in its leadership by specifying that its standing committees include family representatives. The Executive Director of HFAA is an ex-officio member of CAMHD's Executive Management Team. CAMHD's Quality Steering Committee, Grievance and Appeals Committee, Safety and Risk Management, Compliance Committee, Utilization Management Committee, and Evidence Based Services Committee all require family representatives in its membership.

Based on its contract with CAMHD, HFAA is required to establish Parent Partner positions to correspond with the needs of the population, which is generally one per CAMHD community-based Family Guidance Center. CAMHD provides office space for the Parent Partners at each of its six Family Guidance Centers and at the Family Court Liaison Branch so that the Parent Partners can be immediately available to provide guidance and support to families. HFAA's hiring philosophy is to find family members of SED youth who live in the communities they serve. Except for the Office Manager, every employee of HFAA is a biological, grand, foster, adoptive or hanai (Hawaiian-style adoptive) parent of a youth with emotional and/or behavioral challenges. HFAA provides parent-to-parent support to families navigating the children's mental health and child serving systems. Their activities include providing supports to parents in service planning meetings, guiding parents in advocating for services and supports, conducting workshops and conferences for families of SED youth, operating a parent warm line, representing the family perspective at the community and policy levels, providing youth with empowerment and leadership opportunities, supporting the political engagement of families and youth, and conducting public awareness activities around bullying and stigma.

The community-based Parent Partners develop collaborative relationships with their local schools, Family Guidance Centers, Community Children's Councils and other organizations. The Parent Partners are included as members of the FGC's management teams, and often accompany the FGC Branch Chiefs to local agency meetings to provide the family perspective on local system issues. Each full-time Parent Partner provides one parent workshop a month in their respective communities. The Family Court Coordinator/Youth Program Assistant at CAMHD's Family Court Liaison Branch is responsible for establishing support groups for families who have children in the child welfare and juvenile justice systems.

Recently HFAA identified a need in the Micronesian community and approached CAMHD with a proposal. CAMHD approved the proposal and extended their contract to establish a new program to support the Micronesian community. HFAA now has an ethnic Chuukese and an ethnic Marshallese on its staff. After orientation and training, the two half-time Parent Partners began to work on establishing community relationships and translating materials into their native languages.

Adult Mental Health Division (AMHD)

Consumers are afforded the opportunity to be actively involved in planning, quality improvement, system transformation, program implementation and service delivery in the Adult Mental Health system. This occurs through a variety of organized mental health structures including the State Council on Mental Health, County Service Area Boards, Multicultural Advisory Committee, AMHD Office of Consumer Affairs (OCA), Clubhouse Coalition, and the newly created Consumer, Family and Youth Alliances.

The monthly Chief's Roundtable, provides an opportunity for consumers and family members to make their concerns and needs known to the Division Chief. The OCA actively participates in the AMHD Action Plan tasks for Recovery/Treatment Planning, which is transforming the way in which recovery/ treatment planning practices occur, including improved accountability and functioning of the Interdisciplinary Teams throughout the system. Consumer representation is also present in the development of scopes of service, selection and awarding of state contracts. AMHD consumer staff is the entry for grievance and complaints to ensure that individuals have support in expressing their concerns.

The Mental Health Transformation State Incentive Grant (MHT SIG) has fostered the Consumer, Family and Youth Alliances (CFY Hui) across the state. There are affiliates in each county and CFY conferences have been held in each county rather than one large state annual conference for consumers. The goal of the Hui's is to increase networking, facilitate collaboration, identify and accomplish shared goals, and strengthen local communities. These groups are actively involved in advocating for needed services, promoting recovery and wellness, and involved in meaningful discussions, which have impacted decision making at the state level. Over the past three years, MHT SIG has provided various trainings, expert consultations, administrative supports and meetings supports to assure that expertise input and guidance is available at local community and state levels. MHT SIG has also made a commitment to secure continued involvement of Hui members to serve on boards, committees and in the workforce of various state agencies to improve clinical and business outcomes once the grant ends.

In an effort to reach a larger audience of consumers, family members, the MHT SIG has initiated the Speakers Bureau in which consumers and family members play a significant role in speaking to communities. Community engagement activities have sought agreement with county and city mayors to allow greater mental health information in county facilities. This allows consumers to share their story with the hope of reducing stigma while changing attitudes about mental illness.

The introduction of the Network of Care (NOC) is also a medium that engages consumers, family members and the community. The NOC is a dynamic interactive website designed to assist individuals to be involved in community services. The website is designed to provide information about each county program and all of its providers, support efforts of consumers and families toward successful recovery, link to extensive resources about mental health, track bills in the Hawai`i legislature, and make contact with legislators. The NOC system is housed within the Community Mental Health Centers statewide to be more accessible for consumers and families. Although the startup of the program has not been without its challenges, the system is currently working effectively.
Another of MHT SIG's initiatives is the Wellness Recovery Action Planning (WRAP) program. MHT SIG has trained numerous AMHD consumers on how to construct their personalized wellness plans as well as these consumers in turn facilitating other individuals in developing their own plans.

NAMI, United Self Help, and Mental Health America have also played an integral role in providing supports to families through educational programs, advocacy, understanding evidence-based practices, stigma reduction, support groups and community forums. In these settings, individual and families have the opportunity to share and connect with other families who are experiencing similar challenges, and have access to more information to understand mental illness.

IV: Narrative Plan

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

IV. Narrative Plan

M: Use of Technology

Child and Adolescent Mental Health Division (CAMHD)

CAMHD has three initiatives planned that are related to Interactive Communication Technologies (ICTs). The first is the Telehealth initiative which has already been launched with the support of the Block Grant. The infrastructure is now in place to use the Telehealth system to increase the ability of clients to access services and to support staff trainings and meetings. The next phase is to identify a Telehealth Coordinator who will manage use of the system, trainings, documentation, and so forth, to ensure the system is used successfully.

The second initiative related to ICT is to develop further the Open Vista/RPMS EHR system. When fully functioning, this system will support Care Coordinators, supervisors, providers, and other users in accessing needed data reports for ongoing service planning. The system will be able to provide alerts when information is needed (e.g., assessments) as well as progress of their youth over time.

The third initiative, which has also been started, but needs continued support, is the development of a local, culturally-sensitive, family-friendly website that provides information on mental health and services provided in Hawaii, including research about the effectiveness of different services. CAMHD will also explore the possibility of linking this site with a mental health social networking site that was developed by Hawai`i's MHT-SIG project. This initiative is part of larger efforts to build public awareness and support and to support families in directing their services.

Adult Mental Health Division (AMHD)

The Adult Mental Health Division plans to expand use of Interactive Communication Technologies (ICT) over the course of the next two years to promote recovery. This includes implementation of Netsmart's Consumer Connect application. Benefits including improved outcomes through promoting communication with care givers, access to information about their medications and side effects, appointment scheduling, etc. More information can be found at http://www.ntst.com/Connected%20Care/Consumer.asp

AMHD plans to expand the use of telepsychiatry to rural areas with an initial focus on the Big Island of Hawaii with hopes to expand to Maui County, specifically the islands of Lana`i and Moloka`i. Due to distances and air travel required, both scheduled and unscheduled psychiatry services can be provided more effectively and efficiently. Costs of acquiring equipment, availability of high speed internet services and perceptions of telepsychiatry are the primary challenges in increasing use of this technology.

AMHD will also expand its use of Provider Connect, a web based application currently used by providers to seek authorizations. The plan is to capture quality and outcome information through building data capture screens and training staff in their use. This project has just begun as part of the TIC IT Grant where providers will enter assessment information. It will be expanded over the next year to include the Quality of Life Inventory and a measure of acuity.

Feedback from participants will be utilized to make ICT's more effective.

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

IV. Narrative Plan

N: Support of State Partners

Child and Adolescent Mental Health Division (CAMHD) and Adult Mental Health Division (AMHD)

Support of State Partners

Members the State Mental Health Council also known as the Hawaii Planning council is tasked with the following responsibilities:

- Advise the department on allocation of resources, statewide needs and programs affecting two or more service areas
- Review and comment on the state plan
- Serve as an advocate for adults with serious mental illness, children with serious emotional disturbances, other individuals with mental illness or emotional problems, and individuals with combined mental illness substance abuse disorders

In their advisory capacity to the Department of Health, the Council will submit a letter to SAMHSA with recommendations for modification to the FY2012 Block Grant Application.

A stakeholder workgroup will convene in January 2012 to assist the AMHD to outline agency-specific tasks and functions s they relate to each area of the Strategic Quality Mental Health Program Work Plan. The project details of the work plan will be based on activities for the coming year, such as the objectives and performance measures. AMHD will solicit letters of support from these individuals that indicate their agreement in collaborating with the implementation of the FY2012 Block Grant Plan.

Members of this Task Force will be from:

- The Department of Public Safety
- The Department of Education
- The Honolulu Police Department
- The Judiciary
- Two members from the State Council on Mental Health
- Two Community Members
- Two Purchase of Service providers from the Neighbor Islands
- A staff from the Community Mental Health Center System Administration
- A staff from the Hawaii State Hospital
- Four Statewide Service Directors

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

IV. Narrative Plan

O: State Behavioral Health Advisory Council

Child and Adolescent Mental Health Division (CAMHD) and Adult Mental Health Division (AMHD)

The monthly Mental Health State Council meeting for August was cancelled due to lack of a quorum. As a result, CAMHD and AMHD were not able to present their proposed goals, strategic activities, and performance indicators to the State Council for feedback prior to the submission of the application. However, the discussion of the plan is on the agenda for the State Council meeting scheduled for September 13-14 of 2011. Any written feedback from the State Council will be forwarded to SAMHSA when it is received after this meeting.

IV: Narrative Plan

Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year: 2012

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Alan Buffenstein, M.D.	Providers		P.O. Box 3346 Honolulu, HI 96801 PH: 808-479-7673	abuffenstein@hawaii.rr.com
Liesje Cattaneo	State Employees	Criminal Justice		
Charlene Daraban	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		275 Olive Avenue Wahiawa, HI 96786 PH: 808-723-2372	charlie.daraban@hfaa.net
G. Mike Durant	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		2311 Ferdinand Avenue Honolulu, HI 96786 PH: 808-295-2611	gmdurant@earthlink.net
Susan Foard	State Employees	Vocational Rehabilitation	1901 Bachelot Street Honolulu, HI 96817 PH: 808-586-9746	sfoard@dhs.hawai.gov
Peter Gonzalez	Individuals in Recovery (from Mental Illness and Addictions)		P.O. Box 896 Kaunakakai, HI 96748 PH: 808-553-8650	petergonzalez1956@yahoo.com
Randolph Hack	State Employees	Department of Health, Adult Mental Health Division	1250 Punchbowl Street, #256 Honolulu, HI 96813 PH: 808-586-4685	randolph.hack@doh.hawaii.gov
			601 Kamokila	

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Jonathan Harris	State Employees	Department of Human Services	Boulevard, Kakuhihewa Building Kapolei, HI 96707 PH: 808-692-8149	jharris@medicaid.dhs.state.hi.us
Alva Kaneaiakala	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		87-165 Laiku Street Nanakuli, HI 96792 PH: 808-258-2034	
Ku'ulei Kiliona	Individuals in Recovery (from Mental Illness and Addictions)		P.O. Box 844 Volcano, HI 96785 PH: 808-557-9666	kuuleikiliona@hawaii.rr.com
Theresa Minami	State Employees	Department of Human Services, Social Services Division	810 Richards Street, 4th Floor Honolulu, HI 96813 PH: 808-586-5667	timinami@dhs.hawaii.gov
Candace Sandal	Individuals in Recovery (from Mental Illness and Addictions)		4850 Kawaihau Road, 18B Kapaa, HI 96746 PH: 808-821-2167	candysandal@hawaiiantel.net
Steven Shiraki	State Employees	Department of Education, Student Support Service Branch	637 18th Avenue, Bldg. C Honolulu, HI 96816 PH: 808-753-3110	steve_shiraki@notes.k12.hi.us
Sandra Simms (Retired Judge)	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		94-415 Kealakaa Street Mililani, HI 96789 PH: 808-625-1834	sandra.simms48@gmail.com
Maile Watters	Individuals in Recovery (from Mental Illness and Addictions)		92-630 Malahuna Loop Mililani, HI 96707 PH: 808-780-3849	daguuio_maile@yahoo.com
Noelani Wilcox, APRN	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		1968 Paula Drive Honolulu, HI 96816 PH: 808-382-4213	noelaniwilcox@yahoo.com
Donna Hansen	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		161 Wailea Alanui, Suite D-103 Wailea, HI 96753 PH: 808-757-3114	dad@MauiRealEstate.net

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Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year: 2012

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery (from Mental Illness and Addictions)	4	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	6	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	12	57.14%
State Employees	6	
Providers	1	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	9	42.86%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Comments on the State Plan

The FY2012 Block Grant Application will be posted on the websites of the Adult Mental Health (www.amhd.org) and the Child and Adolescent Mental Health (http://hawaii.gov/health/mental-health/camhd/index.html) Divisions for public comment. The websites are accessible to the general public and allow for comments to be sent to the email addresses of the AMHD and CAMHD planners.

The FY2012 Block Grant Application will be reviewed and discussed with the State Mental Health Planning Council at its September 13, 14, 2011 retreat. At that time, council members will be educated on significant changes to the application, and feedback/comments will be recorded. The document will also be shared with the county Service Area Boards, staff, and other stakeholders for their review and comments.

Since this is the first year of the new guidance, beginning in January 2012, on a monthly basis, sections of the Plan will be added to the Council's agenda for planning purposes.

Attachment CAMHD1

REPORT TO THE TWENTY-SIXTH LEGISLATURE
STATE OF HAWAII
2011

PURSUANT TO SECTION 321-175, HAWAII REVISED STATUTES, STATEWIDE CHILDREN'S MENTAL HEALTH SERVICES PLAN, AND SECTION 321-176 BIENNIAL REVIEW OF PROGRESS MADE ON THE CHILD AND ADOLESCENT MENTAL HEALTH DIVISION'S FOUR-YEAR STRATEGIC PLAN

PREPARED BY:

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

NOVEMBER 2010

EXECUTIVE SUMMARY

This report is submitted pursuant to Sections 321-175 and 321-176, Hawaii Revised Statutes, which require the Department of Health to submit to the legislature and the governor, a statewide children's mental health services plan every four years and a biennial review of progress on the statewide children's mental health services plan every two years.

Section I presents the Statewide Children's Mental Health Services Plan as required by statute.

Section II presents Child and Adolescent Mental Health Division's Strategic Plan 2011-2014.

The strategic plan aims to position the Child and Adolescent Mental Health Division for the future based on the current environment. As the Child and Adolescent Mental Health Division began preparing to develop its plan for children's mental health services, the most pressing issues are the poor economy, the depressed state budget, the restructuring of the behavioral health information management system, and national health care reform.

Based on the changed environment, CAMHD developed a strategic plan to maximize federal dollars and seek additional funding streams, integrate health information technology to streamline operations and move toward excellence in care by targeting younger children and strengthening evidence-based clinical care. CAMHD's four goals are:

Goal 1:	Integrate Health Information Technology
Goal 2:	Strengthen Clinical Services
Goal 3:	Implement a Strategic Financial Plan
Goal 4:	Strengthen Effective Collaborations to Increase Early Access to Care

Section II presents the Biennial Review of Progress Made on the Child and Adolescent Mental Health Division's Four-Year Strategic Plan.

Progress was made in all seven areas of the 2007-2010 Strategic Plan. The most progress, and ongoing work is in priority area 7 – information technology program.

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SECTION I

HAWAII STATEWIDE CHILDREN'S MENTAL HEALTH SERVICES PLAN

STATUTORY REQUIREMENT

According to Hawaii Revised Statute §321-175, Every four years, the department of health is required to develop and present to the governor and legislature, as well as release for public comment, a statewide children's mental health services plan.

The vision, mission and guiding principles of the Child and Adolescent Mental Health Division of the Hawaii State Department of Health are:

CAMHD MISSION

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

CAMHD VISION

Happy and Healthy Children and Families Living in Caring Communities

GUIDING PRINCIPLES - HAWAII CHILD AND ADOLESCENT SERVICE SYSTEM PRINCIPLES (CASSP)[1]:

Respect for Individual Rights

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

Individualization

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

Early Intervention

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

Partnership with Youth and Families

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

Family Strengthening

[1] Stroul, B.A. & Friedman, R. E. (1986). System of Care for Children and Youth with Severe Emotional Disturbances. Washington, D.C.: Georgetown University Center for Child and Human Development.

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

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

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

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

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

PREVALENCE ESTIMATE
According to the President's New Freedom Commission's report, *Achieving the Promise: Transforming Mental Health Care in America,* about 5% to 9% of children ages 9-17 have a serious emotional disturbance[2]. Using the 2000 census, the prevalence of SED by county for individuals aged 9-17 is shown in the table below, and is observed to be 7,518 – 13,531 statewide.

Estimated Range of Number of SED Youth Aged 9-17 Years by County, based on 2000 Census			
County	Total Youth	Lower SED Number (5%)	Upper SED Number (9%)
Hawaii	21,104	1,055	1,899
Honolulu	103,912	5,196	9,352
Kauai	8,359	418	752
Maui	16,977	849	1,528
STATE	150,352	7,518	13,531

[2] Friedman, R. M., Katz-Levey, J. W., Manderschied, R. W., & Sondheimer, D. L. (1996b). Prevalence of serious emotional disturbance in children and adolescents, cited in R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71–88). Rockville, MD: Center for Mental Health Services.

The Department of Education's School-Based Behavioral Health (SBBH) program serves about 8,300 youth per year.

The distribution of children and youth receiving intensive mental health services in 2009 from CAMHD is:

Honolulu	226
Central Oahu	185
Windward Oahu	178
Leeward Oahu	402
Family Court Liaison Branch	118
Hawaii	812
Maui	229
Kauai*	728
Hawaii	2878

*Kauai High End Only is 97

Together, the DOE SBBH and CAMHD serve about 11,200 youth per year, well within the range of the expected population.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION ORGANIZATION

The Child and Adolescent Mental Health Division is situated in the Behavioral Health Administration of the Hawaii State Department of Health. The Behavioral Health Administration is the home to the Adult Mental Health Division, Child and Adolescent Mental Health Division (CAMHD), Alcohol and Drug Abuse Division and the Developmental Disabilities Division.

CAMHD is headed by a CAMHD Administrator and consists of both line and staff offices. The staff offices are maintained at the state level and consist of approximately 79 positions. The line offices are organized into seven (7) CAMHD branches consisting of six (6) Family Guidance Centers (FGCs) and one (1) Family Court Liaison Branch (FCLB), and include approximately 164 positions. A network of approximately 18 contracted provider agencies located throughout the State provides an array of home and community-based and residential treatment services.

The CAMHD state office includes the Research & Evaluation Office, Administrative Operations Office, Clinical Services Office and the Performance Management Office. The Research & Evaluation Office is responsible for designing and overseeing a comprehensive, statewide evaluation and reporting system for the purpose of improving effectiveness and efficiency, improving clinical practice and client outcomes. Administrative Operations Office is responsible for budgeting, accounting, personnel resource management, and contracting. The section is also responsible for maximizing alternative funding sources, such as Title XIX, Title IV-E and grants. The Clinical Services Office is responsible for clinical practice issues, training, specialty case consultation, utilization review, and resource management. The Performance

Management Office (PMO) develops, implements, and monitors a Division-wide, structured system for continuous improvement of mental health services delivery and youth outcomes. CAMHD's Management Information System provides the organizational foundation for CAMHD's outcome tracking, utilization management, and accountability systems, as well as billing and general registration. MIS is the lead for CAMHD's two information technology initiatives—electronic health records, and telehealth.

The community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGC's are strategically located in geographic areas that correspond with the Dept. of Education school districts. Three FGCs are located on Oahu, where close to 72% of the State's population resides. Also, there is one FGC each on the neighbor island counties--Kauai, Maui, and the Big Island. Most of the FGCs also have satellite offices. Each FGC is headed by a Branch Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide intensive case management. Services provided by the centers include facilitating access to care coordination (intensive case management), direct service provision, service procurement, utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

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

INTENSIVE CASE MANAGEMENT

Within 48 hours of registration, youth at CAMHD are assigned a Mental Health Care Coordinator (MHCC) from their regional Family Guidance Center to provide intensive case management. The care coordinator serves as the central point of contact for the delivery and coordination of mental health services to youth and the family. The care coordinator ensures that needed services, interventions and strategies are identified and delivered in a coordinated manner and in partnership with the families. The MHCC is responsible for engaging the youth and family, referring the youth for appropriate services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of

interventions. The youth's MHCC is responsible for convening an initial Coordinated Service Plan meeting within 30 days of eligibility determination, or immediately if the youth has immediate needs and assuring service delivery within 30 days of identification for routine services. When appropriate, responsibilities also include coordination of care with Family Court, the Department of Human Services and other state and community agencies. The MHCC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and to initiate necessary adjustments o services when needed through the team based process.

In order to assure youth-centered, culturally competent and effective services, care coordinators undergo internal training on engagement skills, intensive case management, coordinated service planning process, mental health assessments, CAFAS, CALOCUS and Achenbach tools, evidence-based services and evidence-based practice elements, and interagency performance standards and practice guidelines.

SERVICE ELIGIBILITY

The CAMHD provides timely, consistent, and responsive mental health services in the following categories:

Emergency Public Mental Health Services. These services are available to all children and youth in Hawaii, ages 3-18 years, experiencing an imminent life threatening mental health crisis. Services include: 24-hour crisis telephone service, crisis mobile outreach, crisis therapeutic foster home and community-based crisis group home.

Educationally Supportive (ES) Mental Health Services. ES Mental Health services are available for students with an educational disability who have been determined to be in need of intensive mental health services to benefit from their public education. The services are for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific support via their IEP. The criteria for enrolling a youth in the ES program are IDEA eligibility, an individualized education program (IEP) plan with recommendation for services from CAMHD, and an IEP meeting with CAMHD participation to determine the goals of mental health services to be provided. The available mental health services are: ancillary services, respite supports, psychosexual assessment, intensive case management, intensive in-home intervention, MultiSystemic Therapy, respite home, community mental health shelter, therapeutic foster home, Multidimensional Treatment Foster Care, therapeutic group homes, independent living program for 16-18 year olds, community-based residential levels III-I, and hospital-based residential.

Support for Emotional and Behavioral Development (SEBD) Program. SEBD is an acronym for the Child and Adolescent Mental Health Division's Support for Emotional and Behavioral Development program. CAMHD's unique "Support for Emotional and Behavioral Development (SEBD)" designation was suggested by youth who rejected the

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previous stigmatizing labels. Formerly known as SED (Serious Emotional Disturbance) or Serious Emotional Behavioral Disturbance, CAMHD's SEBD program provides an array of services need by families to support children and youth with high-end intensive mental health support. Eligible are children and youth ages 3-21 and are Hawaii Medicaid QUEST or Fee-for-Service eligible, and have a Child and Adolescent Functional Assessment Scale (CAFAS) or PECFAS score of 80 or above and an eligible DSM-IV Axis I diagnosis of at least 6 months.

Co-Occurring Disorders.
Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, mental retardation, developmental disorders, or medical impairments (e.g., blindness, deafness, diabetes, etc.) Consequently, the presence of co-occurring disorders is assessed with all youth at initial evaluation, as well as routinely during the course of on-going treatment. All youth receive services appropriate to their strengths and needs. Providers are required to provide integrated treatment for co-occurring disorders.

PROFESSIONAL DEVELOPMENT

CAMHD has partnerships and contracts with the University of Hawaii to support the development of the mental health workforce. Through these contracts, graduate students in the Department of Psychology can receive clinical therapy and assessment training or can participate in mental health research and evaluation. A John A. Burns School of Medicine contract provides child psychiatry residency opportunities, training residents on various levels of clinical psychiatric treatment. CAMHD also contracts with the Schools of Nursing and Social Work to provide specialty mental health tracks for their students.

CAMHD'S Clinical Services Office (CSO) also provides a number of continuing education opportunities for CAMHD staff, graduate therapists and paraprofessionals working in our contracted provider agencies. Because of funding restrictions, CSO has been focusing on developing partnerships with other agencies to meet the training needs of professionals in the field. CAMHD recently completed a pilot project in partnership with DOE and UH. The project trained system supervisors in a model of supervision designed to help them train supervisees to utilize Evidence-Based Practice Elements. We anticipate expanding this effort in the future, based on lessons learned through this initial pilot.

PROVIDERS OF MENTAL HEALTH SERVICES

As of the date of this printing, the following community-based providers have Purchase of Service contracts to provide mental health services to CAMHD youth.

Alakai Na Keiki, Inc.
Aloha House
Bobby Benson Center
Bountiful Psychiatric Hospital
CARE Hawaii, Inc.

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Catholic Charities of Hawaii
Child and Family Service
Hale Kipa, Inc.
Hale Opio Kauai, Inc.
Hawaii Behavioral Health, LLC
Marimed
Maui Youth & Family Services, Inc.
Parents & Children Together
Queen's Medical Center
Sutter Health Pacific, dba Kahi Mohala
The Institute for Family Enrichment
Waianae Coast Community Mental Health Center, Inc.

For a Description of CAMHD's Array of Services, see Appendix A.
For Geographic Providers and Care Levels, see the Appendix B.

SECTION II

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION'S STRATEGIC PLAN – 2011-2014

ENVIRONMENTAL SCAN

Prior to the development of the four-year strategic plan, CAMHD conducted an environmental scan and found that the following factors will impact CAMHD's service system:

- Downturned economy
- Budget constrictions
- Behavioral health information management system restructuring
- Health Care Reform

Economy and budget. It is anticipated that it may take some time before the economy fully recovers and that the state budget will be similarly affected.

Behavioral Health Information Management System Restructuring. Within the last two years, the Department of Health embarked on a plan to centralize the multiple billing and utilization management functions conducted by the four divisions in the Behavioral Health Administration and the Family Health Services Division. A Third-Party Administrator was contracted to centralize and conduct the billing functions on behalf of the Department of Health, and a Center on Operational and Regulatory Excellence was created to conduct the utilization management functions for the department. This creates a shift for CAMHD, as it has developed policies, procedures, and safeguards, as well as trained specialized staff who manage the billing and utilization management functions. As the department marches ahead with its initiatives, CAMHD will need to realign its system to accommodate the changes.

Health Care Reform. National health care reform will radically change the health care and health insurance environments. This will greatly impact CAMHD, as CAMHD is a health care provider, serves the Medicaid population, and has a fee-for-service contract agreement with the Med-Quest Division to provide mental health carve-out services in exchange for Medicaid reimbursements. There are four strategies in the Affordable Care Act. These strategies are insurance reform, coverage expansion, delivery system redesign and payment reform. Insurance reform will allow dependent coverage up to age 26 and former foster care children up to age 25, and prohibits pre-existing (health or mental health) condition exclusions. Coverage expansion expands Medicaid for all under 133% of the federal poverty level. It is estimated that nationally an additional 16 million new Medicaid enrollees will qualify for Medicaid services, with 5-6 million of those with mental illness and/or substance abuse service needs. Delivery system redesign embraces the medical home model where a multidisciplinary care team, which can include behavioral specialists as team members or as specialty referrals, provide coordinated and integrated health care. The system redesign will include prevention

and early intervention services and dramatically improve the management of chronic health conditions. The growing awareness that behavioral health is necessary for health, that prevention and treatment of mental illness is effective and that mental illness/substance abuse disorders are chronic conditions, presents an opportunity for the behavioral health system in Hawaii to radically improve the lives of its residents. Payment reform in the Affordable Care Act will eventually phase out fee-for-service carve-outs and move toward case rates in a medical home model.

Federal Strategic Initiatives. At the federal level, the Substance Abuse & Mental Health Services Administration (SAMHSA) has adjusted its priorities to better compliment the sweeping changes in the Affordable Care Act and Parity. The Affordable Care Act makes significant steps to include behavioral health in the Nation's health delivery system; to increase access to health and behavioral health care; to grow the country's health and behavioral health workforce; to reduce physical and behavioral health disparities experienced by low-income Americans, racial and ethnic minorities, and other underserved populations; and to implement the science of behavioral health promotion and of prevention, treatment, and recovery support services. SAMHSA developed a strategic plan to address eight new strategic initiatives within the context of health care reform:

- Prevention of Substance Abuse and Mental Illness is SAMHSA's leading Strategic Initiative. Create Prevention Prepared Communities where individuals, families, schools, faith-based organizations, workplaces, and communities take action to promote emotional health and reduce the likelihood of mental illness, substance abuse, and suicide.

- Reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral health care systems and by diverting people with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

- Support America's service men and women together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

- Broaden health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions.

- Provide housing and reduce barriers to accessing effective programs that sustain recovery for individuals with mental and substance use disorders who are homeless.

- Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of Health Information Technology.

- Realize an integrated data strategy that informs policy, measures program impact, and results in improved quality of services and outcomes for individuals, families and communities.

- Increase understanding of mental and substance use disorder prevention and treatment services and activities to achieve the full potential of prevention and assist people in accessing/getting help for these conditions with the same urgency as any other health condition.

National Vision of a Modern Addictions and Mental Health Service System. The passage of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, together referred to as "The Affordable Care Act" marks the beginning of an historic evolution for the nation's health care system. The Affordable Care Act recognizes that prevention, early intervention and, when necessary, treatment of mental and substance use disorders are an integral part of improving and maintaining overall health. To help the nation move toward a transformed and integrated system, SAMHSA developed a draft position paper describing a modern addiction and mental health system, "Description of a Modern Addictions and Mental Health Service System," Draft, October 9, 2010.

> **Vision**
> "The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. …The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidence-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes...."
> (Description of a Modern Addictions and Mental Health Service System, Draft, October 9, 2010)

Service elements that comprise a good and modern mental health and substance use system include:

Health Promotion. Health promotion is a significant component of a comprehensive prevention and wellness plan, and plays a key role in efforts to prevent substance abuse and mental illness.

Prevention. The system must have three levels of prevention practice: Universal, which addresses populations at large; selective, which targets groups or individuals who are at higher risk of developing a substance abuse problem or mental illness; and indicated, which addresses individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable.

Screening and Early Intervention. Screening should include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). Screening may also be used to identify warning signs for suicide.

Care Management. Effective care management integrates primary care and specialty health services through approaches that coordinate an individual's medical care and provide assistance in navigating other healthcare systems, including behavioral health. Intensive case management provided in mental health is an exemplary model.

Self Help and Mutual Support. 'Family to family' and 'youth to youth' groups provide a social network offering their members: support in managing their lives, role models and the strong belief that they can recover. These voluntary supports will continue be needed in a good and modern system that creates strong relationships with self-help and mutual supports.

Proposed Continuum of Services. Prevention, treatment and recovery support services should be available both on a stand-alone and integrated basis with primary care and should be provided by appropriate organizations and in other relevant community settings.

Core Structures and Competencies for a Modern System are:

Workforce. Experienced and competent staff will have the information, supervision, technical assistance, and culturally relevant training to effectively implement improved practices. Providers will embrace team-based and collaborative care. The workforce will have an improved ability to use technology to provide, manage and monitor quality care.

Empowered Health Care Consumers. The system will support health literacy, shared decision making, and strategies for individuals and families to direct their own care. Health literacy is the first building block of self-care and wellness. Shared decision making will become the standard of care for all treatment services.

Information Technology. To achieve optimum individualized care, all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and the patient's providers. Interoperable, integrated electronic health records will be necessary, as well as community-wide indicators of mental health and substance use disorders.

Funding and Payment Strategies. Medicaid will be required to streamline eligibility and enrollment. Systems must blend or braid funds in support of comprehensive services for consumers, youth and families.

Quality and Performance Management. Quality improvement will become standard practice, utilizing outcomes and performance measures.

Sustainable Practice Improvement. Continuous practice improvement can incorporate new evidence and ensure more accountability, with a focus on "practice-based evidence" as well as evidence-based practice.

Continued Partnerships. The good and modern system focuses on better integration of primary care and behavioral health, with links to the child welfare, criminal and juvenile justice, education and aging systems.

POSITIONING CAMHD FOR THE FUTURE

Based on the economic situation and the vision of a changed and new health care landscape, CAMHD has identified strategies to better position itself for the future. CAMHD has taken many of the elements identified in the "Modern Addictions and Mental Health Service System" and prioritized them into its Strategic Plan. At the same time, CAMHD must be more efficient with existing resources and increase new sources of revenues while striving for excellence in care. Strategies include maximizing federal dollars by increasing billable direct care; maximizing existing resources by integrating health information technology; and moving toward excellence in care by targeting younger children and strengthening evidence-based clinical care.

STRATEGIC GOALS

CAMHD's four broad strategic goals are:

- Integrate health Information technology
- Strengthen clinical services
- Implement a strategic financial plan
- Strengthen effective collaborations to increase early access to care

Goal 1:	Integrate Health Information Technology

In 2006, the White House identified IT as key to making health care more affordable and available to all American families. The President observed that health care takes advantage of the most advanced technology for diagnosis and treatment, but continues to use an antiquated paper-based medical record system.[3] The RAND Corporation analyzed the costs and benefits of information technology in other industries and prepared mathematical models to estimate the costs and benefits of HIT implementation

[3] Eckman, B. (n.d.). Information Integration for Healthcare Interoperability. Retrieved October 28, 2010 from http://db.cis.upenn.edu/iiworkshop/postworkshop/positionPapers/Eckman.pdf .

in health care. They found that health information technology has the potential to lower costs, improve quality of health care, and facilitate efficient management of chronic conditions. [4]

During the previous 4-year Strategic Plan, CAMHD initiated its IT Program and achieved several milestones. The status of CAMHD's IT infrastructure was appraised, health information needs were identified, and literature searches to identify cutting-edge strategies and technology were conducted to identify the best strategies for CAMHD to pursue. Based on that information, CAMHD embarked on a plan to establish an electronic health record system and to develop the capacity to provide telehealth services to remote and shortage areas.

The International Organization for Standards, a network of national standards institutes from 156 counties, issued a technical report that defines EHR for an integrated health care system:

> Integrated Care Electronic Health Record is a repository of information regarding the health of a subject of care, in a form to be processed by a computer that is stored and transmitted securely and accessible by multiple authorized users using different applications. Its primary purpose is the support of continuing, efficient and quality integrated health care and it contains information that is retrospective, concurrent and prospective.

The integrated EHR supports continuing, efficient and quality integrated health care. The long-term vision is that integrated electronic health record will provide various functions:

Health information and data - medical diagnoses, medication lists, allergies, demographics, clinical narratives and test results;
Order entry management – computerized physician order entry, electronic prescribing of medication orders, ancillary service and consult referrals;
Decision support – screening for correct drug selection, dosing and interactions with other medications, preventive health reminders for screening and risk detection, clinical guidelines and pathways for patient treatment, management of chronic disease;
Electronic communication and connectivity – electronic communication tools including integrated health records, email and web messaging for use among health care team, telemedicine or electronic communications between providers and patients who reside in remote areas;
Administrative processes – electronic scheduling system for visits; validation of insurance eligibility, claim authorization and prior approvals;
Reporting and population health management – clinical data to meet federal, state and local health reporting requirements, and to meet organizational reporting requirements for key quality indicators.

[4] Hillestad, R. & Bigelow, J. H. (2005). Health Information Technology: Can HIT Lower Costs and Improve Quality? Retrieved October 28, 2010 from http://www.rand.org/pubs/research_briefs/RB9136/

After exploring various options, CAMHD opted to use the Resource and Patient Management System (RPMS) used by the U.S. Indian Health Service. RPMS is in use at most health care facilities within the Indian health care delivery system. The RPMS is an integrated solution for the management of clinical, business practice and administrative information in healthcare. The RPMS Electronic Health Record (EHR) is intended to help providers manage all aspects of patient care electronically, by providing a full range of functions for data retrieval and capture to support patient review, encounter and follow-up. CAMHD will also be taking advantage of the pre-designed behavioral health templates in the RPMS Electronic Health Record.

After implementing the RPMS VistA Electronic Health Record, CAMHD made the necessary modifications to support provider billing. Family Guidance Center staff training is almost fully completed and progress notes are being entered. The billing process has been streamlined and substantial operational efficiencies have been gained. The Division has also experienced increased capabilities due to the real time management of work flow and staff output.

It is anticipated that CAMHD's integration of health information technology will achieve four objectives.

Objective 1.1: Use electronic health information to increase real-time decision making

Objective 1.2: Use electronic health information to increase quality of care

Health information technology will allow CAMHD to establish a system to monitor the quality of health information, establish a review schedule of quality measures and provide relevant and timely feedback, and establish a decision support system to enhance compliance with best clinical practice. CAMHD plans to further enhance Electronic Health Record functions to gain efficiencies in the area of automatic computer notifications in the area of incomplete work or necessary review, patient alerts for identified problems, and the streamlining of operations as data flows seamlessly from one section to another. All data in stored in CAMHD's health record will automatically be replicated to the overall Department of Health TPA structure which is expected to be in place within six months.

The RPMS includes a medications management function. This will allow clinicians to see the current and past prescriptions of medications for the youth, the dosages, and clinical notes on the positive and negative effects. With this information available at their fingertips, clinicians will be better equipped to make clinically appropriate decisions.

Objective 1.3: Increase the accuracy of standard outcome and practice measures

As staff are trained and acquainted with more and more features of the RPMS Electronic Health Record, efforts will also be made to increase the accuracy of standard outcome and practice measures.

Objective 1.4: Increase access to care in remote and shortage areas

Another initiative in Health Information Technology is telehealth. CAMHD, like the rest of the nation, often experiences shortages in mental health professionals. Access to services is also affected by Hawaii's geography, with the Pacific Ocean creating a barrier to service. Due to cost-cutting measures, travel for family members was severely curtailed. By providing telehealth capability at each of the CAMHD's Family Guidance Center, CAMHD will be able to increase access to care in remote/shortage areas and increase family contact and family therapy for youth and their families who are physically separated. This will benefit youth in residential placement on one island, who have family on another. Telehealth will allow the family to have some contact with the youth and will also provide opportunity for the family to continue family therapy. The telehealth system is on a secure system, adhering to HIPAA privacy requirements.

CAMHD's goal is to integrate telehealth functions with Electronic Health Record operations. Not only will operations be more efficient but cost savings will arise from reducing travel costs as well as pooled professional services that can be accessed anywhere across the telehealth network.

During the recent budget cycle, the restricted travel curtailed CAMHD's training efforts. The videoconferencing system will allow CAMHD to provide EBP training to staff and providers across the state. The training series will include a monthly case conference session, training on Evidence-Based Practice Elements, training on trauma informed care, and opportunities for contracted provider agencies to share innovative practices with the field. Once CAMHD's Clinical Services Office has revised its Foundation Training for Mental Health Care Coordinators, trainings will resume, utilizing the telehealth network and incorporating Family Guidance Center staff as trainers.

Goal 2:	Strengthen Clinical Services

Capitalizing on the previous achievements of CAMHD's Evidence Based Services Committee in identifying evidence-based practice and programs, CAMHD is focusing on increasing utilization of evidence-based practices (EBP's).

The term evidence-based practice (EBP) or empirically-supported treatment (EST) refers to preferential use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. Professional organizations, such as the American Psychological Association, have been advocating the use of EBPs. Evidence-based signifies that the approach is based in theory and has undergone

scientific evaluation. Program refers to an intervention designed to bring about specific outcomes for specific purposes or populations. Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Therapeutic Foster Care (MTFC), are examples of evidence-based programs.

A "Practice Elements Approach" is advocated by Chorpita, et al.[5] Their idea is to:

> "create evidence-based practitioners by training them in the component elements common to the most effective treatment protocols, and these components can then be implemented as needed. The practice elements approach is designed to encourage clinicians to borrow strategies and techniques from the best known treatments, using their judgment and clinical theory to adapt the strategies to fit new contexts and problems for which there is an insufficient evidence base."

Examples of practice elements are strategies such as "relaxation," or "assertiveness training."

In a study by Mueller, et al.[6], the application of evidence-based practices found an increased rate of youth functional improvement and that the increase of one additional EBS practice element increases rate of improvement about 6-7%.

CAMHD and its provider network have invested time, staffing and resources to bring the evidence-based programs of FFT, MST and MTFC to Hawaii. CAMHD has supported provider agencies as they developed their programs to meet fidelity standards and trained their staff to effect the program principles. CAMHD's Clinical Services Office has also invested many hours developing and providing training on evidence practice and mentoring to practitioners in the field. Youth in Hawaii are now able to access cutting-edge treatments. Despite the availability of these evidence-based programs and practice, not everyone who can benefit from the program is gaining accessing, and not all practitioners are consistently applying evidence based practice. Thus CAMHD and its EBS Committee will implement multiple strategies to increase the utilization of evidence programs and practices.

To achieve this goal, CAMHD has identified five objectives.

Objective 2.1: Increase utilization of evidence-based programs and implementation of practice elements.

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[5] Chorpita, B. F., Becker, K. D., Daleiden, E. L. (May 2007). Understanding the Common Elements of Evidence-Based Practice: Misconceptions and Clinical Examples. 648 J. Am. Acad. Child Adolesc. Psychiatry, 46:5.

[6] Mueller, C. W., Tolman, R., Ebesutani, C., Bernstein, A. (March 2009). "Improvement for Youth with Disruptive Behaviors Provided Evidence-Based Practices", 22nd Annual Research and Training Centers Conference, Tampa, Florida.

This will be accomplished by building local capacity by developing Best Practice trainers within the state. Initiate pre-service training collaborations with universities and colleges to increase knowledge and use of evidence-based programs and practice for the future mental health workforce. Increase CAMHD's stakeholder's participation and promotion in EBP implementation. Develop decision tree guides to promote consideration of EBPs.

CAMHD is currently pilot testing a specific model of supervision designed to help train supervisees to utilize Evidence-Based Practice Elements. The plan is to expand this effort in the future, based on lessons learned through this initial pilot.

CAMHD plans to utilize the telehealth system to offer weekly training opportunities for providers and CAMHD staff. This training series will include a monthly case conference session, training on Evidence-Based Practice Elements, training on trauma informed care, and opportunities for contracted provider agencies to share innovative practices with the field.

Objective 2.2: Strengthen the quality and involvement of CAMHD's clinical services

Taking advantage of the expertise on staff, CAMHD will redeploy them to provide increased direct client care services. CAMHD's child psychiatrists and clinical psychologists move toward co-managing youth with provider agencies. Efforts are underway to revise the treatment planning process to increase congruence among the major treatment planning tools. Utilizing the videoconference equipment, CAMHD will conduct a professional development program around evidence-based services.

Objective 2.3: Strengthen trauma-informed clinical practice

CAMHD was recently awarded a six-year multi-million dollar grant from the U.S. Substance Abuse and Mental Health Services Administration. Project Kealahou is to designed to increase the capacity of the Hawai`i system of care to provide effective mental health treatment to girls who have experienced significant trauma. The initiative will establish some new gender-specific, trauma-informed programs, and will work with existing CAMHD-contracted programs and agency partners to enhance the effectiveness of their interventions with traumatized girls. Once best practices around trauma-informed care is identified, CAMHD will develop a system to introduce, monitor and evaluate the effects of trauma-informed practice. Included will be training for providers in evidence-based trauma treatment.

Objective 2.4: Strengthen utilization management of CAMHD services

With the leadership of the Utilization Management Committee, CAMHD has already embarked on an initiative to critically review the services provided in our service array. The reviews identify those services which produce positive clinical outcomes and are

financially cost-effective. These reviews will continue during the next few years. With these reviews, the UM workgroups will be able to identify areas for improvement and develop action plans. Once the actions are implemented, the effects will be evaluated. Capitalizing on the data in the RPMS Electronic Health Record to support patient review, encounter and follow-up, efforts will be made to standardize branch level utilization management processes and integrate with statewide analyses.

Objective 2.5: Identify and implement strategies to strengthen involvement of youth and family members in treatment planning and system reform

A good and modern mental health system includes empowered health care consumers. CAMHD will support the empowerment of its youth and families by supporting health literacy and shared decision making. To aid families to be more involved in decision making, CAMHD will develop resources, such as clinical decision-making trees, to share with the families so that families can be aware of the options available and the pros and cons of each option. Information resources, such as a website, will be developed to increase family knowledge of evidence based practice, and to concurrently increase demand for EBPs. CAMHD will support the family support organization, Hawaii Families as Allies, by strengthening the role of their Parent Partners within CAMHD's community-based branches. CAMHD will also review how information from the consumer survey and provider survey can be better used to improve services.

Goal 3:	Implement a Strategic Financial Plan

CAMHD has two objectives to manage its financial situation: to maximize existing resources, and to maximize the revenue stream.

Objective 3.1: Maximize existing resources

To maximize existing resources, CAMHD will capitalize on the ability of its clinical staff to provide services which can be reimbursed through Medicaid. The clinicians will be provided guidelines, training and support to bill for services. CAMHD will also evaluate and prioritize staff activities and data needs. CAMHD's aim is to do work smarter, and more efficiently.

Objective 3.2: Maximize revenue stream

CAMHD plans to explore opportunities for diversifying revenue streams, such as federal or private grants, and federal Medicaid reimbursements. As good stewards of public funds, CAMHD will establish accountability measures to link billing data to clinical service records.

Goal 4:	Strengthen Effective Collaborations to Increase Early Access to Care

The Institute of Medicine's (IOM) 2009 report, "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities" documents that behavior and symptoms signaling the likelihood of future behavioral disorders such as substance abuse, adolescent depression, and conduct disorders often manifest two to four years before a disorder is actually present.

If communities and families can intervene earlier, before mental and substance use disorders are typically diagnosed, future disorders can be prevented or the symptoms mitigated. Doing so requires multiple and consistent interventions by all systems touching these children and youth (e.g., schools, health systems, churches, families, and community programs).

In the good and modern system envisioned by SAMHSA, there is better integration of primary care and behavioral health, with links to the child welfare, criminal and juvenile justice, education and aging systems.

CAMHD will continue to work with and strive toward more effective collaborations with other agencies in the child-serving system.

Objective 4.1: **Collaborate with the department of education to facilitate early identification of CAMHD-eligible youth**

Objective 4.2: **Improve working relationships with the department of human services and juvenile justice, including youth with trauma**

Objective 4.3: **Establish working relationships with primary care**

Objective 4.4: **Improve interdepartmental and intradepartmental coordination around multisystem youth**

Objective 4.5: **Improve working relationships around statewide quality assurance**

SECTION III

BIENNIAL REVIEW OF PROGRESS MADE ON THE CHILD & ADOLESCENT MENTAL HEALTH DIVISION FOUR-YEAR STRATEGIC PLAN

BACKGROUND

As required by statute, in 2007 the Department of Health Child & Adolescent Mental Health Division (CAMHD) developed a four-year children's mental health plan-- "A Strategic Plan for Strengthening Child & Adolescent Mental Health Services 2007-2010". The plan described seven priority areas which would enhance and sustain Hawaii's children's mental health system. To implement the plan, committees and task forces were formed to initiate and monitor the objectives of the seven priority areas in the plan. After two years, in 2009 CAMHD submitted a Report to the Legislature detailing the progress made and successes achieved in the Strategic Plan.

CAMHD STRATEGIC PLAN 2007-2010

In CAMHD's last four-year plan (2007-2010), the following priority areas were identified and addressed.

1. Decrease stigma/increase access
2. Resource management plan
3. Performance management program
4. Practice development program
5. Personnel management plan
6. Financial plan
7. Information technology program

While progress was made in all the priority areas during the early years, during the later years, the state budget crisis, staff layoffs and furloughs severely hampered CAMHD's ability to focus on the strategic iniaitives. The major exception was CAMHD's Information Technology Program which rocketed off within the last two years. Following recommendations at the national level, CAMHD invested its federal block grant dollars into developing an electronic health record system and a telehealth system. The investments included securing equipment and a secure bandwidth capable of serving the state-wide network, while meeting confidentiality security measures. After a series of staff trainings, the EHR and telehealth systems are now operational, with plans to increase utilization.

CAMHD'S successes in implementing the 2007-2010 Four-Year Strategic Plan include:

Priority Area 1.	Decrease Stigma and Increase Access to Care

- A multi-agency, community-based Anti-Stigma Workgroup, including family members, was formed with the goal of reducing stigma around mental illness,

mental health services or people with emotional or behavioral challenges. The workgroup successfully developed an annual awareness campaign which coincided with the national children's mental health efforts.

- A "Children's Mental Health Matters" logo incorporating the green ribbon was developed and subsequently utilized in public campaigns. The green ribbon represents the national children's mental health movement to "own" the green of the former green mental hospital inmate uniforms and transform it into a symbol of growth and hope, like that of a green growing plant.

- The Anti-Stigma Workgroup changed its name to Children's Mental Health Matters Campaign Committee to promote the notion that mental health is important for overall health.

- The motto, "Make a Friend, Be a Friend" was crafted and adopted by the committee as a message to the public that they can promote mental wellness by befriending people and practice being kind and inclusive.

- The annual children's mental health awareness campaign has grown over the past four years, resulting in an annual community carnival on the Big Island, conferences and an annual Mayor's Mental Health Dinner on Maui, health fairs on Kauai and Oahu, youth art and poetry galleries on Maui and Hawaii, sign-waving in every county, and proclamations by the Governor, the Mayors of Honolulu and Maui County and the Honolulu City Council. The committee also distributed information through email blasts, newsletters and a newly developed brochure. The activities and membership of the committee grows every year.

- A brainstorming session was recently held with Parent Partner and staff to review Parent Partner role and to come up with recommendations on how we can enhance Parent Partner utilization in assisting our families and Care Coordinators. We will be working on improving our tracking and follow-up of family requests for Parent Partner services. Care Coordinators will continue to work with families and schools to strongly encourage Parent Partner services.

- To improve access to care for Child Welfare System a Family Guidance Center Branch Chief serves as a panel expert in Child Welfare permanency planning round table reviews to discuss family findings.

- Family Guidance Center staff hosted coffee hour meetings with Family Court Judge and with Deputy Attorney General to discuss issues/concerns/barriers to services for youth in the juvenile justice system.

- To strengthen access to care for the education system, the Family Guidance Centers have initiated multiple initiatives. At one FGC, a DOE referral form for FGC services was recently finalized. The development of the form was a collaborative

effort with the Windward District DOE Complex Program Managers. This will hopefully streamline referrals into our Kaneohe office. Additionally, we have instituted monthly meetings with the Windward District Educational Specialists that now include the MHS I for our Kaneohe Office. For our Pearl City office, we have now instituted quarterly meetings with our staff and the Central District School and Clinical Psychologists.

- To improve access to care, Utilization Management convened a subcommittee to investigate barriers to access.

- To strengthen the youth voice in the individualized service planning process, core components of a successful "youth-guided planning meeting" were defined and are being implemented at the Family Guidance Centers.

- To strengthen the family voice across all aspects of the system, CAMHD has integrated Parent Partner involvement in multiple areas of the CAMHD system, such as including them on management teams and quality assurance committees, inviting them to staff meetings, and providing co-located office space at CAMHD Family Guidance Centers.

- To improve access to care for the general community, care coordinator staff provide information and referral services.

- To improve access to care for the Child Welfare System, Branch Chiefs have provided training to CWS line staff.

- To improve access to care for juvenile justice, presentations have been made to Family Court judges and probation officers.

- To strengthen access to care for the education system, training was provided to DOE staff about peer reviews and the emphasis on decreasing gate keeping.

- To strengthen partnerships with community organizations, CAMHD branch chiefs participate in multiple community-based initiatives and committees.
-
- To strengthen outreach to youth in crisis, several CAMHD staff underwent suicide gatekeeper training to identify the warning signs and appropriately intervene to save the youth's life.

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

- To improve the capture of "real-time" data, CAMHD switched from a 90-day Accepted Records data report to a 30-day Service Authorization data report. This

has increased the ability of the utilization management committee to make real time decisions regarding expansion and/or contraction of services and for Family Guidance Centers statewide to individually monitor the significant trends in their utilization of services per level of care.

- The Utilization Management report has been streamlined to show statistically significant statewide trends and Family Guidance Center trends. The trend information will help focus efforts to improve the CAMHD system of care at both the state and regional levels.

- Resource Management is automating reports to reduce the time-consuming burden of generating high-frequency reports.

Priority Area 3.	Implement a Publicly Accountable Performance Management Program

- In early 2008, a Memorandum of Understanding to establish working agreements regarding a Statewide Interagency Quality Assurance system that monitors the quality and effectiveness of services for children and youth with special needs was executed by the Superintendent of Education, Director of Health, Director of Human Services, Chief Court Administrator and the Executive Director of Hawaii Families as Allies.

- In May of 2009, a structural change to monitoring System Quality Assurance and Improvement was developed through the development of the Quality Steering Committee (QSC) which replaced the Performance Improvement Steering Committee. CAMHD's current infrastructure (through its committee data reports and recommendations to QSC and the Executive Management Team (EMT) facilitates a cohesive and accountable reporting structure. Every section or committee is required to report on identified measures for the time period described below:

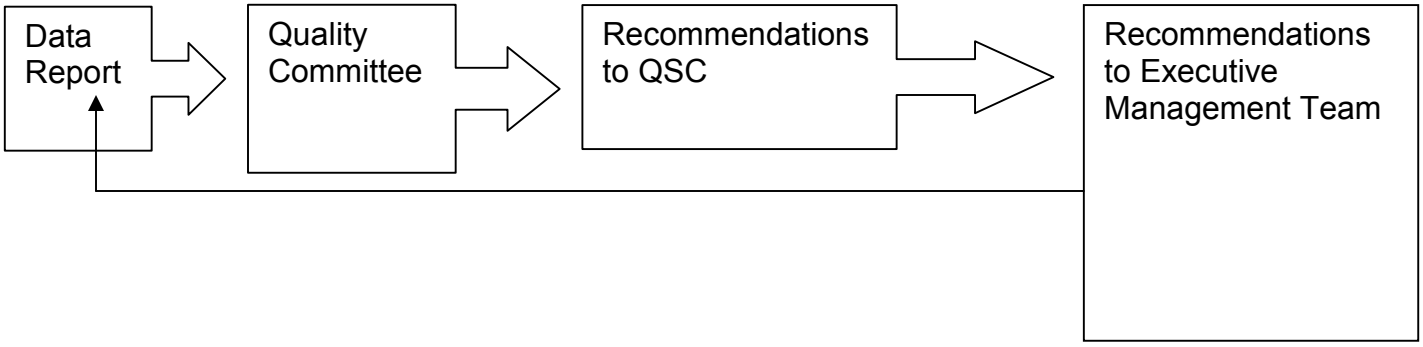
    - Utilization Management – Quarterly Report
    - Credentialing – Annual Report
    - Grievance and Appeals – Annual Report
    - Compliance – Annual Report
    - Safety and Risk Management – Quarterly Report
    - Evidence Based Services – Annual Report
    - Interagency and Performance Monitoring Report – Biannual
    - Consumer Survey – Annual Report
    - Provider Survey – Annual Report
    - Program Monitoring Report – Annual
    - CAMHD Annual Report

- The reports include specific performance measures, data trends, an analysis of findings with strengths and recommendations for improvement, recommendations

and updates on recommendations from previous reports. Recommendations from the report are implemented at the committee or section level unless the recommendations will impact other committees, individuals or sections or there is a recommendation to change a system process. Risk Management issues, Policy changes, or Special Study reports are also forwarded to EMT for approval, implementation, or assignment.

- The activities are tracked at both a section and QSC Level through reporting. The committee structure diagram can be found below.

Reporting Structure Graphic



- CAMHD performed annual evaluations with recommendations for system refinements.

- The Fiscal Year 2009 Annual Evaluation was completed and posted on the CAMHD website for community access and the fiscal year 2010 annual evaluation is in the process of being completed. In January of 2010 all CAMHD Staff, providers and system stakeholders were invited to the 2009 Annual Evaluation presentation provided by the CAMHD Research and Evaluation Office. Subsequently, the QSC met in March of 2010 to develop strategic initiatives from report data. The QSC set the following goals from the report:

    - Improve Intensive In-Home outcomes, decrease length of stay and develop a process to identify when youth are not making improvement;

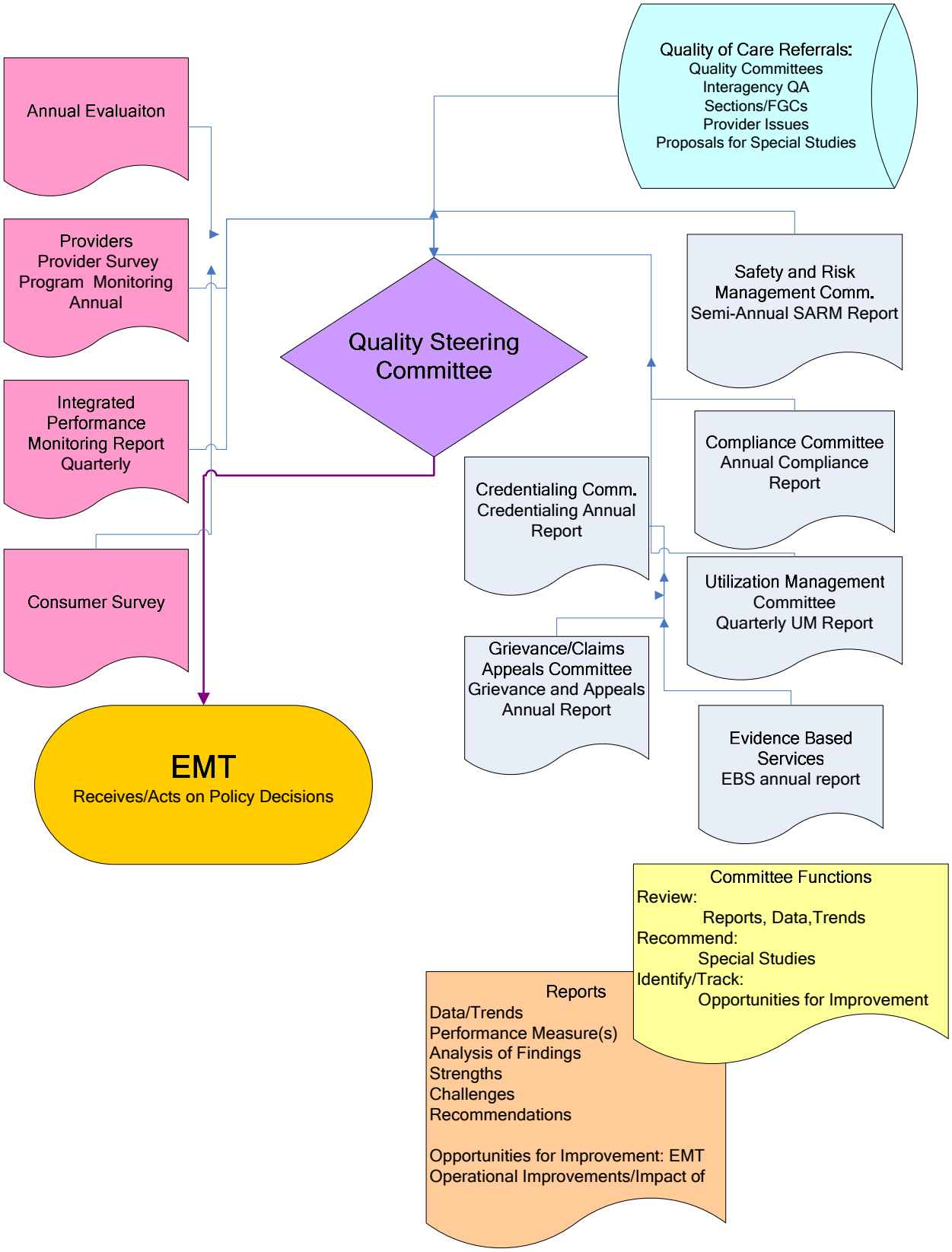
    - Convene a regularly scheduled Data Task Force to identify data being collected in our system, determine the efficiency and efficacy of the data being collected, and identify other outcome data should be collected.

    - Develop a Utilization Management Structure that coincides with Industry standards.

    - Use the System of Care Grant to understand and report to the broader system how trauma, anxiety, and mood effects treatment planning and outcomes across the system.

- Interagency Quality Assurance Group meetings are consistently held. The CAMHD Administrator chairs these meetings on a regular basis. A revised Memorandum of Agreement is in development which describes the new direction and focus of the committee.

- A Quality Steering Committee flow chart was developed to illustrate the types information analyzed, the interactions between CAMHD's committees and the information flow process.


Annual Evaluaiton
Providers
Provider Survey
Program Monitoring
Annual
Integrated
Performance
Monitoring Report
Quarterly
Consumer Survey
Quality of Care Referrals:
Quality Committees
Interagency QA
Sections/FGCs
Provider Issues
Proposals for Special Studies
Quality Steering
Committee
Safety and Risk
Management Comm.
Semi-Annual SARM Report
Compliance Committee
Annual Compliance
Report
Credentialing Comm.
Credentialing Annual
Report
Utilization Management
Committee
Quarterly UM Report
Grievance/Claims
Appeals Committee
Grievance and Appeals
Annual Report
Evidence Based
Services
EBS annual report
EMT
Receives/Acts on Policy Decisions
Committee Functions
Review:
Reports, Data,Trends
Recommend:
Special Studies
Identify/Track:
Opportunities for Improvement
Reports
Data/Trends
Performance Measure(s)
Analysis of Findings
Strengths
Challenges
Recommendations
Opportunities for Improvement: EMT
Operational Improvements/Impact of

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

- The Clinical Services Office strengthened and expanded academic liaisons to impact pre-service educational programs and has arranged practicum training sites for local universities including new training slots for psychology students and advanced nursing students.

- The 2007 Biennial Report on Effective Psychosocial Interventions for Youth with Behavioral and Emotional Needs was published and widely disseminated.

- Over the past year, the Clinical Services Office focused on strengthening services to be responsive to the needs of youth who have experienced trauma. Training on trauma assessment tools was provided, an inter-agency trauma conference was held, and a communication network for providers of mental health services supportive of alternatives to seclusion and restraint for traumatized youth was maintained.

- Secured System of Care Grant to improve access to services for emotionally and behaviorally troubled adolescent girls, aged 11-20, who have a history of trauma and are involved with the juvenile justice system, or are at risk for involvement

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

- A definition of workload structure has been developed for Clinical Psychologists and Clinical Directors (Child and Adolescent Psychiatrists). The licensed clinicians are now providing more direct services, and the turn-around time for eligibility for Support for Emotional and Behavioral Development (SEBD) clients has decreased.

- The Department of Health has facilitated hiring through mechanisms such as recruitment/hiring above the allowed minimum for shortage areas to facilitate recruiting qualified mental health professionals in rural areas.

Priority Area 6.	Implement and Monitor a Strategic Financial Plan

- The Title XIX Medicaid billing practices have been strengthened to provide a better stream of revenues for CAMHD.

- Staff training on the importance of the Random Moments Studies (administrative claims for staff time for MedQuest-eligible youth) has greatly improved staff response, resulting in strengthened billings.

- CAMHD partnered with the Adult Mental Health Division to secure Data Infrastructure Grants. These grants have enabled the collection and analysis of a variety of data.

- Secured a federal grant to improve access to services for emotionally and behaviorally troubled adolescent girls, aged 11-20, who have a history of trauma and are involved with the juvenile justice system, or are at risk for involvement

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

- Two task forces were established, one for electronic health records and one for Telehealth. Champions to move the initiatives forward were recruited for both areas. The task forces were later consolidated into an health information technology project management team. The team is now responsible for developing the roll-out of the various projects and for monitoring results. This team is also the liaison with the Behavioral Health Administration's Center on Regulatory and Operational Excellence (CORE) and will strategize how to implement the CORE"s new initiatives within CAMHD's existing framework.

- After evaluation of several electronic health records systems, CAMHD selected the RPMS version of VistA as a cost-effective choice for the state. VistA was developed by and is fully maintained by the U.S. Veterans Administration.

- CAMHD established a partnership with the University of Hawaii Department of Psychiatry to collaborate on a telehealth system that links the University of Hawaii and the multiple Family Guidance Centers to help provide mental health services across the state, especially remote locations.

- After four years, the equipment and infrastructure for CAMHD's telehealth project has been acquired and installed. It is projected that by the end of 2010, all CAMHD's Family Guidance Centers will be using the telehealth equipment on a regular basis. Policies and procedures for telehealth were developed by the first site, Hawaii Family Guidance Center, and those policies and procedures have been adopted for use across the Family Guidance Centers.

- The next phase for telehealth expansion is the inclusion of CAMHD's residential provider sites. This will allow youth who are in residential placements to have more family contact and participate in more family therapy sessions without requiring to fly youth between islands.

- CAMHD is currently developing IT and electronic health records trainings in collaboration with the University of Hawaii to create tutorials that can be accessed from the internet at any time.

- The submission of monthly treatment provider summaries by providers has been tied to payment. This has resulted in an increase in the quality and quantity of reports on the progress of individual youth in treatment.

- CAMHD made the necessary modifications for RPMS to support provider billing. Family Guidance Center staff training is almost fully completed and progress notes are being entered. The billing process has been streamlined and substantial operational efficiencies have been gained. The Division has also experienced increased capabilities due to the real time management of work flow and staff output.

- The telepsychiatry available at the Family Guidance Centers now have the capacity to deliver direct service clinics to Hawaii's underserved children and their families, as well as to offer consultative services to our community of providers, hospitals, community healthcare centers, schools and the judicial system. Through state of the art Videoconferencing equipment, CAMHD is rapidly expanding the expertise of Board Certified Child/Adolescent Psychiatrists to serve a much broader segment of the population than could be delivered previously.

CAMHD's Service Array and Definitions

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

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

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

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

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

EMERGENCY PUBLIC MENTAL HEALTH SERVICES

H0030 1101 24-Hour Crisis Telephone Stabilization
24-Hour Crisis Telephone Stabilization serves all youth whose immediate health and safety may be in jeopardy due to a mental health issue. After receiving support, consultation and referral that dissipate the crisis situation, the youth's natural environment has the capacity to allow the youth to remain safely in the community. The absence of this capacity would indicate need for mobile outreach services to assess situation and arrange appropriate course of actions. **Service provided State-Wide by Adult Mental Health Division.**

H0007-52 2101 Crisis Mobile Outreach
This service provides mobile face-to-face outreach assessment and stabilization services for youth in an active state of psychiatric crisis. Services are provided twenty-four (24) hours per day, seven(7) days per week and can occur in a variety of settings including the youth's home, local emergency facilities, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, and immediate crisis resolution/stabilization and de-escalation if necessary

H0018 4101 Community-Based Crisis Group Home
This service offers short-term, acute residential interventions to Crisis Group Home youth experiencing mental health crises. This is a structured residential alternative to, or diversion from, Acute Psychiatric

Hospitalization or Community Hospital Crisis Stabilization. Crisis stabilization services are for youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in a less restrictive setting. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health stabilization needs of the youth.

EDUCATIONALLY SUPPORTIVE (ES) INTENSIVE MENTAL HEALTH SERVICES

90801 HK 5201 Psychosexual Assessments

Specialized diagnostic and evaluation services involving a strengths-based approach to identify youths' needs in the specific context of sexually abusive behaviors that have led to the youth being arrested, charged, or adjudicated for a sexual offense. Service components include conducting a comprehensive risk assessment and providing a written assessment report. Psychosexual assessments are preceded by information gathering from existing sources and should not occur unless a Comprehensive Mental Health assessment, Focused Mental Health assessment, Emotional Behavioral assessment, or Psychiatric Diagnostic Assessment has been completed within the last year. The psychosexual assessment is designed to build on the prior mental health assessment, using specialized psychometric instruments designed to assess sexual attitudes and interests

H0036 13101 Intensive In-Home Intervention

This service is designed to stabilize and preserve the family's capacity to improve the child's functioning in the current living environment and to prevent the need for placement outside the home. This service is a time-limited approach that incorporates evidence-based interventions. The service utilizes family and youth-centered interventions and adheres to the CASSP principles. This service may be delivered primarily to youth and their families in the family's home or community.

H0036-22 13201 Multisystemic Therapy (MST) services

The MST approach uses an intensive family- and community based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders, youth at-risk of out-of-home placement due to behavioral problems, and youth at risk of school failure because of behavioral problems. Thus, the primary goals of MST are to (a) reduce youth criminal activity, (b) reduce other types of antisocial behavior such as drug abuse, and (c) achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placements. MST aims to achieve these goals through a treatment that addresses risk factors in an individualized, comprehensive, and integrated fashion; and that empowers families to enhance protective factors.

H0018 28401 Therapeutic Foster Home

This service is an intensive community-based treatment service provided in a home setting for youth with emotional challenges. Specialized therapeutic foster care incorporates evidence-based psychosocial treatment services. These homes provide a normative, community-based environment through therapeutic parental supervision, guidance, and support for youth capable of demonstrating grow1h in such a setting. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youth in transition from a more restrictive placement as these homes offer a family-like orientation. Foster homes with therapeutic services are appropriate for youth in need of relatively long-term treatment placements of six (6) to nine (9) months and/or shorter-term crisis stabilization.

H0018-22 28601 Multi-dimensional Treatment Foster Care

Multidimensional Treatment Foster Care implementers recruit, train, and supervise foster families to offer youth treatment and intensive supervision at home, in school, and in the community. The program provides parent training and other services to the biological families of treated youth, helping to improve family relationships and reduce delinquency when youth return to their homes. Youth who participate in this program also receive behavior management and skill-focused therapy and a community liaison who coordinates contacts among case managers and others involved with the youth.

H0045 28940 Respite Homes / Respite Therapeutic Foster Home

Mental health respite homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This service provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care. (This home may be the same home used for the crisis group home.)

H0037 29401 Therapeutic Group Homes

These homes provide twenty-four (24) hour care and integrated evidence-based treatment to address behavioral, emotional, or systemic issues, which prevent youth from taking part in family or community life. Therapeutic Group Homes are designed for those whose needs can best be met in a structured, small group, community-based setting. The youth usually remain involved in community-based educational, recreational, and occupational activities. These homes typically provide services for four (4) to eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessional staff that have been recruited and trained to work with youth with emotional and behavioral challenges.

H0037-22 29602 Independent Living Programs 18 - 21

The programs provide twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues that prevent young adults from living independently in the community. Independent Living Programs are designed to assist residents in developing the skills necessary to live independently in the community upon discharge. The Independent Living Program is responsible for linking young adults to educational, vocational, employment, health services and community resources. At admission, residents are not necessarily involved in community-based educational, recreational, and/or occupational activities during the day. Independent Living Programs typically provide services for four (4) to eight (8) young adults per home. In this level of care, young adults are supervised and provided services by professionals and paraprofessionals that have been recruited and trained to work with transitioning adults.

H0037-22 29603 Independent Living Programs 16-18

These programs provide twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues that prevent youth from living independently in the community. Independent Living Programs are designed to assist transitioning youth in need of emotional and behavioral supports to develop the skills necessary to live independently in the community upon discharge. The Independent Living Program links youth to educational, vocational, employment, health services and community resources. At admission, the youth are may be involved in community-based educational, recreational, and/or occupational activities. Independent Living Programs typically provide services for four (4) to eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessionals that have been recruited and trained to work with transitioning youth.

H0037-52 29801 Community Mental Health Shelter

This service provides twenty-four (24) hour temporary short-term care for youth who are awaiting placement in an appropriate treatment facility. The youth usually remain involved in community- based educational, recreational, and occupational activities. These shelter homes typically provide services for eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessional staff that have been recruited and trained to work with youth with emotional and behavioral challenges.

H0019 30201 Community-Based Residential Level III

This service provides twenty-four (24) hour care and integrated service planning that addresses the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose needs can best be met in a structured program of small group living that includes onsite educational programs and highly structured therapeutic activities. Community-based Residential programs may be specialized (e.g., substance abuse).

Community-Based Residential programs provide therapy, support, and assistance to the youth and the family to enhance participation in group living and community activities, increase positive personal and interpersonal skills and behaviors and to meet the youth's developmental needs.

H0019-22 30301 Community-Based Residential Level II

This service provides twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression or deviance that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.

Community-Based Residential programs Level II provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.

H0019-22 30403 Community-Based Residential Level I

This service provides twenty-four (24) hour locked care and integrated evidence-based services that address the behavioral and emotional problems related to sexually aggressive or deviant offending, that prevent the youth from taking part in family and/or community life. This program provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth display responsible and accountable behavior for sexually abusive or antisocial behavior with minimizing risk of re-offending and externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems.

H0017 31101 Hospital-Based Residential

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

SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT (SEBD) PROGRAM SERVICES

90801-HA 5101 Comprehensive Mental Health Assessment

This assessment is performed (a) as part of the data collected to determine eligibility for youth/young adults referred for CAMHD services through the SESD program, and/or (b) to provide needed comprehensive clinical information on youth/young adults in the SESD program, to assist with coordination of services and with treatment planning. This strengths-based approach seeks to identify the needs of the youth or young adult in the context of their family and community. This service includes interviews, assessment activities, written report, and feedback to the young adult or youth and the parent(s) or guardian(s).

90801-22 5102 Focused Mental Health Assessments

This assessment is performed any time the treatment team determines that an in-depth evaluation of the youth/young adult is necessary for satisfactory clinical care. This assessment is done to clarify diagnostic and treatment issues when new clinical symptoms have emerged or when there is a lack of expected progress. The assessment builds upon previous evaluations, incorporates additional relevant data (e.g., from interviews and the review of new information) and answers one or more specific referral questions. This service includes assessment activities, written report, and feedback to the young adult or the youth and his/her parent(s) or guardian(s).

90801-52 5103 Summary Annual Assessments

This assessment is performed in order to describe the current status of the young adult or youth and his or her circumstances. It is performed yearly, when the CSP team determines that there are no clinical concerns that would call for a focused or comprehensive assessment to be performed instead. The service includes a brief assessment and report, with feedback to the young adult or youth and his/her parent(s) or guardian(s). The CAMHD contracted providers that are currently providing services and that have known the young adult or youth for at least three (3) months shall provide the Summary Annual Assessment when it is due or as defined in the specific service standard.

90804 7101 Individual Therapy

Individual Therapy is regularly scheduled face-to-face therapeutic services with a youth or young adult focused on improving his/her individual functioning. Individual therapy includes interventions such as cognitive-behavioral strategies, behavioral plans, skills training, systemic interventions, crisis planning and facilitating access to other community services and supports. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited, with interventions reduced and discontinued as the young adult or youth and family are able to function more effectively. The usual course of treatment is six (6) to twenty-four (24) sessions or six (6) months. This service most often will be provided in conjunction with at least occasional family therapy sessions.

90849 7102 Group Therapy

This service is regularly scheduled face-to-face therapeutic services for groups of three or more young adults or youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges and to provide support for the use of these skills. Group Therapy services are focused and time limited. This service can include groups that address young adult or youths' needs utilizing a "multi-family group" format, in which the parents or guardian attend the group along with the young adult or youth.

90846 7103 Family Therapy

Family Therapy is regularly scheduled face-to-face interventions with a young adult or youth and his/her family, designed to improve young adult or youth/family functioning and treat the young adult or youth's emotional challenge. The family therapist helps the young adult or youth and family increase their use of effective coping strategies, healthy communication, and constructive problem-solving skills. The therapist also provides psycho-education about the nature of the young adult or youth's diagnosis. Frequently, Family Therapy sessions are held in the course of on-going Individual Therapy in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued, as young adult or youth/family are able to function more effectively.

H0036 7104 Functional Family Therapy

This is an evidence-based family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression).

The goals of Functional Family Therapy are the following.

1. Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems
2. Phase II: Behavior change - target and change specific risk behaviors of individuals and families
3. Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships

Functional Family Therapy services range from eight to twelve (8 to 12) one-hour sessions for mild challenges, **up** to thirty (30) hours of direct service (i.e., clinical sessions, telephone calls, and meetings involving community resources) for more difficult situations, and are usually spread over a three to six (3 to 6) month period. Functional Family Therapy can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits.

90801 9101 Psychiatric Evaluation

Psychiatric diagnostic examination, specifically completed by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service is limited to an initial or follow-up evaluation for medically complex or diagnostically complex young adult or youth. This evaluation does not involve psychiatric treatment or medication management.

90862 10101 Medication Management

This service is the ongoing assessment of the young adult or youth's response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine

medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practical Registered Nurse with prescription privileges.

H0035 27101 Partial Hospitalization

This service is composed of day programming in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for coverage of partial hospitalization that allows for a more intensive milieu treatment with a focus on medical/psychiatric resources. This service is available to stabilize a youth whose psychiatric condition needs a high level of monitoring to stabilize symptoms or as a transition step for youth who have been in more restrictive settings. The primary goal of the partial hospitalization programs is to keep youth connected with his/her family/community while providing short-term intensive treatment.

Other Services Under Educationally Supportive Intensive Mental Health Category

Ancillary Services

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

Respite Supports

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

Child and Adolescent Mental Health Division
Geographic Providers and Care Levels

ISLAND	PROVIDER	CARE LEVEL
OAHU	Alakai Na Keiki, Inc	Intensive In-Home Intervention, Comprehensive Mental Health Assessment, Focused Mental Health Assessment, Summary Annual Assessment ,Individual Therapy, Group Therapy, Family Therapy
	CARE	Crisis Mobile Outreach
	Catholic Charities	Therapeutic Foster Home
	Child and Family Service	Therapeutic Foster Home
	Hale Kipa	Intensive In-Home Intervention, Therapeutic Foster Home
	Hawaii Behavioral Health	Intensive In-Home Intervention, Comprehensive Mental Health Assessment, Focused Mental Health Assessment, Summary Annual Assessment ,Individual Therapy, Group Therapy, Family Therapy, Therapeutic Foster Home
	Parents and Children Together	Functional Family Therapy, MultiSystemic Therapy
	The Institute for Family Enrichment	Intensive In-Home Intervention, Comprehensive Mental Health Assessment, Focused Mental Health Assessment, Summary Annual Assessment ,Individual Therapy, Group Therapy, Family Therapy
	Kahi Mohala	Partial Hospitalization
	Waianae Coast CMHC	Therapeutic Foster Home
MAUI	Aloha House	Intensive In-Home Intervention
	Child and Family Service	Therapeutic Foster Home
	Maui Youth and Family Services	Intensive In-Home Intervention, Therapeutic Foster Home
	Parents and Children Together	Functional Family Therapy, MultiSystemic Therapy

KAUAI	Hale Kipa	Intensive In-Home Intervention, Therapeutic Foster Home
	Hale Opio Kauai	Therapeutic Foster Home
	Hawaii Behavioral Health	Intensive In-Home Intervention, Therapeutic Foster Home
	Parents and Children Together	Functional Family Therapy, MultiSystemic Therapy
HAWAII	Catholic Charities	Therapeutic Foster Home
	Child and Family Service	Therapeutic Foster Home
	Hale Kipa	Intensive In-Home Intervention, Therapeutic Foster Home
	Hawaii Behavioral Health	Intensive In-Home Intervention, Comprehensive Mental Health Assessment, Focused Mental Health Assessment, Summary Annual Assessment ,Individual Therapy, Group Therapy, Family Therapy, Therapeutic Foster Home Multi-dimensional Foster Care
	Marimed Foundation	Therapeutic Foster Home
	The Institute for Family Enrichment	Intensive In-Home Intervention, Comprehensive Mental Health Assessment, Focused Mental Health Assessment, Summary Annual Assessment ,Individual Therapy, Group Therapy, Family Therapy, MultiSystemic Therapy
STATEWIDE	Bobby Benson Center	Community Based Residential III
	Benchmark	Community Based Residential I, Psychosexual Assessment
	Child and Family Service	Community Based Residential III
	Hale Kipa	Independent Living Skill 16-18
	Acadia-KBH	DELETED
	Marimed Foundation	Community Based Residential III
	Kahi Mohala	Hospital Based Residential,
	The Queen's Medical Center	Hospital Based Residential
	Waianae Coast CMHC	Independent Living Skill 16-18

Attachment CAMHD2

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

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

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

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

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

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

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

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

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

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

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

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

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Attachment CAMHD3

Link Between SAMHSA's Strategic Initiative Goals and CAMHD's Strategic Plan Goals

SAMHSA Strategic Goals	CAMHD's Strategic Plan Goals and Objectives *(Some objectives are being addressed through non-Block Grant strategies)*
Prevention of Substance Abuse and Mental Illness-Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This initiative will focus especially on the Nation's high risk youth, youth in Tribal communities, and among military families.	**Goal 4: Strengthen Effective Collaborations to Increase Early Access to Care** *Obj. 4.1:* Collaborate with the Department of Education to facilitate early identification of CAMHD-eligible youth *Obj. 4.2:* Improve working relationships with the Department of Human Services and Juvenile Justice, including youth with trauma *Obj. 4.3*: Establish working relationships with primary care *Obj. 4.4*: Improve interdepartmental and intradepartmental coordination around multisystem youth *Obj. 4.5:* Improve working relationships around statewide quality assurance
Trauma and Justice-Reducing the pervasive, harmful, and costly impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.	**Goal 2: Strengthen clinical services** *Obj. 2.2*: Strengthen the quality and involvement of CAMHD's clinical services *Obj. 2.3:* Strengthen trauma-informed clinical practice **Goal 4: Strengthen Effective Collaborations to Increase Early Access to Care** *Obj. 4.2*: Improve working relationships with the Department of Human Services and Juvenile Justice, including youth with trauma
Military Families-Supporting America's service men and women – Active Duty, National Guard, Reserve, and Veterans – together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.	N/A
Recovery Support-Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.	N/A
Health Reform-Broadening health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions.	**Goal 3: Implement a Strategic Financial Plan** *Obj. 3.1*: Maximize existing resources *Obj. 3.2*: Maximize revenue stream
Health Information Technology-Ensuring the behavioral health system, including States, community providers, peer and prevention specialists, fully participates with the general healthcare delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).	**Goal 1: Integrate Health Information Technology** *Obj. 1.4*: Increase access to care in remote and shortage areas

Data, Outcomes, and Quality-Realizing an integrated data strategy that informs policy and measures program impact leading to improved quality of services and outcomes for individuals, families, and communities.	**Goal 1: Integrate Health Information Technology** *Obj. 1.1*: Use electronic health information to increase real-time decision making *Obj. 1.2:* Use electronic health information to increase quality of care *Obj. 1.3*: Increase the accuracy of standard outcome and practice measures **Goal 2: Strengthen clinical services** *Obj. 2.1*: Increase utilization of evidence-based programs and implementation of practice elements *Obj. 2.4*: Strengthen utilization management of CAMHD services
Public Awareness and Support-Increasing understanding of mental and substance use disorders to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.	**Goal 2: Strengthen clinical services** *Obj. 2.5*: Identify and implement strategies to strengthen involvement of youth and family members in treatment planning and system reform

	Priority-Setting meeting		8/11/2011	
	First Name	**Last Name**	**Attending Mtg?**	**Dept.**
1	Charlene	Daraban	yes	HFAA (Hawaii Families As Allies)
2	David	Drews	yes	Catholic Charities
3	Debra	Farmer	no	DOE
4	DeeDee	Letts	yes	Family Court -Judiciary
5	Kelly	Stern	yes	DOE
6	Punky	Pletan-Cross	no	Hale Kipa
7	Rachael	Guay	yes	MHT-SIG
8	Steven	Vannatta	no	CCCO
9	Maile	Watters	no	Consumer, Youth Rep

Attachment CAMHD4

Priority-Setting meeting			8/11/2011	
	First Name	Last Name	Attended Mtg?	Affiliation
1	Charlene	Daraban	yes	HFAA (Hawaii Families As Allies)
2	David	Drews	yes	Catholic Charities
3	Debra	Farmer	no	DOE
4	DeeDee	Letts	yes	Family Court -Judiciary
5	Kelly	Stern	yes	DOE
6	Punky	Pletan-Cross	no	Hale Kipa
7	Rachael	Guay	yes	MHT-SIG
8	Steven	Vannatta	no	CCCO
9	Maile	Watters	no	Consumer, Youth Rep

You have determined the order in which the SAMSAH Goals serve the needs of Hawaii's children with emotional and behavioral challenges, and their families. Now put a number in the box next to the CAMHD Initiative to show how you rank it in order of importance to the corresponding SAMHSA Goal.

Attachment CAMHD5

MASTER RANKING SHEET

You have determined the order in which the SAMSAH Goals serve the needs of Hawaii's children with emotional and behavioral challenges, and their families. Now put a number in the box next to the CAMHD Initiative to show how you rank it in order of importance to the corresponding SAMHSA Goal.

Participants' Ranking:

SAMHSA Strategic Goals								
Prevention Substance Abuse and Mental Illness								
• Support Youth homeless outreach programs								
• Support Suicide prevention programs								
• Implement Primary Care Collaboration **								
Trauma and Justice Conduct MH assessments, screening, consultation and services for JJ youth								
Military Families Support Dept. of Defense collaborations **								
Recovery Support Fund Transition Age Youth (TAY) services								

MASTER RANKING SHEET

You have determined the order in which the SAMSAH Goals serve the needs of Hawaii's children with emotional and behavioral challenges, and their families. Now put a number in the box next to the CAMHD Initiative to show how you rank it in order of importance to the corresponding SAMHSA Goal.

Health Reform Increase Medicaid reimbursement **								

Health Information Technology								
• Upgrade data repository/system **								
• Hire Telehealth Coordinator **								

Data, Outcomes, and Quality								
• Support Evidence Based Services Committee and initiatives								
• Support Clinical staff training								
• Fund Annual Consumer Survey								
• Hire Programmer/Developer for new HER system **								
• Develop centralized and real-time data outcome reporting system **								

MASTER RANKING SHEET

You have determined the order in which the SAMSAH Goals serve the needs of Hawaii's children with emotional and behavioral challenges, and their families. Now put a number in the box next to the CAMHD Initiative to show how you rank it in order of importance to the corresponding SAMHSA Goal.

Public Awareness and Support								
• Support Family Partner organization								
• Promote Children's mental health public awareness activities								
• Assist Family Partner organization in meeting new requirements **								
• Maintain and update information website **								

**** Designates "New Initiative"**

Attachment CAMHD6

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The Child and Adolescent Mental Health Division Quality Assurance and Improvement Program

Fiscal Year 2012
(July 1, 2011 to June 30, 2012)

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Purpose of the CAMHD Quality Assurance and Improvement Program

The mission of the Child and Adolescent Mental Health Division (CAMHD) is to provide timely and effective mental health services to children and youth with emotional and behavioral challenges, and their families. These services are provided within a system of care that integrates Hawaii's Child and Adolescent Service System Program (CASSP) principles, evidence based services, and continuous monitoring.

In implementing a mission that allows children and families to lead full and productive lives, CAMHD delivers effective and efficient services that are located in communities throughout the State of Hawaii. Services are provided in accordance with evidence-based practices, and address the individual needs of each child, youth and family served. Each child or youth's services are coordinated across all agencies and individuals involved. Engagement of the child, youth and family as active participants in the service delivery process is central to CAMHD's mission.

CAMHD's mission is supported through its commitment to continuous performance monitoring, evaluation and improvement at all levels of its service system This provides a base for accomplishing its mission through open acceptance of accountability for results and achieving efficiencies at all levels of the organization.

The CAMHD Quality Assurance and Improvement Program (QAIP) is a statewide system and addresses all services and service delivery sites. Local-level implementation of the QAIP may consider local context while continuing to reflect a consistent statewide program for quality assurance and improvement. The CAMHD QAIP encompasses its Utilization Management Program. CAMHD's Utilization Management Program reviews utilization at all levels of care and for all aspects of utilization including availability, accessibility, coordination and continuity of care. The purpose of utilization review is to assure that children and youth receive the most appropriate level of service in the least restrictive environment possible. Utilization review data is used for continuous quality improvement.

The overall purpose of the CAMHD Quality Assurance and Improvement Program is to assure eligible youth and families receive the best possible and most appropriate care through highly qualified staff and providers. The program is conducted to ensure positive functional outcomes for youth. The QAIP includes comprehensive monitoring of all types of services provided by CAMHD, clinical quality investigations, maintenance of clinical records, assurance that youth are served in the least restrictive environment possible, and wherever possible in their own home and community. The QAIP program assures that care for youth is continuous and coordinated with all members of the child and family team. Accountability and participation in continuous quality improvement occurs at all levels of the CAMHD service system and includes active involvement of families and service providers.

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Goals and Objectives of the Quality Assurance and Improvement Program (QAIP)

The overall system goals of CAMHD are exemplified in its current Strategic Plan, which was submitted in 2010 to the Hawaii State Legislature as statutorily required. It is a document that guides the direction of CAMHD for the four-year period 2010-2014.

Quality improvement in CAMHD occurs systematically and continuously at all levels of clinical service delivery, service infrastructure, and administrative services related to quality of care. The Quality Assurance and Improvement Program is comprehensive and addresses all services provided by CAMHD in all service settings. These services include emergency mental health services, mental health and psychosexual assessments, intensive home and community based interventions, multisystemic therapy, therapeutic residential services, and hospital-based programs.

The QAIP supports the CAMHD service system statewide, including its provider network, in assuring coordinated, timely and appropriate care for all registered youth. Quality improvement focuses on the demographic and epidemiological features of the CAMHD population, which includes youth who are enrolled in QUEST and youth who are not.

The goals of the CAMHD Quality Assurance and Improvement Program, and its Work Plan Activities, support CAMHD in achieving its goals related to quality assurance and improvement. The goals of the CAMHD QAIP are designed to maintain a system of continuous quality improvement so that care and services for children and families contribute to positive life outcomes. The goals are achieved through planned, accountable and systematic performance improvement activities.

The status and results of the QAIP are communicated to staff at all levels through committee reports, presentations at the Quality Steering Committee, and Executive Management team. The quarterly Integrated Performance Monitoring Report is posted on the CAMHD website bi-annually

Objectives of the QAIP are achieved through the implementation of the annual QAIP Work Plan. The Work Plan identifies specific QI activities for each objective, including the individual position and committee that is accountable and timelines for data collection and completion of activities. The QAIP Work Plan for July 2011 to June 2012 (FY2012) is attached to this document.

The goals and objectives of the QAIP are:

1. Ensure that services are provided by Qualified Practitioners.
    a. Ensure that all Qualified Mental Health, Mental Health, and Para professional providers of CAMHD services are actively credentialed.
    b. Ensure CAMHD re-credentialing of providers.

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c. Ensure CAMHD contracted providers meet Credentialing Standards, practices, and processes through annual monitoring visits.

2. Ensure that CAMHD youth receive services in a timely and effective manner through an effective Utilization Management Program.
    a. Ensure eligible youth are provided access to services.
    b. Ensure that services are made available to eligible youth.
    c. Monitor the overutilization of overly restrictive levels of care (i.e., Hospital-based Residential, Mainland placement).
    d. Identify and address areas of underutilization and overutilization of services.
    e. Monitor actual length of stay in services versus CAMHD standards
    f. Monitor access to urgent and emergent care.
    g. Monitor the utilization and outcomes of Evidence-based service contracts.
    h. Gather and analyze utilization data, communicate findings and make appropriate recommendations through accepted records data.

3. Ensure that CAMHD youth are provided quality services that promote positive outcomes and demonstrate treatment progress.
    a. Monitor Sentinel Events to ensure that youth are safe.
    b. Track longitudinal CAFAS, MTPS, and Ohio Functioning Scales for CAMHD youth.
    c. Conduct annual monitoring of all contracted provider agencies for quality of service provision.
    d. Review and revise on an annual basis performance standards and practice guidelines and internal CAMHD polices and procedures.
    e. Support quality care coordination through the monitoring of caseload ratio and Coordinated Service Plan (CSP) timeliness and quality.

4. Monitor consumer and provider satisfaction.
    a. Monitor consumer satisfaction through grievances and appeals.
    b. Monitor consumer satisfaction survey results.
    c. Monitor provider satisfaction survey results.

5. Ensure that CAMHD has processes in place to reduce the risk of fraud and abuse.
    a. Minimize fraud and abuse through a comprehensive Compliance Plan and Fraud and Abuse Program.

6. Monitor the implementation of CAMHD Strategic Plan Activities (2010-2014).
    a. Monitor the implementation of activities outlined in the CAMHD Strategic Plan (2010-2014).

7. Be informed of the activities of the Evidence-based Services Committee.
    a. Be informed on an annual basis on the activities of the Evidence-Based Services Committee.

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Methods used to Systematically Monitor Care and Services

Quality Monitoring Methods

Priorities for quality monitoring are identified through the review of available epidemiological, demographic, and performance reporting information. Monitoring occurs for each of the objectives established for the QAIP, and across demographic groups and service settings**.**

Quality is systematically reviewed through monitoring of performance activities established in the QAIP Work Plan. Methodologies for monitoring are established in the form of written guidelines. Frequency of monitoring is established at a level that can detect the need for any programmatic changes. Quality of clinical care and utilization management is monitored against the Integrated Performance Standards and Practice Guidelines.

CAMHD acknowledges the interdependence of components of systems, and the role they collectively play in impacting performance and outcomes. Performance data are reviewed from a multi-disciplinary, cross-team perspective in order to understand issues and identify opportunities for improvement.

CAMHD follows a basic continuous quality improvement cycle that includes the following components:

1. A plan to improve services
2. Data collection
3. Data analysis
4. Actions and interventions
5. Data collection to determine if the actions had the desired results
6. If the desired result was not achieved, return to the plan stage.

How Issues are Identified

Opportunities for quality improvement are identified through ongoing review of clinical, quality and utilization management data. Data are systematically reviewed through the monitoring of performance data, and reports from specific committees to the Quality Steering Committee. The QSC and its subcommittees, as well as any organizational unit of CAMHD can identify and recommend areas that provide opportunities for improvement.

Criteria for selecting areas for quality improvement include, but are not limited to:

1. Areas that represent a high-risk or high-volume issue for the CAMHD population.
2. Areas that have a high probability of improving care and mental health outcomes for the population served by CAMHD.

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3. Areas that there are objective criteria for assessment of improvement.
4. Adequate resources are available to implement the quality improvement and the benefits of the improvement exceed its costs.
5. Areas that support CAMHD achieving its organizational mission.

Documentation of Performance Improvement Activities

Performance improvement activities are systematically implemented, and continuously monitored and tracked. Activities are documented through the following methods:

1. Reporting to the QSC according to the the QSC calendar of reporting requirements specific to each committee and the schedule designated in the annual QAIP Work Plan.
2. Documentation is in the format identified in the QSC Report Cover Page (see attached). Reports include the following: Performance Measures, Data Trends, Analysis of Findings, Recommendations (internal to the specific committee and referrals to the QSC and EMT).
3. Tracking occurs for issues that are identified as opportunities for improvement, or remedial actions in need of correction. The QAIP maintains policies and procedures for taking remedial action including tracking and documentation of actions.

Stakeholder Involvement in Performance Improvement

Involvement of stakeholders in the performance improvement process is integral to assuring joint ownership and participation in quality improvement. Communication and training are conducted for staff, providers and families as described below:

1. Staff

Upon hire, all CAMHD employees are oriented to the QAIP and the QAIP Work Plan, including the function of performance improvement and utilization management in CAMHD. Updates are disseminated through standing committees at least annually. Staff members also receive feedback about performance improvement activities periodically.

2. Provider Agencies

Provider agencies and contractors are informed about contractual obligations related to the CAMHD QAIP, CAMHD performance standards and practice guidelines, and their own quality assurance and utilization management activities through their contracts. All updates to standards and guidelines are communicated to provider agencies and contractors. All provider agencies receive a Provider Manual and all updates as they occur. Further feedback and updates about the CAMHD program, including performance improvement is distributed through a provider newsletter. Meetings with representatives from the provider agencies occur at least quarterly.

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Involvement in performance improvement further occurs through participation by representatives of provider agencies on the QSC and various standing committees including the Policies and Procedures Committee, the Safety and Risk Management Committee, and the Training Committee.

3. Families

Families are involved in performance improvement and receive education about the CAMHD program in a number of ways including through the Consumer Handbook, distribution of information through family organizations, and the CAMHD website. Family members receive education through the treatment process. There is family member representation on the QSC and select standing committees: including Grievance and Appeals, Evidence-Based Services, Utilization Management, and various quality-related task forces and focus groups as they occur. The Performance Manager assures orientation is provided for all family member representatives on the CAMHD quality improvement processes including on confidentiality.

4. Providers of Delegated Activities

For providers that are delegated quality management activities, ongoing training and communications are continuously available and systematically provided. Any updates or changes to quality expectations that impact the delegated activity are disseminated in a timely manner. All providers of delegated activities are monitored according to CAMHD policies and procedures for delegation on an annual basis. Findings of the monitoring audits are provided to the delegated provider.

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Quality Assurance and Improvement Work Plan

How Priorities are Set

CAMHD establishes a range of areas for working on performance improvement, and establishes priorities as not all areas can be implemented simultaneously. The QAIP Work Plan, based on a fiscal year unless otherwise designated by EMT, guides the performance improvement implementation process. Priorities can be changed through acceptance of THE QSC and approval of EMT based on the identification of opportunities for quality improvement during the year.

Revision of the Work Plan occurs through identification and review of issues by THE QSC or its standing committees, evaluation of revisions by EMT, and approval of EMT. Any revisions to the Work Plan require oversight by THE QSC who assigns accountability for development and monitoring of improvements.

Standards and Criteria

The standards and criteria that guide the QAIP are based wherever possible on monitoring of trends based on CAMHD goal setting, and use the knowledge and experience of experts in the field of children's mental health and the evidence-based literature. The QAIP is further guided by the CAMHD Practice Guidelines and any updates to the Practice Guidelines based on the research of the Evidence-based Services Committee. Standards applied by other similar health plans, children's mental health systems, and industry standards may be used to guide the QAIP, with attention paid to criteria that are objective, measurable and current. Regular review of available sources within CAMHD and its provider network, are used for periodic adjustment to priorities and standards and criteria.

Collection and Analysis of Data

Data required for each activity of the QAIP Work Plan are pre-determined and reflect indicators that allow for evaluation of the effects and findings of interventions. The frequency of data collection varies and is reflective of the nature of the activity. The sources of data include, but are not limited to encounter data, surveys, grievance data, state databases, qualitative data, clinical quality-related referrals, and utilization data.

Delegation Program

CAMHD maintains a delegation program to provide oversight for any areas of quality management that are delegated to another entity. CAMHD may delegate a quality function, but follows its policies and procedures for delegation, and retains ultimate responsibility and accountability of the function, including the right to terminate any delegation agreement. The responsibilities and requirements of CAMHD and the delegated entity are documented in each delegation agreement.

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Components of the QAIP Work Plan

The QAIP Work Plan includes the following components:

1. A statement of the purpose
2. Scope
3. Population Demographics
4. Systematic Monitoring
5. Goals and Strategies
6. Activities

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Overall Program Administration and Oversight of the QAIP

Governing Body: Authority, Responsibility, and Implementation

The governing body of CAMHD is its Executive Management Team (EMT). The EMT assigns responsibility of its Quality Assurance and Improvement Program to the CAMHD Quality Steering Committee (THE QSC). The voting members of the EMT are the Administrator, the Medical Director, the Performance Manager, the Public Health Administrative Officer, all Branch Chiefs, the Provider Relations Specialist, the Chief Executive Officer of a family organization, a representative from the CAMHD Research and Evaluation Office, and a Psychologist appointed from the Clinical Services Office.

The QSC reports directly to the EMT. The QSC submits the QAIP description, and QAIP Work Plan to the full EMT on an annual basis to the EMT for formal approval. The QSC monitors the overall effectiveness of the QAIP through the Annual The QSC Final Report Evaluation, which is also reviewed and approved by EMT. Periodic updates to the EMT are received through committee reports and updates from the Performance Manager.

The EMT meets at least once monthly. When written reports or issues are received from The QSC, upon review of the reports or issues EMT may:

- Accept the report and findings with confirmation of acceptance;
- Ask for clarification of findings or reassessment of results;
- Direct that the QAIP or QAIP Work Plan be assessed for modification to accommodate the findings or issues of concern; or
- Direct and follow up on the necessary actions pertaining to quality of the CAMHD program.

The CAMHD Administrator is the senior executive responsible for directing, maintaining and supporting an effective system for mental health service delivery for eligible youth and their families. The Administrator is the chair of EMT and a member of the QSC. The Administrator assigns the responsibility of the CAMHD quality improvement program to the Performance Manager and the responsibility of the utilization management program to the Medical Director.

The Administrator further assigns the responsibility of overall oversight of the clinical and medical components of the program to the Medical Director. The Medical Director is, chairperson of the Safety and Risk Management Committee, co-chairperson of the Evidence-based Services Committee, chair of the Utilization Management Committee, a standing member of the Compliance Committee, and is an *ex-officio* member of the Credentialing Committee and Professional Activities Review Committee (PARC).

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Organizational and Committee Structure

The CAMHD Executive Management Team has final responsibility for approval and oversight of the management and direction of the Quality Assurance and Improvement Program. The EMT designates the Performance Manager to develop and manage the QAIP and to provide reports on quality management activities, findings and actions to the EMT when actions require policy and procedure change, the actions impact the structure of the system, or as needed. The Quality Steering Committee designates the chair of each committee, shown below, to provide reports on quality management activities related to the respective committee's responsibility. The organizational committee structure is shown below.

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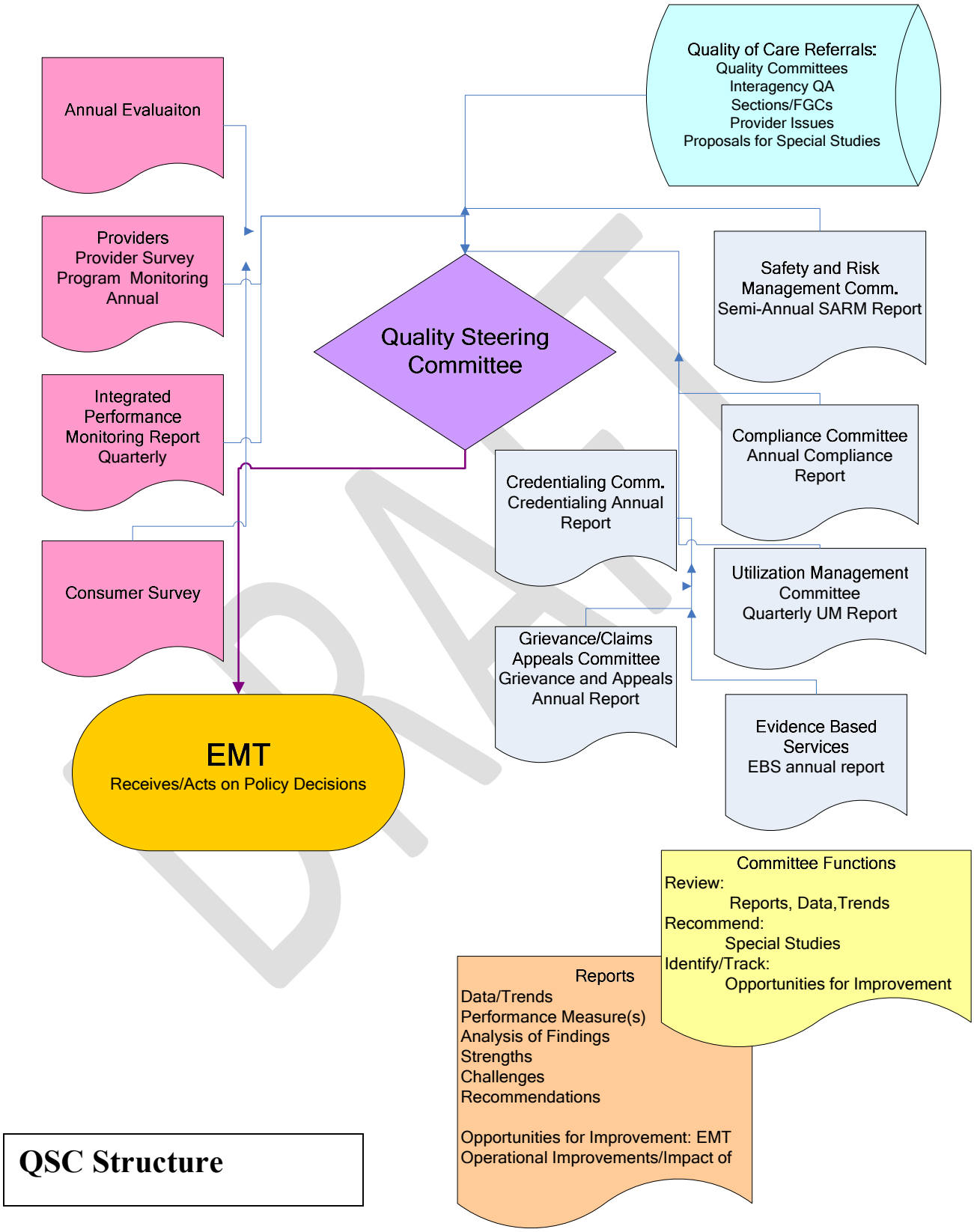

QSC Structure

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CAMHD Committee Descriptions and Functions

I. Quality Steering Committee (QSC)

Description: The Quality Steering Committee (QSC) oversees the activities of the CAMHD Quality Assurance and Improvement Program (QAIP). The Performance Manager chairs the QSC. The QSC is composed of chairpersons of CAMHD standing committees (as identified above and described below), the Administrator, Medical Director, a representative of the Branch Chiefs, representative from the Research and Evaluation Office, representatives from agencies in the CAMHD provider network, a representative from an organization representing family members, and Chief Psychologist. Standing committees review client care and service delivery for opportunities for improvement that support CAMHD's systems and processes. All standing committees are comprised of members representing various functional disciplines throughout CAMHD. All applicable committees' membership includes provider and family representatives.

Functions: The functions of the Quality Steering Committee include:

1. Identify opportunities for improvement within the CAMHD system from a variety of data collecting sources.
2. Track and/or take actions to address opportunities for improvement in the CAMHD system.
3. Track and evaluate how well the implemented actions worked both at the committee and the QSC level.
4. Develop a QAIP that identifies the reporting requirements for each committee, special or other reports to the QSC, and task groups.
5. Assure the QAIP is comprehensive, systematically implemented, and reviews aspects of care that include availability, accessibility, coordination, appropriateness, quality and outcomes of care.
6. Maintain a process and methodologies for empirically detecting opportunities for improvement and adherence to standards of service delivery and care.
7. Review and discuss areas that have resulted in poor performance or service to consumers with focus on causes of issues.
8. Recommend appropriate improvement strategies and corrective actions.
9. Track issues and quality activities to assure resolution and implementation.
10. Maintain policies and procedures for the QSC including for all standing committees and the QSC functions.
11. Promote systematic distribution of quality information to relevant stakeholders including providers, staff, and EMT.

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12. Assure the contents of written reports to EMT provide appropriate information that allows for oversight, actions or recommendations.
13. Review and recommend approval of the annual QAIP description, Utilization Management Program description, QAIP Work Plan, and QAIP Evaluation.
14. Assure that confidentially is kept and HIPAA requirements are maintained in reporting and meetings.

Reports and Report Summaries: Reports submitted to the QSC are documented in sufficient detail to allow for thorough discussion and formulation of recommendations regarding quality issues. A report summary, in a format approved by the QSC, is attached as a cover to each report. The report summary identifies the type of report, author(s) of the report, and time period covered by the report. The cover sheet also includes recommendations to be approved by the QSC and recommendations to be referred to EMT. The QSC further documents its recommendations before submittal to EMT. The reports attached to the cover sheet include performance measures (if applicable), data trends, an analysis of findings that includes identified strengths and opportunities for improvement, recommendations for the committee report (planned actions/activities, implemented actions/activities, and an update on previously implemented actions/activities), and recommendations to the QSC and subsequently referrals to EMT. The cover sheet is provided as an attachment to the QAIP description.

Referrals to EMT or to other CAMHD Committees: Referrals of issues from Standing Committees to other committees or to theC should be documented in writing. Referrals from the QSC to EMT should be documented in writing, and include sufficient information and recommendations for action. Referral document provided as an attachment to the QAIP description. The CAMHD quality review committees that report to the the QSC consist of the Compliance, Credentialing, Evidence-Based Services, Grievance and Appeals, Policy and Procedure, Safety and Risk Management, and Utilization Management Committees. A description of each committee with respective purpose and reporting requirements to the QSC are described below.

II. Compliance Committee – Annual Report

Description: The purpose of the Compliance Committee is to provide a means for reviewing potential issues, and make recommendations for the CAMHD Compliance Plan. It promotes the prevention, detection and resolution of instances of conduct that do not conform to Federal and State law and Federal health care requirements in respect to fraud and abuse, as well as CAMHD's ethical and business policies. The Public Health Administrative Officer who is the Compliance Officer chairs the committee. It meets no less than quarterly.

Functions: The functions of the Compliance Committee include:

1. Review all CAMHD and provider issues of fraud and abuse.

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2. Analyze the CAMHD's regulatory environment, the legal requirements with which it must comply and identify specific risk areas.

3. Work with appropriate CAMHD sections, as well as affiliated providers, to develop standards of conduct and policies and procedures that promote allegiance to CAMHD's Compliance Plan.

4. Recommend and monitor the development of internal systems and controls to carry out CAMHD's Compliance Plan

5. Determine the appropriate strategy to promote compliance with the program and detect any potential violations.

6. Develop a system to solicit, evaluate, and respond to complaints and problems.

7. Monitor internal and externals audits and investigations to identify troublesome issues and deficient areas experienced within CAMHD and implement corrective and preventive actions.

8. Revise and update the Compliance Plan and Fraud and Abuse Program to meet updated federal requirements.

9. Review and recommend approval for the Annual Compliance Report to the QSC.

Reports: The Compliance Committee submits an annual report the QSC.

III. Credentialing Committee – Annual Report

Description: The process of credentialing direct service staff is significantly applicable to Qualified Mental Health Professionals (QMHP) serving CAMHD youths and families since such licensed professionals serve as clinical supervisors of direct service staff. However, because of health, safety, and risk factors involved in serving CAMHD youth, unlicensed Mental Health Professionals as well as Paraprofessionals are also credentialed. As such, in the CAMHD contracted agency network, all providers of direct services to youth are credentialed. This serves as the primary purpose of the Credentialing Committee.

The Credentialing Supervisor chairs the committee. Membership is comprised of cross disciplines representing various CAMHD sections. Provider agencies are not represented because the predominance of applicants credentialed is from CAMHD's contracted agencies. CAMHD's Medical Director is an *ex-officio* member. Frequency of formal meetings are once monthly; however, to accommodate the high rate of agency-submitted documents for credentialing approval, weekly voting of screened and cleared applicants are conducted via e-mail.

Peer review is conducted through the Credentialing Committee, and through a Professional Activities Review Committee (PARC) chaired by a senior Family Guidance Center Clinical Director or Clinical Psychologist with multi-disciplinary membership

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comprised of clinicians from the CAMHD Central Offices and Family Guidance Centers. The Credentialing Committee reviews performance data collected through quality monitoring and makes determinations about credentialing and recredentialing practitioners. The PARC reviews both internal and network practices. The Medical Director is an *ex-officio* member of the PARC and maintains guidelines for peer review.

Functions: The functions of the CAMHD Credentialing Committee include:

1. Review and approval of the credentials of all CAMHD and contract agency direct service staff and their supervisors who provide direct services.

2. Oversight over registration of individual providers into CAMHD's billing system - VISTA.

3. Establish protocols relative to clinician credentialing suspensions and terminations and makes decisions based on parameters established.

4. Establish protocols, procedures, and activities designed to achieve progressive credentialing goals such as levels of privileging.

5. Oversee credentialing data, areas of priority focus, and reports. Determine performance measures and indicators that are measures of Committee's progress and achievements.

Reports: The Credentialing Committee submits an annual report to the QSC.

III. Evidence Based Services Committee (EBS) – Annual Report

Description: The EBS Committee has shifted its major focus from knowledge accumulation to dissemination and implementation of evidence-based practices. The committee is comprised of several smaller work groups spearheading several separate, but related, service initiatives outlined below. The committee meets once monthly and is co-chaired by the Medical Director and a University of Hawaii Assistant Professor of Clinical Psychology.

Functions: The functions of the committee are:

1. Provide CAMHD and our larger system of care a cohesive interdisciplinary vehicle for researching, discussing, and designing best practice implementation efforts.

2. Support CAMHD's Practice Development Office for developing and implementing intensive training opportunities for youth mental health supervisors within our system of care.

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3. Assess and support our state's pre-service training programs for providing best practice training opportunities to its students.

4. Collaborate with SPIN, HFAA, and other consumer-oriented stakeholders for developing and maintaining a consumer-centric website, with the purpose of increasing consumer knowledge of and demand for youth EBPs.

Reports: The EBS Committee submits an annual report to the QSC.

IV. Grievance and Appeals Committee (GAC) – Annual Report

Description: The purpose of the Grievance and Appeals Committee is to hear and act upon consumer and provider issues forwarded as a result of oral or written requests of appeals to decisions made by any area of CAMHD operations. The Performance Manager chairs the Committee. Membership is comprised of staff represented by various sections, including the Public Health Administrative Officer, a FGC Clinical Director, Branch Chief, Provider Relations Specialist, Clinical Services Office representative, and a parent representative. The committee meets at least quarterly.

Functions: The functions of GAC include:

1. Reviewing and rendering decisions following reviews of compilation of documents relating to all factors addressed, investigated, and resolved by the Grievance Office, Clinical Services Office, Fiscal Section staff, or Credentialing Office.

2. Reviewing and endorsing CAMHD yearly reports and work plan activity data related to grievances with action recommendations forwarded to the for review.

Reports: The GAC submits an annual report to the QSC.

V. Policy and Procedures Committee – Annual Report

Description: The purpose of Policy and Procedure Committee is to coordinate and review the development of policies. Membership is comprised of representatives from various CAMHD sections or offices. The Provider Relations Specialist chairs the Policy and Procedure Committee. The committee meets at least quarterly.

Functions: The functions of the committee include:

1. Oversight and coordination of the development and revision of all CAMHD policies and procedures (P&P).

2. Assure policies and procedures are written in standard format.

3. Determining necessary actions to take in processing policies to completion.

4. Processing formal review of final drafts of policy and procedures prior to forwarding for EMT review and Chief's approval and execution.

5. Publish and distribute all official policy and procedure statements to all organizational sections of CAMHD, the Behavioral Health Administration and the Administrative Services Office of the Department of Health, and the Children's Community Council Office.

Reports: The committee submits an annual report to the QSC.

VI. Safety and Risk Management Committee – Bi-Annual Report

Description: This Committee's purpose is to assure staff, visitors and consumers experience a high level of safety in the work place and treatment settings and to identify opportunities for improvement through an on-going effort of risk identification, evaluation, mitigation, resolution, or monitoring. The Medical Director chairs the committee, and vice-chair is a Family Guidance Center Branch Chief. The committee meets at least quarterly.

Functions: The Safety and Risk Management Committee has oversight of quality trends and issues for the following areas:

1. Specific disaster/emergent situations
2. Security (including HIPAA security issues)
3. Preventive maintenance and safety inspections
4. General health issues
5. Safety and well being of clients in CAMHD-contracted facilities/programs
6. Sentinel events and incidents
7. Safety/risk training & education
8. Policies and procedures for safety and risk management issues

Reports: The SARM Committee submits a bi-annual report to the QSC.

VIII. Utilization Management Committee – Quarterly Report

Description: The purpose of the UM Committee is to review all UM data and make recommendations for change in UM guidelines or strategies. The reports reviewed by the committee include a variety of reports designed to look at underutilization or over utilization of services; access to emergency, urgent and routine care; availability of care; least restrictive environment; network adequacy; provider practice patterns; coordination of care and provider satisfaction with the CAMHD utilization management program. The committee meets at least every other month. The UM Committee is chaired by the

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Medical Director. The UM Committee participants are the CAMHD Medical Director, a representative from the provider network, a Family Guidance Center Branch Chief, a Family Guidance Center Clinical Director, and representatives from the Clinical Services Office, Performance Management Office, and Administrative Office of CAMHD.

Functions: The functions of the UM committee include:

1. Oversee utilization data review strategies and areas of focus.
2. Review and analyze all UM reports to identify opportunities for improvement in the delivery, availability, or access of services and to identify UM achievements.
3. Propose solutions to problems and concerns identified by utilization review activities.
4. Establish procedures designed to achieve the goals and objectives of the UM program.
5. Conduct or recommend specialized studies.
6. Maintain awareness of confidentiality in utilization management activities, decisions, and recommendations.

Reports: The UM committee submits a quarterly report to the QSC.

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Additional Reports to the QSC

As noted in the QSC calendar, additional reports are submitted to the QSC. Below is an explanation for each report.

1. Strategic Plan Reports: On a quarterly basis, the CAMHD planner will present to the QSC updates on the activities developed to meet CAMHD's Strategic Plan Goals for FY2010 – 2014.
2. Interagency and Performance Monitoring Report: On a bi-annual basis, the CAMHD Performance Manager will present to the QSC performance highlights identified from the IPMR. If applicable, activities will be developed and implemented to address concerns in performance.
3. Program Monitoring Report: On an annual basis, the CAMHD Program Monitoring Supervisor will present to the QSC cumulative data for the previous fiscal year's case-based reviews, which occur through the annual review of provider agencies. If applicable, activities will be developed and implemented to address concerns in performance.
4. Annual CAMHD Factbook Presentation: On an annual basis, the CAMHD Research and Evaluation Office will present to the QSC data for the previous fiscal year. This meeting will be open to all CAMHD employees and contracted providers. If applicable, activities will be developed and implemented to address concerns in performance.
5. Consumer Survey: On an annual basis, the CAMHD Research and Evaluation Office will present to the QSC the results from the annual consumer survey. If applicable, activities will be developed and implemented to address concerns in performance.
6. Provider Survey: On an annual basis, the CAMHD Provider Relations Liaison will present to the QSC the results from the annual provider survey. If applicable, activities will be developed and implemented to address concerns in performance.

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Appendix

Appendix One: Quality Assurance and Improvement Program Work Plan for Fiscal Year 2012

Appendix Two: QSC Cover Pate for Reports

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Attachment CAMHD8

References

Earls, F. (1980). Prevalence of behavior problems in 3-year-old children: a cross national replication. Archives of General Psychiatry, 37:1153–1157.

Friedman R.M., Kutash K., Duchnowski A.J. (1996). The population of concern: defining the issues. Pp. 69-95 in: Stroul B.A. (Ed.). Children's Mental Health: Creating Systems of Care in a Changing Society. Paul H. Brookes: Baltimore, MD.

Friedman, R.M., Katz-Leavy, J.W., Manderscheid, R.W. & Sondheimer, D.L. (1996). Prevalence of serious emotional disturbance on children and adolescents. Pp. 71-89 in: Manderscheid RW, Sonnenschein MA, editors. Department of Health and Human Services: Rockville, MD.

Gould, M.S., Wunsch-Hitzig, R. & Dohrenwend, B.P. (1980). Formulation of hypotheses about the prevalence, treatment, and prognostic significance of psychiatric disorders in children in the United States. Pp. 9-44 in: Dohrenwend, B.P., Dohrenwend, B.S. & Gould, MS, (Eds.) Mental Illness in the United States. New York.

Pasko, L. (2007). Profiles of Female and Serious Juvenile Offenders in Hawai'i Power Point. Department of the Attorney General. Available at: http://hawaii.gov/ag/cpja/main/rs/
Under: Special Reports 2003-2006.

Stroul, B.A. & Friedman, R. E. (1986). System of Care for Children and Youth with Severe Emotional Disturbances. Washington, D.C.: Georgetown University Center for Child and Human Development.

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

Vikan, A. (1985). Psychiatric epidemiology in a sample of 1,510 ten-year old children. Journal of Child Psychology and Psychiatry, 26:55–75.

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Mission/Purpose	The mission of the Adult Mental Health Division (AMHD) of the Hawaii State Department of Health is to provide a comprehensive, integrated mental health system supporting the recovery of adults with severe and persistent mental illness (SPMI). The Strategic/ Quality Management (QM) Program supports the mission of the AMHD.
Core Values	The AMHD Core Values are: Commitment: We value and are dedicated to providing the public's mental health services. Integrity: We expect honesty, professionalism, and ethics in our work environment. Collaboration: We value teamwork and endeavor to build partnerships, consumer and community participation to attain our goals. Diversity: We celebrate diversity and treat all people with fairness, respect and compassion. Excellence: We strive to ensure high quality and effective use of our resources. Wisdom: We learn from each other and acknowledge that there are many ways of knowing. Innovation: We seek to explore new and creative ideas. Accountability: We are committed to personal responsibility for our actions and for achieving our planned outcomes.
Population Covered by the Strategic/Quality Management Program	The AMHD provides intensive mental health services to a population with diagnoses identified in AMHD Eligibility Policy and Procedure (60.601), that result in emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with one's capacity to remain in the community without treatment, Psychosocial Rehabilitation Services (PSR) and other community supports of a long-term or indefinite duration. The mental disability is severe and persistent resulting in a long-term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment and recreation.

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Quality Management Program Scope	The Adult Mental Health Division (AMHD) operates its programs through an improvement approach that is directly linked to its core values, guiding principles and strategic organizational goals. The scope of the AMHD Strategic/Quality Management Program (SQMP) encompasses processes and monitoring occurring at all levels of the organization and network on an ongoing basis. It improves and monitors consumer outcomes; monitors the implementation and impact of best evidence-based and promising practices; and communicates the results of the SQMP to all stakeholders. The SQMP establishes specific annual goals, priorities, key initiatives and measures that track and assure access and availability of appropriate and effective services and supports. A formal evaluation of the SQMP is conducted on an annual basis to establish priorities for the subsequent year and make adjustments to the SQMP as indicated. The SQMP is structured and designates specific responsibilities for governance, reporting, documentation, committee rolls, committee training and staffing resources. Functions of the SQMP committees are described in policies and procedures of the SQMP. The SQMP committees meet on a specified basis to review performance indicators designated in the SQMP Work Plan, and make recommendations for improvement to the AMHD Quality Improvement Committee. Purchases of Service providers (POS) have an opportunity to dialogue with the AMHD Chief in monthly Provider Roundtable meetings. These meetings are informational and used to discuss current initiatives so providers are aware of the services AMHD provides and how providers and consumers access these services. Providers include physicians and non-physicians. Individual reports will be mailed to the provider agency, which [presents information about performance results specific to the provider. AMHD providers receive frequent information about quality improvement activities. This information is sent to them in the form of a newsletter and is coordinated by the Director of Provider Relations. AMHD consumers participate through direct representation by the Consumer Affairs Chief and attendance at consumer forums. Consumer involvement in committees, sub-committees, and Quality Improvement Teams is expected. Consumers and consumer advocates will have access to an informational copy of the SQMP Evaluation Summary and Work Plan. This will be accomplished through inclusion on the AMHD website and targeted mailings to consumer advocates, such as AMHD Chief's Consumer Roundtable, Service Area Boards and the State Council on Mental Health.

Quality Improvement Committee	The Quality Improvement Committee (QIC) meets at least once a month and is chaired by the AMHD Chief or designee.
	• The focus of the QIC is:
	  • Oversight of Dashboards for 1) AMHD administration, 2) Hawaii State Hospital, 3) Community Mental Health Center Systems Administration, and 4) Providers.
	  • Dashboard focus areas are: 1) Fiscal, 2) Customer service, 3) Internal processes, 4) Staff learning and growth
	  • Dashboard will be developed for all major areas in AMHD administration: Service Directors, Utilization Management, Performance Improvement, Fiscal, Contracts, MIS, Personnel, etc.
	  • Oversight of Quality Improvement Initiatives

ELEMENTS	DESCRIPTION
Quality Improvement Committee (continued)	Membership on the QIC includes: 1. AMHD Chief (or designee) 2. HSH Administrator or designee 3. CMHC System Administrator or designee 4. Chief of Consumer Affairs 5. AMHD Medical Director 6. Chief of Clinical Operations Team 7. Performance Improvement Coordinator 8. Utilization Management Coordinator 9. Chief Financial Officer 10. Chief Information Officer 11. All Service Directors 12. Planner Committees which report to QIC are: • A newly established Policy & Procedures Committee • Quality Review Committee • Task Teams, which will be established as needed Advisory Groups are to ensure provider and consumer input about relevant performance improvement activities. The following is a list of the advisory groups and where they connect: • State Council on Mental Health via AMHD Chief to QIC • Chief Provider Roundtable via AMHD Chief to QIC • Chief Consumer Roundtable via AMHD Chief to QIC • Medical Executive via AMHD Medical Director to QIC • Service Area Boards on Mental Health and Substance Abuse via Service Area Administrators to the Community Mental Health Center System Administrator or designee to QIC • Continuity of Care meeting via Service Director to QIC There are two workgroups that can forward information to the QIC for further discussion or approval. • The Clinical Operations Team (COT) Workgroup is responsible for assuring that all services in the community that become part of the array of AMHD services, and promotes optimal utilization of AMHD clinical and operational standards. • The Business Operations Team (BOT) Workgroup is responsible for assuring that all services subject to reimbursement are proper and in compliance with all applicable payer and contractual guidelines, rules and regulations.

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Strategic/Quality Management Program Goals, Key Initiatives and Actions	The Strategic/Quality Management Program goals, key initiatives and actions are: **PRIORITY AREA I. LEADERSHIP** Goal: Promote the AMHD Leadership Initiatives. Key Initiative #1: Update AMHD's organizational mission, vision, values and performance expectations. • Disseminate and communicate to AMHD's workforce, consumers and stakeholders. • Include in each day's activities within the organization. Key Initiative #2: Incorporate the Department of Health's broader strategic initiatives and actions into AMHD's strategic plan related to AMHD's practices and consumer outcomes. • Reorganize AMHD for increased efficiency and effectiveness. • Involve consumers, employees, and vendors in planning and governance activities. **PRIORITY AREA II. RECOVERY-BASED SYSTEM OF CARE** Goal: Ensure the rights of consumers are advanced through continuing implementation and advancement of a recovery based system that provides culturally informed and evidence-based service and treatment. Key Initiative #1: Develop processes to increase consumers' recovery to its maximum level of independence. • Increase collaboration with providers in moving consumers to the appropriate levels of care. • Use community and stakeholder involvement to plan, develop, and implement new and innovative types of services to support independence. Key Initiative #2: Decrease the Hawaii State Hospital (HSH) Census • Implement Utilization Management / Continuity of Care Project at HSH. • Implement Hawaii's new laws (which provide limits on length of stay for Forensic consumers) through new types of discharge planning activities. Key Initiative #3: Develop a Trauma Informed System of Care • Implement services funded through the Federal Mental Health Transformation II grant for Trauma Informed Care. • Sustain Trauma Informed Care after the grant ends. Key Initiative #4: Incorporate Forensics into principles of recovery • Expand programs to support consumers with Forensic issues. • Incorporate recovery principles into Forensic programs.

ELEMENTS	DESCRIPTION
Strategic/Quality Management Program Goals, Key Initiatives and Actions (continued)	Key Initiative #5: Integration of bi-directional physical and behavioral health services • Collaborate with primary care sites to provide behavioral health services. • Support behavioral health care sites to incorporate primary care services. **PRIORITY AREA III. PERFORMANCE EXCELLENCE** Goal: Improve value to consumers and stakeholders through demonstration of publicly accountable goals as a function of organizational transformation, integration, and sustainability that guides management decisions and practice development. Key Initiative #1: Build a culture of Excellence. • Train on Performance Improvement methodology. • Implement an organizational assessment to identify gaps in services and performance. • Promote customer Service excellence. Key Initiative #2: Review current AMHD Performance Improvement practices/processes for the selection of performance indicators to be more recovery outcome oriented. • Streamline provider monitoring. • Evaluate the effectiveness of the Quality of Life Interview Surveys and collaborate with OPIE on alternative tools. • Enhance the participation and action-based processes of the Mental Health Statistics Improvement Program participation. • Enhance Sentinel Events analysis and improvement process. Key Initiative #3: Develop a data set (dashboard model) to monitor and inform process improvement efforts for better outcomes. • Communicate performance data results to consumers and stakeholders. • Coordinate monitoring activities with Information Services. **PRIORITY AREA IV. COLLABORATIVE RELATIONSHIPS** Goal: Sustainable collaborative relationships with key internal and external stakeholders which achieve AMHD's mission of providing a comprehensive, integrated mental health system which supports the recovery of adults with severe mental illness. Key Initiative #1: Strengthen internal and external communications. • Solidify the integration of AMHD's governmental partners (e.g. Department of Human Services, Department of Public Safety, and Honolulu Police Department) and other community partners. • Strengthen relationships with key stakeholder groups including consumer groups, Legislature, and advocacy groups (*Collaborate with Performance Excellence*).

ELEMENTS	DESCRIPTION
Strategic/Quality Management Program Goals, Key Initiatives and Actions (continued)	**PRIORITY AREA V. BUSINESS PRACTICES** Goal: Develop and implement fiscally sound, accountable business practices that are state and federal compliant, in the context of an environment that supports the consumer and promotes recovery. Key Initiative #1: Implement the Systems Improvement Project. • Internalize self-sufficient Utilization Management, billing and claims payment system. • Modernize the Information Technology system including upgrades to both hardware and software. Key Initiative #2: Everything that is done quickly and in compliance with procurement laws to achieve any organizational goal will cause our division to function better. • Ensure timely and proactive communications with key stakeholders through metric reports. • Ensure that any initiative is approved by both clinical and fiscal sections before implementation to assure smooth and appropriate reimbursements. Key Initiative #3: Increase revenue streams • Achieve Commission on the Accreditation of Rehabilitation Facilities (CARF) accreditation for the Community Mental Health Centers. • Attain Center for Medicaid and Medicare Services (CMS) certification for the Hawaii State Hospital. • Actively work denied insurance claims to maximize reimbursement. **PRIORITY AREA VI. INFORMATION MANAGEMENT** Goal: Research, develop and implement a secure customer responsive information management plan that adheres to state and federal mandates, that facilitates access and utility, and utilizes current technology to support AMHD's goals and objectives. Key Initiative #1: Support the system to know how to manage protected health information effectively and in compliance with state and federal law. • Compliance with Minimum necessary rule. • Compliance with statutes and rules. Key Initiative #2: Participate in the development of a health information exchange (HIE). • Representation on the Hawaii Health Information Exchange • Participate in intergovernmental agency planning • Plan for implementation of interoperable electronic health records.

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Strategic/Quality Management Program Goals, Key Initiatives and Actions (continued)	Key Initiative #3: Develop a registry of reports from the Department of Health's Office of Performance Improvement Excellence (OPIE) to AMHD. • Request listing of reports submitted to the Department. • Disseminate incoming reports and use them to take relevant action (*Collaborate with Performance Excellence*). **PRIORITY AREA VII. WORKFORCE DEVELOPMENT** Goal: Implement a comprehensive and integrated workforce development program for current staff and POS providers with a thrust toward future workforce development, recruitment and retention. Key Initiative #1: Focus on the retention practices of AMHD's workforce, including the capacity for major shortage areas such as physicians and professional staff. • Create and implement a strategic recruitment initiative. • Implement a staff development program. • Collaborate with educational institutions to support the development and education of pre-graduation students. Key Initiative #2: Implement an AMHD new employee orientation program. • Expose and equip new employees to the principles of recovery. • Standardize the information given to all new employees entering the system. Key Initiative #3: Improve AMHD's Performance Appraisal System (PAS) • Conduct regular employee performance reviews. • Assess the timeliness of employee reviews completed annually. • Encourage and celebrate positive performance • Guide and support employees to improve performance when needed.
Annual Work Plan	See attached SQMP Work Plan.

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Methodology	The **PDCA** will be used as an approach to quality improvement throughout the organization. This approach will be included in new staff orientation to introduce the concept of a scientific, applicable method to collect, analyze and evaluate data so that continuous improvement can be realized. Quality Improvement Process **P** Plan the Improvement: Description of plan for action – who, what, where, when, how. **D** Do the Improvement: Dates of implementation; description of any variation from the plan. **C** Check the results: Data collection and display; lessons learned. **A** Act to hold the Gain: Comparison to initial data; assessment/conclusions, action plan.

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA I: LEADERSHIP

GOAL: Promote AMHD's Leadership Initiatives

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1 Update AMHD's organizational mission, vision, values and performance expectations.	• Disseminate and communicate to AMHD's workforce, consumers and stakeholders. • Include in each day's activities within the organization			
Key Initiative #2 Incorporate the Department of Health's broader strategic initiatives and actions into AMHD's strategic plan related to AMHD's practices and consumer outcomes.	• Reorganize AMHD for increased efficiency and effectiveness. • Involve consumers, employees, and vendors are involved in planning and governance activities.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA II: RECOVERY-BASED SYSTEM OF CARE

GOAL: Ensure the rights of consumers are advanced through continuing implementation and advancement of a recovery based system that provides culturally informed evidenced-based service and treatment.

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1: Develop processes to increase consumers' recovery to its maximum level of independence.	• Increase collaboration with providers in moving consumers to the appropriate levels of care. • Use community and stakeholder involvement to plan, develop, and implement new and innovative types of services to support independence.			
Key Initiative #2: Decrease the Hawaii State Hospital (HSH) Census	• Implement Utilization Management / Continuity of Care Project at HSH. • Implement Hawaii's new laws (which provide limits on length of stay for Forensic consumers) through new types of discharge planning activities.			
Key Initiative #3: Develop a Trauma Informed System of Care	• Implement services funded through the Federal Mental Health Transformation II grant for Trauma Informed Care. • Sustain Trauma Informed Care after the grant ends			
Key Initiative #4: Incorporate Forensics into principles of recovery	• Expand programs to support consumers with Forensic issues. • Incorporate recovery principles into Forensic programs.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #5: Integration of bi-directional physical and behavioral health services	• Collaborate with primary care sites to provide behavioral health services. • Support behavioral health care sites to incorporate primary care services			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA III: PERFORMANCE EXCELLENCE

GOAL: Improve value to consumers and stakeholders through demonstration of publicly accountable goals as a function of organizational transformation, integration, and sustainability that guides management decisions and practice development.

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1: Build a culture of Excellence.	• Train on Performance Improvement methodology. • Implement an organizational assessment to identify gaps in services and performance. • Promote customer Service excellence.			
Key Initiative #2: Review current AMHD Performance Improvement practices/processes for the selection of performance indicators to be more recovery outcome oriented.	• Streamline provider monitoring • Evaluate the effectiveness of the Quality of Life Interview Surveys and collaborate with OPIE on alternative tools. • Mental Health Statistics Improvement Program participation • Enhance Sentinel Events analysis and improvement process.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #3: Develop a data set (dashboard model) to monitor and inform process improvement efforts for better outcomes.	• Communicate performance data results to consumers and stakeholders. • Coordinate monitoring activities with Information Services.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA IV: COLLABORATIVE RELATIONSHIPS

GOAL: Develop and sustain internal/external mutually collaborative relationships and agreement with key stakeholders to achieve unity with the community and organizational objectives.

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1 Strengthen internal and external communications.	• Solidify the integration of AMHD's governmental partners (e.g. Department of Human Services, Department of Public Safety, and Honolulu Police Department) and other community partners. • Strengthen relationships with key stakeholder groups including consumer groups, Legislature, and advocacy groups (*Collaborate with Performance Excellence*).			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA V: BUSINESS PRACTICES

GOAL: Develop and implement fiscally sound, accountable business practices that are state and federal compliant, in the context of an environment that supports the consumer and promotes recovery.

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1 Implement the Systems Improvement Project.	• Internalize self-sufficient Utilization Management, billing and claims payment system. • Modernize the Information Technology system including upgrades to both hardware and software.			
Key Initiative #2 Everything that is done quickly and in compliance with procurement laws to achieve any organizational goal will cause our division to function better.	• Ensure timely and proactive communications with key stakeholders through metric reports. • Ensure that any initiative is approved by both clinical and fiscal sections before implementation to assure smooth and appropriate reimbursements.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #3: Increase revenue streams	• Achieve Commission on the Accreditation of Rehabilitation Facilities (CARF) accreditation for the Community Mental Health Centers. • Attain Center for Medicaid and Medicare Services (CMS) certification for the Hawaii State Hospital. • Actively work denied insurance claims to maximize reimbursement.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA VI: INFORMATION TECHNOLOGY

GOAL: Research, develop and implement a secure customer responsive information management plan that adheres to state and federal mandates, that facilitates access and utility, and utilizes current technologies to support AMHD's goals and objectives.

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1 Support the system to know how to manage protected health information effectively and in compliance with state and federal law.	• Compliance with Minimum necessary rule. • Compliance with statutes and rules.			
Key Initiative #2 Participate in the development of a health information exchange (HIE).	• Representation on the Hawaii Health Information Exchange. • Participate in intergovernmental agency planning. • Plan for implementation of interoperable electronic health records.			
Key Initiative #3: Develop a registry of reports from the Department of Health's Office of Performance Improvement Excellence (OPIE) to AMHD.	• Request listing of reports submitted to the Department. • Disseminate incoming reports and use them to take relevant action (*Collaborate with Performance Excellence*).			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

PRIORITY AREA VII: WORKFORCE DEVELOPMENT

GOAL: Implement a comprehensive and integrated workforce development program for current staff and POS providers with a thrust toward future workforce development, recruitment and retention.

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #1 Focus on the retention practices of AMHD's workforce, including the capacity for major shortage areas such as physicians and professional staff.	• Create and implement a strategic recruitment initiative. • Implement a staff development program. • Collaborate with educational institutions to support the development and education of pre-graduation students.			
Key Initiative #2 Implement an AMHD new employee orientation program.	• Expose and equip new employees to the principles of recovery. • Standardize the information given to all new employees entering the system.			

ADULT MENTAL HEALTH DIVISION
Strategic/Quality Management Program Work Plan
2011 - 2012

KEY INITIATIVE	ACTION	PERSON (S) RESPONSIBLE	OUTCOMES / MEASUREMENT	TARGET DATE
Key Initiative #3: Improve AMHD's Performance Appraisal System (PAS)	• Conduct regular employee performance reviews. • Assess the timeliness of employee reviews completed annually. • Encourage and celebrate positive performance. • Guide and support employees to improve performance when needed.			

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.648**
AMHD Administration	Effective Date: 06/03/05 History: Rev. 06/06
SUBJECT: Recovery (Treatment) Planning	Page: 1 of 9
REFERENCE: CMS; State Licensure Requirements; Plan for Community Mental Health Services	APPROVED: Title: Chief, AMHD

PURPOSE

To ensure that the recovery (treatment) planning process and documentation meet recognized professional standards and result in effective, person-centered, individualized, collaborative and coordinated care of the consumer.

POLICY

An initial recovery (treatment) plan is developed for each consumer within 72 hours of admission to an AMHD funded service. An individualized Master Recovery Plan, consistent with the consumer's goals and preferences is developed by an interdisciplinary team of professional staff within 30 days of admission. The Master Recovery Plan contains the following elements: a case formulation; statements describing the nature of the specific problems and needs of the consumer; the consumer's strengths and treatment preferences, clear, objective, behaviorally written goals with time frames for completion; a comprehensive program of treatment that includes individualized, specific treatment interventions. The consumer's recovery plan is formally re-evaluated at least every 6 months. The plan is revised as appropriate to reflect the consumer's current status, progress and treatment needs. It is then implemented according to the revisions. Progress notes shall be documented in the clinical record and shall describe the consumer's progress toward achievement of his/her goals, interventions provided, and their results.

RESPONSIBILITY STATEMENT:

- The Master Recovery Plan fully directs and integrates all care and treatment.
- Responsibility for the Master Recovery Plan is to be shared between the consumer and his/her recovery (treatment) team.

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- The consumer is the focal point of the interdisciplinary treatment process. The consumer's role and responsibilities are delineated in the Consumer Recovery Guide.

- The AMHD funded psychiatrist (or APRN-RX Nurse -- in areas with demonstrated shortages of psychiatrists, such as rural neighbor island locales) shall be in charge of the recovery team and has the ultimate authority for all clinical decisions). The AMHD funded psychiatrist or APRN-RX shall be responsible for:

  - Ensuring that the Master Recovery Plan is the result of collaboration between the consumer's own expressed goals for recovery and the interdisciplinary team's perspective.

  - Ensuring that the consumer and all the disciplines are involved in the recovery planning process as directed by each consumer's needs.

  - Delegating as appropriate some responsibilities to other team members.

  - Ensuring that performance improvement findings are used to improve recovery planning.

  - Ensuring that the Master Recovery Plan is implemented.

- The AMHD funded case manager or ACT team shall be responsible for:

  - Writing, updating and maintaining the original, signed Master Recovery Plan for each consumer;

  - Coordinating among various providers and others chosen by the consumer, the development of the Master Recovery Plan;

  - Monitoring the implementation of the Master Recovery Plan; and

  - Integrating the Master Recovery Plan as the overarching plan that encompasses and incorporates subsidiary individual service plans of various providers (e.g., Housing, Clubhouse, PSR, Supported Employment, Peer Specialist/WRAP, etc.).

- All members of the interdisciplinary recovery team come prepared to the recovery planning meeting and collaborate with the consumer to formulate the case, plan for recovery and follow through on treatment interventions. Ideally, meetings should be face-to-face with all participants. If exceptions need to be made, the consumer must be fully informed and involved.

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PROCEDURE

A. INITIAL RECOVERY (TREATMENT) PLAN

The Initial Recovery Plan is developed by a mental health professional within 72 hours of admission to an AMHD funded service. It is used to direct the consumer's care until the individualized Recovery Plan is developed. The focus of the Initial Recovery Plan is to meet the consumer's immediate health and safety needs.

B. COMPOSITION OF THE RECOVERY (TREATMENT) TEAM

1. For every AMHD consumer assigned a psychiatrist, the recovery (treatment) team shall, at a minimum, consist of the consumer, the psychiatrist, and the case manager.

    a. Exception: An APRN-RX Nurse may replace the psychiatrist on the recovery team in areas with demonstrated shortage of psychiatrists, such as rural neighbor island locales.

    b. Teleconferencing via telephone and/or video connection, is an acceptable alternative to the in-person presence of the psychiatrist/APRN-RX.

2. The consumer is considered an essential member of the treatment team and shall be present at his or her treatment team meetings and be encouraged to participate actively.

3. Family/significant others shall be invited with the consent of the consumer and encouraged to participate in the Recovery Plan review meetings or have input into recovery planning.

C. RECOVERY PLANNING PROCESS

1. Interdisciplinary planning is based on multiple mental health professionals' assessments, is consumer focused and culturally informed, and incorporates the consumer's strengths and recovery goals and preferences.

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2. The recovery planning process begins as early as intake and ideally occurs in every meeting between the consumer and a recovery team member leading up to (and proceeding from) each Master Recovery Plan meeting, so that the meeting can be as comprehensive and efficient as possible.

    a. For example, the case manager or ACT worker may conduct "pre-planning" meetings to help the consumer understand and prepare for the recovery planning process and begin thinking about his/her goals, before involving the psychiatrist and other recovery team members.

3. The planning process identifies and describes the consumer's strengths and goals, behavioral challenges and needs, and prioritizes identified needs. It establishes measurable long/intermediate and short term goals as appropriate, identifies approaches or interventions based on identified strengths and facilitates consumer's meeting those goals. The Recovery Plan review evaluates the consumer's progress toward those goals on identified target dates throughout the course of care.

4. The consumer's medical/dental problems are identified and significant medical/dental problems are included in the Recovery Plan in coordination with primary care services.

5. The process involves periodic review and/or revision of the Recovery Plan to reflect the consumer's progress and current treatment needs.

6. Review of each consumer's Recovery Plan shall occur at least once every six (6) months, or whenever there is a significant change in it (e.g. change in problem identification, focus of treatment, level of care, or services provided, such as Crisis Mobile Outreach contact), and are structured to maximize consumer, family and community involvement. Further examples of triggers for revision of Master Recovery Plan from the AMHD Clinical Alert (May 31, 2005-01) include: suicide attempt; ER visit; significant clinical change; homeless or immediate risk of losing housing; at risk of revocation of conditional release order; loss of significant member of consumer's support system; decreased or no treatment participation; and substance abuse relapse.

7. Recovery Plans are written and modified based on the consumer's identified goals and needs.

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8. New problems and associated goals are documented in the progress notes and evaluated for possible inclusion in the Recovery Plan.

9. For each consumer, timely progress notes are written by all mental health professionals involved in the consumer's care.

D. CONTENT OF THE MASTER RECOVERY PLAN

The Master Recovery Plan consists of various components, including, but not limited to those described below.

1. The Master Recovery Plan includes:

   a. Case Formulation: The case formulation is the synthesis of assessment formation and consumer goals illustrating the interactions of specific areas in need of attention. As this understanding evolves the formulation changes. The formulation drives the Recovery Plan and:

      i. Is based on the domains of the LOCUS (Risk of harm; Functional Status; Medical, Addictive and Psychiatric Co-Morbidity; Recovery Environment (Level of Stress and Level of Support); Treatment and Recovery History; and Engagement).

      ii. Includes a summary of the interrelationship and prioritization of LOCUS domains for recovery, and is based on the results of multidisciplinary mental health professionals' assessment.

   b. Legal Status: This indicates the consumer's legal status on admission and is updated to reflect court actions over the course of treatment.

   c. Diagnosis: The multi-axial diagnoses (I - V) are documented on the Recovery Plan. Provisional or deferred diagnoses are to be eliminated within 30 days.

   d. Contain at least the following elements:

      i. All of the written explanations for each identified need that is not addressed in the Master Recovery Plan;

      ii. A written quote by the consumer describing what he or she considers to be the measure of success;

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iii. A case formulation that results from the multidisciplinary assessments used in developing the Master Recovery Plan;

iv. Written treatment goals that are prioritized based on the consumer's preferences, strengths and needs;

v. Goals that are worded in behavioral terms, with a completion time frame for each goal;

vi. Identification of specific treatment and PSR services and other community supports to be provided to the consumer, including the amount, duration and scope;

vii. Designation of the person responsible for each intervention of the Recovery Plan;

viii. Crisis planning that shall include the preferences of the consumer and detail the steps to be taken if a crisis occurs; and

ix. Written criteria for transition from one level of care to another as appropriate.

e. Be reviewed and updated at least once every six (6) months or whenever there is a significant change in treatment.

f. Comply with requirements of the service provider's accrediting body, and/or Centers for Medicare and Medicaid Services.

g. Reference and incorporate all Individual Service Plans (as they are developed) from various providers (e.g., Housing, Clubhouse, PSR, Supported Employment, Peer Specialist/WRAP, etc.) that the Master Recovery Plan overarches and encompasses.

i. For example, Individual Service Plans may be attached to the Master Recovery Plan in their entirety or may be summarized under the Goal/Plan/Status section of the Master Recovery Plan.

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2. Needs, Goals and Interventions:

   a. Problem/needs title is brief, but descriptive.

      i. The statement describes the nature of the specific needs of the consumer.

      ii. The individualized statement is meaningful to the consumer and reflects his/her goals and treatment contract with the recovery team.

      iii. The initial date is included when the need is identified (and, when applicable, the date it is resolved).

   b. For each need, at least one long-term goal is identified. This is objective, behaviorally worded and is framed in the consumer's own words or in words the consumer can understand.

   c. A statement of consumer strengths related to the long-term goal.

   d. At least one clear, objective, behaviorally worded short-term goal.

      i. Each short-term goal is measurable and includes the time frame for completion.

      ii. Key indicators are used to define how the consumer's progress is measured.

   e. At least one specific treatment intervention for each short-term goal.

      i. All interventions described in the Recovery Plan shall be directed toward improving the consumer's level of function, and successful community integration.

      ii. A brief statement and rationale for each intervention designed to achieve the specified short- and long-term goals specified in the plan.

      iii. Start date, frequency, duration, and the name of the clinician(s) providing the intervention(s) are documented for all interventions on the Recovery Plan.

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3. The individual Recovery Plan includes other elements:

   Behavior Management Plans (BMP), when present, are to be an integral part of the Recovery Plan and are integrated into the overall Recovery Plan. They are developed by the treatment team for identified behavioral problems.

E. RECOVERY PLAN REVIEW (RPR)

1. Recovery Plan Review meetings are scheduled and convened by the consumer's Treatment Team thirty (30) days after the initial recovery plan is written and at least every six (6) months thereafter. When there is a change of case manager, the case manager will review the current Recovery Plan at the first session with the client. If changes are needed, minor changes can be noted on the current plan.

   a. Additional team meetings are also held to evaluate changes in behavior, e.g., levels of care and services provided.

   b. If the consumer is frequently or consistently refusing treatment and/or groups/classes, the team updates/changes the Recovery Plan. The team establishes a plan to deal with the refusals and considers offering alternate interventions including a BMP.

2. At the Master Recovery Plan Review, the team, including the consumer, considers and evaluates the consumer's progress toward each goal.

   a. At a minimum, this review includes as needed:

      i. A review and update of the case formulation.

      ii. A review of each need, noting response to treatment, data supporting the change(s), and making necessary adjustments to the goals and interventions. (Note: Where a consumer appears to be meeting goals, the goals should be considered for change and where there has been no progress, goals and interventions should be considered for change.)

   b. The review shall be documented in the clinical record.

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F. DOCUMENTATION AND DISSEMINATION OF THE RECOVERY PLAN

1. The AMHD funded case management or ACT service provider maintains a paper record of the Master Recovery Plan. After each recovery planning meeting, the appropriate forms are updated, signed and made part of the clinical record.

2. The AMHD designated case manager shall be responsible for coordinating the development and monitoring the implementation of the Master Recovery Plan and for ensuring its dissemination among the consumer's other providers (e.g., Housing, Clubhouse, PSR, Supported Employment, Peer Specialist/WRAP, etc.) and the linking and incorporation of these providers' individual service plans in the Master Recovery Plan.

3. Recovery Plans must remain fully intact as verified by the participants' signatures. When any significant element of the Recovery Plan is revised, the whole Recovery Plan must be reprinted with the dates when the Recovery Plan was first developed and the date when the Recovery Plan was updated/changed. Only small changes to the Recovery Plan are allowed in handwriting if individually dated and signed by the person making the change.

ATTACHMENTS:

Sample Recovery Plan Format

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__
Initials: [_____] [_____] [_____] [_____]

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RECOVERY PLAN

(INDIVIDUAL SERVICE PLAN) Adult Mental Health Division

For Site Specific Use:

	Date of Birth:		
Last Name:	12-digit ECURA Reference # 2 0 _ _ _ _ _ _ _ _ _ _	Service Plan Date:	
First Name:	Gender: ☐M ☐F ☐Other	Review Due:	
Case Manager:		Review Done:	
Qualified Mental Health Practitioner (QMHP):		2nd Review Due:	

STRENGTHS/PREFERENCES/CULTURAL ISSUES	CONSUMER LONG TERM RECOVERY/DISCHARGE GOALS:

Case formulation can be found in ☐ Psychiatrist's Intake Report in record ☐ Attached ☐ Other:

DIAGNOSES	NEEDS IDENTIFIED BY CONSUMER:
Axis I: a	1.
b	2.
c	3.
d	4.
Axis II:	Criteria For Change in Level of Care:
Axis III:	
Axis IV:	
Axis V: (GAF) Current: Highest in Past Year:	GAF at review:
LOCUS: ☐CC ☐TCM ☐ICM ☐ACT ☐CSM	LOCUS at review: ☐CC ☐TCM ☐ICM ☐ACT ☐CSM

SPECIAL NEEDS CONSIDERATIONS FOR SERVICE PLANNING:

☐ Developmental Disability
☐ Chronic Homelessness
☐ Transportation
☐ Non-ambulatory
☐ Needs Interpreter
☐ Hearing Impaired
☐ Limited Sight
☐ No special needs
☐ Other:

Forensic Status: (*check one*)

☐ Voluntary ☐ Parole ☐ Conditional Release
☐ Probation ☐ Supervised Release ☐ Jail Diversion Participant

Probation/Parole Officer:
Phone:

☐ HCR 20 – Date completed:
Level of risk:

☐ MI/SA

Stage of Change: ☐Engagement ☐Motivation/Persuasion ☐Active/Action ☐Relapse Prevention

☐ Advance Directive:

CRISIS PLAN:

What are my triggers and warning signs?

Actions staff and I will take to *prevent* crisis: (Include names/numbers of my supporters/resources)

Actions	Person Responsible	Contact Information
1.		
2.		
3.		

Actions staff and I will take to *manage* crisis: (Include my preferred treatments/facilities *and* those I want to avoid)

Actions	Person Responsible	Contact Information
1.		
2.		
3.		

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GOAL (Number to correspond with needs)	PLAN (Interventions including frequency, duration and person & discipline responsible. Include referrals here.)	STATUS (See key at bottom of page)

Explanation for identified consumer needs/goals that are not addressed in the ISP:

Consumer:	Date:	Psychologist/ APRN:	Date:
Psychiatrist:	Date:	Legal Guardian:	Date:
Case Manager:	Date:	Other:	Date:

Status Key:
OM = Outcome Met If outcome not met, choose one:
W = Worse NC = No Change I = Improvement DC = Discontinued

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Intended Use of Block Grant Funds

Hawai`i's plan for use of its CMHS Block Grant allotment for federal fiscal year 2012 is based on the spending authority of $1,952,865 with AMHD portion being $1,148,089.

AMHD reviews information to ensure that Mental Health Block Grant (MHBG) funds expenditure is being made consistently with federal and state intent of funds. The following table shows the MHBG allocations to AMHD for fiscal year 2012-2013.

STATE OF HAWAI`I
INTENDED USE OF BLOCK GRANT FUNDS
MHBG #31 (10/1/11 – 6/30/13)

PROJECT	SERVICE	BLOCK GRANT AMOUNT
AMHD: MISA & Special Populations	Forensic System Development: With the assistance of a national expert, develop a strategic plan to develop a forensic service system which includes a plan for 1) infrastructure enhancements such as policies, procedures, data collection, utilization management, fidelity monitoring, etc. 2) Clinical enhancements and technology such as screening, assessment to determine level of criminogenic risk and criminogenic need and determine type of targeted and level of dosing appropriate and fidelity monitoring. Coordination will be via participation in the Interagency Council for Intermediate Sanctions.	$100,000
AMHD: MISA & Other Special Populations	Mental Health Court Project: Provide a structured option to Specialized Residential for Special Populations for individuals who need a high degree of structure, but not necessarily dual treatment that will meet the concerns of the courts.	$189,800
AMHD: Office of Consumer Affairs	Annual Statewide Consumer Conference: Funds are planned for travel expenses for Neighbor Island consumers to attend the Consumer Conferences statewide.	$10,000
AMHD: Office of Planning	Funds for State Council: Conference fees, advertisements, and projects which allow for visitations to local programs are provided. Annual State Council membership training (statutory authority, training in ethics and the Sunshine Laws).	$6,000
DOH/AMHD: Office of Health Status Monitoring:	Hawai`i Health Survey: Questions on Suicide and Advanced Directives: Participation in the annual household telephone survey relative to questions on consider, plan and attempt suicide, and awareness of and implementation of advanced directives.	$12,000
AMHD: Crisis Services	CRD Pharmacy Project: The project will entail providing a range of commonly prescribed medications at the CRD through a portable pharmacy contracted by HPD. Medications will be prescribed by an APRN Rx or Psychiatrist working with the HPD Emergency Psychological Services and Jail Diversion Program's CRD Clinical Services Project, a collaborative project between AMHD and HPD. This project will be of immediate benefit to individuals, including	$30,000

PROJECT	SERVICE	BLOCK GRANT AMOUNT
	AMHD consumers, in urgent need of psychiatric medications to stabilize their symptoms.	
AMHD: Crisis Services	Mental Health Training for Law Enforcement: This project will entail review, compilation, final editing and delivery of a final draft, ready for production, of a mental health training curriculum for law enforcement that will be made available in the public domain and available for use by various counties and other law enforcement entities within Hawai`i state. At a minimum, a finished product will contain instructional modules and supporting documentation (power-point slides, handouts, discussion guides, that adequately addresses the following areas: • Understanding and recognizing the signs and symptoms of mental illness, including those individuals with co- occurring substance abuse disorders, as well as understanding how mental illness and co-occurring substance use effects individuals, families and communities, and development of alternative skills for intervention that help ensure a safe outcome for those persons affected by mental illness. • Recognizing whether those signs and symptoms represent a crisis situation and development of the skills necessary to de-escalate mental health crises, knowing alternative courses of intervention for consumers in crisis, and knowing appropriate steps in following up on these crises, such as contacting the individual's case managers or other treatment providers or providing consumers and family members referral information to mental health/substance abuse treatment agencies or advocacy organizations like the local NAMI and Mental Health Association. • Curriculum must provide a common base of knowledge about mental illness and give the officers a basic foundation on which to build. The curriculum should include specific components designed to provide knowledge in the following areas: o Signs and symptoms of mental illness and co-occurring disorders, common medications for mental illnesses, recognizing that the intent is for officers to know about the disorders and their consequences, but not imply that officers should be able to make a diagnosis: ▪ Schizophrenia and other psychotic disorders, ▪ Mood disorders, ▪ Anxiety disorders, including PTSD, ▪ Personality disorders, ▪ Antisocial behavior and other conduct disorders, ▪ Co-occurring substance abuse disorders, ▪ Disorders unique to children and adolescents, ▪ Developmental disabilities (Mental retardation) ▪ Alzheimer's disease and other dementias;	$105,750

PROJECT	SERVICE	BLOCK GRANT AMOUNT
	o Implications of the mental illnesses and co-occurring disorders above for a person's behavior, as well as for their communication, as well as specific strategies for officers in communicating with a person affected by mental illness; o An overview of biological, psychological and social treatment approaches, including psychiatric medication, its effects and side effects; o Elements of true emergencies, which require immediate action and crises, where an imbalance between the situation and a person's coping skills exists; o Elements of danger to self and others, including suicidal ideation and suicidal behavior, as well as violent behavior that may be a product of mental illness or intoxication; o Methods to safely de-escalate a person experiencing mental health crisis, including at least one method of verbal de-escalation; o Legal framework for interacting with persons suffering from mental illness including the application of involuntary measures; o Cultural, consumer and family perspectives: living with mental illness; o Local resources and how to get help for the person with mental illness, including disposition options;	
AMHD: Crisis Services	CRD Clinical Services Project: An ongoing project based on the partnership between the AMHD and the HPD Human Services Unit to provide clinical services at the Central Receiving Division (main cellblock) of the Honolulu Police Department. The project provides funding support for a range of intervention services within the Central Receiving Division (CRD) of the Honolulu Police Department (HPD). Clinical services are provided at the CRD by licensed APRN, APRN Rx and/or RN staff under contract with HPD, whose focus is assisting with identifying, intervening with and linking individuals with mental illness, including those with a co-occurring substance abuse disorder to services and coordinating those interventions and recommendations for follow-up care with the AMHD Court-based Clinician and/or AMHD-funded Case Management providers/Community Mental Health Centers.	$225,680
AMHD: Crisis Services	Release on Recognizance Pilot Project: To encourage release on recognizance for AMHD consumers who have been arrested on Petty Misdemeanor and non-violent Misdemeanor charges and placed at the CRD. A Certified Peer Specialist will be assigned to the case to ensure that the consumer has the support necessary to make it to their court hearing, including providing assistance in transportation to and from court and support during the hearing. Additional case management units (up to a maximum of 12) will also be made available, upon request, in order to ensure that case management has	$209,771

PROJECT	SERVICE	BLOCK GRANT AMOUNT
	an appropriate and necessary amount of time available to assist the consumer in the process of remaining in the community, including finding alternative shelter, treatment options, and supports necessary to comply with any court orders associated with the most recent arrest and to avoid additional incarceration(s)..	
AMHD: Continuity of Care Office	Tobacco Prevention and Education Program: Primary goal of this project is to demonstrate how quitting tobacco can improve health outcomes on a short-and long-term basis. Secondary goals of this project are to (a) demonstrate the ability to engage AMHD consumers in a community-based tobacco cessation program that targets whole body wellness (psychiatric and physical health), (b) complete a tobacco assessment, and (c) provide a basis for future recommendation for implementation of a statewide AMHD quit program.	$50,000
AMHD: Community Mental Health Center System Administration	The goal of this proposal is to maintain successful community tenure for Forensic Assertive Community Treatment (FACT) level of care forensic consumers that cannot otherwise successfully integrate and benefit from established community programs and services. This goal will be achieved by 1) establishing a pilot FACT team on Oahu within the CMHC System, 2) establishing unique eligibility criteria for the FACT level of care, 3) providing integrated mental health services while incorporating partnerships with officers of the court, public safety, probation officers and purchase of service providers, 4) incorporating best practice techniques adapted to fit the cognitive needs, addiction treatment needs and criminogenic behavioral patterns of the specified population, i.e. Licensed Specialized Residential, Structured 24-hour supervised housing, transitional Living Program housing and programming for individuals with neuro-cognitive disorders for medical co-morbidities and substance abuse programming 5) obtain outcome measures for further evaluation of FACT program and treatment modalities for effectiveness and efficacy.	$105,788
AMHD: Forensic Services	Forensic Examiner Training: Proposal will fund training for forensic examiners, such that attendees are able to complete reliable valid forensic evaluations in a uniform way, while incorporating minimum standards and evidence-based practices. AMHD has made a commitment to increase the standards of forensic examiners statewide. Proposed trainings to either become or continue as a "certified" examiner.	$21,000
AMHD: Forensic Services	Sequential Intercept Model Research Project: Continue research and data entry across a number of areas in forensic mental health, with an emphasis on AMHD forensic program utilization and outcomes. Two half-time research assistants will continue ongoing projects and monitor the effectiveness of the three administrative bills submitted during the last legislative session that became law – Act 53, 99 and 112.	$24,300

PROJECT	SERVICE	BLOCK GRANT AMOUNT
AMHD: Forensic Services	2011 Mental Health Legislation Transition Project: Two legislative bills in 2011 that became law pertained to misdemeanor offenders only. At the end of these time limits, the majority of these individual will become free of their legal encumbrances including court-mandated mental health treatment to voluntary treatment. To mitigate against negative outcomes, this project will monitor affected persons who are at higher risk for clinical decompensation and/or contact with the criminal justice system.	$58,000
GRAND TOTAL: AMHD Fund Allotment		**$1,148,089**
FY2010 Hawai`i MHBG Fund Allotment		**$1,952,865**

NEIL ABERCROMBIE
GOVERNOR

KATHRYN S. MATAYOSHI
SUPERINTENDENT

STATE OF HAWAI'I
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAI'I 96804

OFFICE OF CURRICULUM, INSTRUCTION AND STUDENT SUPPORT

August 22, 2011

To Whom It May Concern

As the Administrator of Special Education in the state of Hawaii, I want to express my support for continuation of the Block Grant to the Child and Adolescent Mental Health Division of the Department of Health. We are working collaboratively with CAMHD to develop programming for children that have special educational needs as well as behavioral problems.

The block grant funds have been used to increase services to at risk youth who are homeless or transitioning to adulthood. Funds have been used to assist adolescents with continuing their educational and vocational efforts. Please allow our continuing efforts that have been built upon Block Grant funding.

Sincerely,

Debra Farmer

Debra Farmer, Administrator
Special Education Section
Hawaii State Department of Education

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First Judicial Circuit — Girls Court — THE JUDICIARY • STATE OF HAWAI'I
777 PUNCHBOWL STREET • HONOLULU, HAWAI'I 96813 • TELEPHONE (808) 534-6150 • FAX (808) 534-6161

August 22, 2011

To Whom It May Concern:

This letter is to strongly urge that Block Grant funds continue to support the collaboration between the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii State Department of Health and Family Court.

As the founding Judge of the Hawaii Girls Court, I cannot say enough about the importance of addressing the mental health issues of juveniles and their families who appear before Family Court. Girls Court was developed by the Family Court of the First Circuit to address the unique pathways to the juvenile justice system for our at risk adolescent girls in light of high increases in the arrest rates for girls. See www.girlscourt.org. Working with CAMHD has been important for us to understand the necessity of trauma informed care and to provide good services for the girls who come before us.

The funds provided by the SAMHSA Block Grant have been used to support group programming for girls who are referred to the Girl's Court. Our results show that this collaboration has been very vital to the girls in our community. It has resulted in not only a reduction in law violations, but also a reduction drug use, cutting and other trauma related symptoms, as well as a return to school or employment and establishing healthy relationships with family and community.

Recently there have been even closer ties developing between CAMHD and the Girl's Court through the Block Grant funds of our most recent System of Care grants, Project Kealahou. This dynamic new program targets traumatized females ages 11 - 21.

We strongly urge that Block Grant funds continue to support the important collaboration efforts being conducted between CAMHD and the Girl's Court.

Very truly yours,

Karen M. Radius
Founding Judge
Hawaii Girls Court

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NEIL ABERCROMBIE
GOVERNOR

KATHRYN S. MATAYOSHI
SUPERINTENDENT

STATE OF HAWAI'I
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAI'I 96804

OFFICE OF CURRICULUM, INSTRUCTION AND STUDENT SUPPORT

Monday, August 22, 2011

To Whom It May Concern:

As Program Manager for the School Based Behavioral Health (SBBH) program at the Hawai'i State Department of Education (DOE), I am writing to support the continued funding of the Block Grant for behavioral health services from the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health.

CAMHD provides services to youth whose level of severity necessitates programming outside the services offered within the school setting. Over the last few years, SBBH has worked closely with CAMHD to ensure many of the barriers that could limit intensive services for youth are overcome. Much of SBBH/CAMHD collaboration could be attributed to the ongoing funding support that comes from the CAMHD Block Grant.

The Block Grant is a resource from CAMHD that translates into a variety of services that include reaching geographically challenged rural and Neighbor Island locales where finding providers is a difficult task. Subsequently, services can be delivered through a teleconferencing and TeleHealth venue in hard to reach places where students and their families benefit from mental health consultation, services and support. The Block Grant also supports a unique integrated mental health program on Kauai that is jointly administered by CAMHD and the Hawai'i Department of Education.

The SBBH Program in the Hawaii DOE strongly urges the continuation of these grant funds to be given to CAMHD so that progress in collaborative programming for intensive behavioral health services can continue to move forward and benefit youth and families who need these resources.

Respectfully Submitted,

Kelly A. Stern
Program Manager
School Based Behavioral Health
Hawai'i State Department of Education

Family Court of the First Circuit — THE JUDICIARY • STATE OF HAWAI'I
RONALD T.Y. MOON KAPOLEI COURTHOUSE • 4675 KAPOLEI PARKWAY • KAPOLEI, HAWAI'I 96707-3272

R. MARK BROWNING
SENIOR JUDGE

JEANNETTE H. CASTAGNETTI
CIRCUIT COURT JUDGE

FA'AUUGA L. TO'OTO'O
CIRCUIT COURT JUDGE

DISTRICT FAMILY JUDGES
JENNIFER L. CHING
SHERRI L. IHA
LANSON K. KUPAU
CHRISTINE E. KURIYAMA
PAUL T. MURAKAMI
STEVEN M. NAKASHIMA
CATHERINE H. REMIGIO
BODE A. UALE
MATTHEW J. VIOLA

August 23, 2011

To Whom It May Concern:

For several years, the SAMHSA Block Grant awarded to the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health here in Hawaii has generously supported the Juvenile Drug Court and Family Court through two separate projects. Some of these funds have purchased psychological assessments for youth that are used by judges in evaluating cases before them.

Family Court not only support the efforts of CAMHD to continue to work closely with us, but we also feel that the services rendered under these agreements contribute to more sensitive handling of individual cases.

We therefore strongly support a continuation of the Block Grant assistance to youth in these two court systems.

Thank you,

R. Mark Browning
Senior Judge, Family Court
First Circuit, State of Hawaii

DEPARTMENT OF VETERANS AFFAIRS
PACIFIC ISLANDS HEALTH CARE SYSTEM
Spark M. Matsunaga Medical Center
459 Patterson Road
Honolulu HI 96819-1522

In Reply Refer
459/116

August 31, 2011

To Whom It May Concern:

The Mental Health Services of the Department of Veterans Affairs, VA Pacific Islands Health Care System, has had a collaborative relationship with the Department of Health, Adult Mental Health Division (AMHD) for the past several years, and has worked closely in providing mental health services to consumers living with severe and persistent mental illness.

I am writing in support of the AMHD receiving the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) Mental Health Block Grant funds to continue the vital work they provide in the community. With the downturn of the economy, the state has had to do more with less, and these funds will enable the AMHD to provide community supports, treatment and crisis services, and outreach to our homeless population.

Therefore, the VA Pacific Islands Health Care System urges the continuation of the CMHS Mental Health Block Grant funds and looks forward to continuing our partnership in providing consumer services and supports in their recovery.

Sincerely,

David M. Bernstein, M.D.
Associate Chief of Staff, Mental Health Services

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LORETTA FUDDY, ACSW, MPH
DIRECTOR OF HEALTH

STATE OF HAWAII
EXECUTIVE OFFICE ON AGING
NO. 1 CAPITOL DISTRICT
250 SOUTH HOTEL STREET, SUITE 406
HONOLULU, HAWAII 96813-2831

WESLEY LUM, PhD, MPH
DIRECTOR

Telephone
(808) 586-0100

Fax
(808) 586-0185

August 31, 2011

To Whom It May Concern:

The Executive Office on Aging (EOA) offers our strongest support and encouragement for the Department of Health, Adult Mental Health Division's (AMHD) application for the Substance Abuse and Mental Health Services Administration FY2012 Block Grant.

EOA has worked in the geriatric mental health field in Hawai`i and has collaborated with AMHD in several capacities, most recently through a project relating to depression among older adults and their family caregivers, the Geriatric Mental Health Hui, and the Statewide Task Force on Alzheimer's Disease and Related Dementias.

Additionally, EOA wishes to emphasize our full support of AMHD by:

- Continuing collaboration in supporting and expanding recovery oriented consumer delivered services for the severe and persistent mental illness population, and
- The integration of physical and behavioral health services to the SPMI population.

Please accept this letter as our commitment to working with the AMHD to bring about a system that embraces health care reform, particularly for Hawaii's older adults and their family caregivers.

Should you have any questions, please feel free to contact me at 808-586-0100 or at wesley.lum@doh.hawaii.gov.

Sincerely,

Wesley Lum, PhD, MPH
Director

Table 3: Prioritizing AMHD Planning Activities

PRIORITY	GOAL	STRATEGY	PERFORMANCE INDICATOR	DESCRIPTION OF COLLECTING & MEASURING CHANGES
Trauma	Integrate the Trauma Informed Care philosophy for AMHD consumers, providers and staff.	• Provide training and education on trauma and trauma informed care for AMHD staff and stakeholders. • Expand the TIC initiative to military and their dependents specifically in the area of PTSD and TBI.	• Train 50% of consumers in trauma support services. • Train 70% providers in trauma informed care. • Increase the number of Military announcements re: trauma trainings by 100%.	• MISA Service Director will track the number of trainings and analyze the Pre and Post test survey results.
Health Integration	Strengthen the CMHC system primary care knowledge base, and increase the integration of behavioral health and primary care.	• Provide training for CMHC clinical staff to ensure the integration of behavioral health and primary care.	• 85% of consumer charts will contain documentation on assessment of primary care health needs and integration with primary care.	• The Community Mental Health Center System Administration will track outcomes based on record review monitoring.
Public Awareness and Support	Increase public awareness and reduce stigma in the community.	• Reduce stigma within the different role groups: indigenous groups, the LBGTQ group, and the law enforcement community. • Implement internet/online resources where family, friends and the community can access information regarding obtaining an assessment, etc. • Advertise the benefits of using the Network of Care (NOC) online website.	• Train 50% of law enforcement personnel statewide. • Increase the number of consumers involved in the Speakers Bureau by county, to increase public awareness and reduce stigma by 50%.	• Provider Survey Results • MHSIP Survey Results • Track the number of consumers trained in the Speakers Bureau. • Track the number of speaking engagements. • Track the number of community members reached through the speaking engagements. • Track the number of CFY Hui members by county that

PRIORITY	GOAL	STRATEGY	PERFORMANCE INDICATOR	DESCRIPTION OF COLLECTING & MEASURING CHANGES
				attended and spoke at Health Fairs. • Track the number of hits that the NOC received in Hawai`i • Collect feedback from the Chief's Consumer Roundtable meetings.
Health Information Technology	Increase the use of Interactive Communication Technology to promote recovery.	• Increase the number of consumers using Telepsychiatry technology in rural areas. • Increase the number of providers using web-based application for authorization of services.	• Establish technology and resources for Telepsychiatry technology in rural areas. • Establish baseline for utilization during a 6 month period in rural areas (October 1, 2011 to March 30, 2012). • Develop plan to increase utilization. • Increase the number of providers using web-based application for authorization of services by 90%.	• Provider Survey Results • Track the number of consumers using the Telepsychiatry technology in rural areas. • Track the number of providers using web-based application for authorization of services. • Collect feedback from the Chief's Consumer Roundtables.
Housing	Promote independent living for consumers.	• Decrease the length of stay in 24-hour group homes statewide. • Improve AMHD's management of housing resources to ensure consumers are transitioning appropriately through the housing continuum of care. • Develop appropriate step-down services from 24-hour group homes.	• Increase the number of consumers served in semi-independent housing by 50%. • Increase the number of eARCH beds by 20%. • Utilization management (UM) to complete 50% chart reviews to ensure	• Tally the number of UM chart reviews quarterly. • Tally the number of eARCH beds quarterly. • Track the number of chronically homeless consumers transitioned into housing within the next 6 months.

PRIORITY	GOAL	STRATEGY	PERFORMANCE INDICATOR	DESCRIPTION OF COLLECTING & MEASURING CHANGES
		• Work with Federal partners to expand the use of proven models (i.e. SOAR)	consumers are in the appropriate level of housing.	• URS tables – Living Situation
Peer Specialists	Develop, train and sustain peer specialists in the workforce.	• Strengthen the sustainability of the certified peer specialist by receiving reimbursement from Medicaid Rehab Option (MRO). • Provide supports for certified peer specialists while they are employed. • Educate staff (CMHC and POS providers) on the educational curriculum and role of a certified peer specialist, before internship placement and hiring into permanent positions.	• Increase the number of working peer specialists by 100%. • Place 75% of newly certified peer specialists in the workforce. • 100% of potential employers will be trained on the role of certified peer specialists.	• Office of Consumer Affairs (OCA) to track the number of trainings completed for peer specialists. • OCA to track the number of staff & provider trainings. • OCA to track the number of certified peer specialists placed in jobs. • URS tables – Supported Employment

Hawaii Injury Prevention Plan 2005–2010

Injury Prevention
Advisory Committee

Injury Prevention and
Control Program

Injury Prevention and Control Program
Hawaii State Department of Health

Hawaii Injury Prevention Plan 2005–2010

Injury Prevention Advisory Committee

Injury Prevention and Control Program
Hawaii State Department of Health

Injury Prevention and Control Program
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July 2005

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Dear Community Colleagues,

We are pleased to present you with the Hawaii Injury Prevention Plan, a call to action to the people of Hawaii to improve our health status in eight injury areas by 2010. It is the product of one and a half years of collaborative work by members of the Injury Prevention Advisory Committee (IPAC), staff of the Department of Health's Injury Prevention and Control Program (IPCP), and people having specialized or related injury expertise from other organizations and the community-at-large.

As a community, we can reduce our toll of needless injury-related deaths and disabilities. To do so, we must change the public's perception of injuries as being "accidents" caused by chance or carelessness, to one in which injuries are viewed as preventable events. Much can be done to alter the dire outcomes that we see in injury statistics today.

The Hawaii Injury Prevention Plan is intended to be a living document that will stimulate action to meet this challenge. While responsibility to facilitate and monitor the implementation of plan recommendations rests with IPCP and IPAC, it is the commitment and active participation of each of you within our diverse community—medical, health, safety and legal professionals; community activists; policy makers; community organizations; government agencies; and businesses—that will determine the extent to which we succeed.

On behalf of the Injury Prevention Advisory Committee and the State Department of Health, we invite you to join us in achieving the recommendations set forth in this plan. By working together we can accomplish what none of us can alone.

Bruce McEwan, Ph.D.
Chair
Injury Prevention Advisory Committee

Chioyme Leinaala Fukino, M.D.
Director of Health
Hawaii State Department of Health

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 239 of 285

Introduction

Injury In Hawaii - A Public Health Priority

Injuries are responsible for more deaths of children and young adults from the first year of life through age 39 than all other causes combined, including heart disease, stroke and cancer. Among all ages, injury is the fourth leading cause of death and disability. Although the greatest impact of injury is in human suffering, the financial cost is staggering. In Hawaii, injury-related hospitalizations cost an estimated $340 million annually.

Mortality statistics, however, do not convey the full extent of the injury problem. Fatal injuries represent less than 0.8% of all injuries requiring medical attention. Although fatal injuries are the most severe, the vast majority of injuries are non-fatal, and in some respects, have much greater public health implications. On an average week in Hawaii 11 residents die from an injury, 160 are hospitalized and nearly 1200 more are treated in emergency departments.

Injuries, however, are not "accidents." They are neither random nor uncontrollable. Injuries are understandable, predictable and preventable. The first step in understanding and preventing injuries is to collect and analyze data. Through epidemiological study, we can answer questions such as, "How serious is Hawaii's injury problem? Who are most affected by injuries?" and, "What are the circumstances under which these injuries occur?" This information can lead to answering other important questions, such as "What causes injuries?" and "How can they be prevented?"

The terms "intentional" and "unintentional" are used in this plan to indicate whether or not the act or event was intended to harm a person. Unintentional injuries are commonly referred to as "accidents" (for example, falls, drownings, poisonings, and injuries to pedestrians, motor vehicle occupants, and motorcyclists). Intentional injuries are purposefully inflicted on others (assaults) or oneself (suicide attempts).

Ten leading causes of death among Hawaii residents, by age group, 2000-2004[1]

	<1 year	1-14 years	15-24 years	25-34 years	35-44 years	45-54 years	55-46 years	65+ years	All ages
1	Perinatal conditions 315	Unintentional injuries 49	Unintentional injuries 236	Unintentional injuries 163	Malignant neoplasm 292	Malignant neoplasm 951	Malignant neoplasm 1,649	Heart disease 9,581	Heart disease 11,927
2	Congenital anomalies 85	Malignant neoplasm 28	Suicide 77	Suicide 110	Heart disease 264	Heart disease 753	Heart disease 1,200	Malignant neoplasm 6,926	Malignant neoplasm 9,970
3	SIDS[2] 40	Congenital anomalies 16	Malignant neoplasm 30	Malignant neoplasm 94	Unintentional injuries 249	Unintentional injuries 269	CVD[3] 236	CVD 3,256	CVD 3,742
4	Unintentional injuries 25	Homicide 11	Heart disease 28	Heart disease 75	Suicide 123	CVD 156	Unintentional injuries 167	Chronic lower resp. diseases 1,191	Unintentional injuries 1,857
5	Heart disease 19	Suicide 8	Homicide 12	Homicide 23	CVD 76	Suicide 140	Diabetes mellitus 167	Influenza and pneumonia 1,021	Chronic lower resp. diseases 1,398
6	Influenza and pneumonia 11	Heart disease 7	Injuries of unk. intent 12	Injuries of unk. intent 14	Homicide 46	Liver disease and cirrhosis 109	Chronic lower resp. diseases 131	Diabetes mellitus 700	Influenza and pneumonia 1,133
7	Septicemia 9	Septicemia 6	Congenital anomalies 10	CVD 11	Injuries of unk. intent 38	Injuries of unk. intent 69	Septicemia 95	Unintentional injuries 699	Diabetes mellitus 962
8	Homicide 8	Influenza and pneumonia 6	Septicemia 4	Diabetes mellitus 11	Liver disease and cirrhosis 26	Diabetes mellitus 67	Liver disease and cirrhosis 81	Alzheimer's disease 696	Septicemia 773
9	Injuries of unk. intent 8	Injuries of unk. intent 4	Other circ. diseases 3	Other resp. diseases 6	Other circ. diseases 18	Septicemia 61	Nephritis, nephrotic synd. 77	Septicemia 575	Alzheimer's disease 706
10	Other resp. diseases 7	Perinatal conditions 3	Chronic lower resp. diseases 3	Other circ. diseases 6	Septicemia 17	Chronic lower resp. diseases 51	Suicide 70	Other resp. diseases 538	Nephritis, nephrotic synd. 651

[1]Deaths grouped as recommended by National Center for Health Statistics (http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_15.pdf).

[2]Sudden Infant Death Syndrome.

[3]Cardiovascular Disease.

Leading Causes of Injury Mortality and Morbidity among Hawaii residents[1]

	Death Certificates (fatal)			**Hospital Admission Records** (non-fatal)			**Emergency Department Records** (non-fatal)		
	Cause	%	No.[2]	Cause	%	No.[3]	Cause	%	No.[4]
1	Suicide	22%	127	Falls	42%	3,616	Falls	26%	15,866
2	Falls	14%	78	Car occupant	10%	886	Striking[6]	15%	9,231
3	Car occupant	13%	75	Suicide attempt	10%	846	Cut/pierce	16%	7,153
4	Poisoning	9%	53	Assault	5%	420	Car occupant	9%	5,358
5	Drowning	5%	30	Striking[5]	4%	350	Overexertion	8%	4,692
6	Assault	5%	30	Motorcyclist	4%	338	Natural/ environmental[7]	6%	3,582
7	Pedestrian	5%	30	Poisoning	4%	300	Assault	5%	3,194
8	Suffocation	5%	28	Pedestrian	2%	168	Bicyclist	2%	1,155
9	Motorcyclist	4%	22	Cut/pierce	2%	159	Fire/burn	1%	905
10	Bicyclist	1%	6	Bicyclist	2%	148	Motorcyclist	1%	835
	All other	16%	87	*All other*	15%	1,293	*All other*	16%	9,802
	Annual total	100%	566	**Annual total**	100%	8,525	**Annual total**	100%	61,773

[1] Non-residents comprise 12% of the victims killed by injuries in the state, 9% of those hospitalized, and 10% of those treated in emergency departments.

[2] Annual number of deaths, from 2000-2004 death certificates. For underlying cause of death in the ICD-10 code series: V01-Y36, Y85-Y87, Y89, and U01-U03.

[3] Number of injury-related hospitalizations, from 2003 records. For any-priority diagnosis in ICD-9CM code series: 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85. Since only 81% of these records contain external cause codes, these estimates are extrapolated from the known number of injury-related hospitalizations.

[4] Number of injury-related ED visits, from 2002 records. For any-priority diagnosis in ICD-9CM code series: 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85. Since only 83% of these records contain external cause codes, these estimates are extrapolated from the known number of injury-related ED visits.

[5] Most (92%) of these patients were "struck accidentally by objects or persons"; the rest (8%) were"struck accidentally by falling object". Of the former, the most commonly specified causes were "struck…in sports" (21%), and "struck…in running water" (6%).

[6] Most (90%) of these patients were "struck accidentally by objects or persons"; the rest (10%) were"struck accidentally by falling object". Of the former, the most commonly specified causes were "struck…in sports" (21%), and "struck…by furniture" (2%).

[7] Most (97%) of these visits were related to the bites or venom of animals, most specifically dog bites (28%), bee and wasp stings (17%), centipedes (16%) and venomous marine animals (5%).

Background

In June 2002, the Injury Prevention Advisory Committee (IPAC) called for a "… strategic plan [that] will help IPAC and IPCP in its next phase of development, i.e., to identify and prioritize key areas of injury …" (*Injury Prevention in Hawaii: Status and Progress Review*). Soon thereafter, in October of that year, the Department of Health's Injury Prevention and Control Program (IPCP) received a Core State Injury Surveillance and Program Development capacity building grant from the Centers for Disease Control and Prevention (CDC) supporting the development of a five-year state injury prevention plan. And in June 2003, an assessment of injury prevention efforts in Hawaii by the State and Territorial Injury Prevention Directors Association (STIPDA) further confirmed the need for a statewide plan.

This document is the resulting Hawaii Injury Prevention Plan (HIPP), a collaborative effort spearheaded by IPAC and IPCP. Goals are to provide:

- Overall direction and focus to IPCP and IPAC-led efforts in the next five years; and
- A stimulus for organizations, agencies and community groups to collaborate on reducing or preventing injuries in Hawaii.

A Community Planning Process

In June 2003, the IPAC Steering Committee laid the groundwork for the state plan by calling for strategy development around the eight (8) leading causes of injury morbidity and mortality in Hawaii, namely:

- Drowning and other water related injuries
- Falls
- Motorcycle injuries
- Motor vehicle occupant injuries
- Pedestrian injuries
- Poisoning
- Suicide
- Violence and abuse

A section on institutional recommendations was included to address the injury prevention infrastructure in Hawaii and overlapping strategies of multiple workgroups.

The eight workgroups consisted of IPAC members and staff from several Department of Health (DOH) programs. In addition, people having specialized or related injury expertise from other organizations and the community-at-large were invited to participate, thereby broadening representation and, hopefully, increasing stakeholder investment and commitment toward implementation of the injury prevention plan. (See Acknowledgements section for listing.)

The IPAC Steering Committee was tasked with developing the plan's institutional recommendations based on its understanding of Hawaii's injury prevention infrastructure and in light of STIPDA's recommendations for model standards of a comprehensive state injury prevention program (*State Technical Assessment Team, State Guide & Materials*). The Committee also reviewed the deliberations of all workgroups and identified crosscutting strategies that would support the progress of multiple workgroups.

In September 2003, prior to the start of plan meetings, workgroup facilitators and IPCP staff participated in a 4-hour training session to achieve a level of consistency in the reporting among all groups.

On January 23, 2004, a Hawaii Injury Prevention Plan (HIPP) kick-off meeting set the stage for community plan development. The meeting was attended by 50 people who had been invited to participate in any of the eight workgroups formulated to address a leading cause of injury morbidity/mortality. Attendees were IPAC members as well as those having injury-specific concerns from related programs, organizations and the community. Dr. Linda Rosen, Deputy Director of Health, welcomed the participants and emphasized the importance of the state plan and its designated process of people working together toward developing and achieving statewide recommendations. The IPCP epidemiologist gave an overview of statewide injury data and the IPCP manager described the steps in which workgroups would develop key injury prevention strategies.

During the next six months, from January through June 2004, the eight injury area workgroups held three meetings each to develop and prioritize their respective draft recommendations. The groups proceeded along the following format: Meeting 1 - Data Presentation and Target Population Discussion, Meeting 2 – Issues Discussion and Strategy Brainstorming, Meeting 3 - Priority Setting and Selection of Strategy Recommendations. A decision matrix was used by some groups to prioritize their top three or four recommendations. At the first meeting of each workgroup, the epidemiologist provided information and data specific to their injury focus. The presentation included data from death certificates, hospital discharge records, and supplementary sources, such as Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), and State Department of Transportation (DOT) observational surveys. Information packets, including injury fact sheets, were also distributed.

On August 13, 2004, IPAC and IPCP hosted a report-back meeting for workgroup participants to present the first draft of the recommendations and to solicit input on the final process of unveiling the Hawaii Injury Prevention Plan. At this meeting, Deputy Director of Health Dr. Linda Rosen highlighted the progress made in developing the HIPP over the 6-month period and the significance of the community-based planning approach. In addition, workgroup members presented their findings and the IPCP manager led a discussion on “Moving HIPP Forward.”

Injury Prevention Advisory Committee

The Injury Prevention Advisory Committee (IPAC) marks its beginning from the task force appointed in 1984 by the Director of Health to determine how Hawaii could achieve its 1990 health objectives in injury prevention and control. The 1984 task force strongly recommended that Hawaii establish a state focal point for injury prevention. This led to the establishment of the Injury Prevention and Control Program in the state health department. IPAC has continued over the years to retain an advisory relationship to IPCP and to call attention to areas in which Hawaii can reduce injuries from occurring. It has served as a forum for convening those who are interested in joining a network committed to making impact in injury prevention.

IPAC’s Mission: To build and sustain a sound focal point and base for injury prevention activities in the state and to guide and monitor the development of state and community-based injury and violence prevention initiatives in Hawaii.

Injury Prevention And Control Program

In 1989, the Injury Prevention and Control Program (IPCP) was established by the Department of Health as a state-level program to coordinate and support efforts by government, community and private organizations to reduce injury morbidity and mortality. Today, IPCP is the Department's focal point for injury prevention activities throughout Hawaii's communities.

IPCP is charged with addressing injury prevention among all age groups. The office is responsible for coordinating, planning, conducting and evaluating injury prevention interventions; policy development and advocacy; collecting, analyzing and disseminating injury data; and, technical support and training. These functions are recommended core components of a model comprehensive injury prevention program in a state health department (State and Territorial Injury Prevention Directors Association. *Safe States*).

Since its inception, IPCP has developed partnerships and worked successfully with community coalitions in advancing legislation, policy and educational measures to reduce unintentional and intentional injuries. IPCP uses a cost-effective approach by leveraging its own resources for maximum benefit--- that is, to harness and focus community resources on injury prevention.

Institutional Recommendations

Infrastructure

Stabilize IPCP funding and support expansion of injury prevention services to all counties throughout the state.

- **Stabilize funding for Core Injury Prevention and Control Program Positions**
- **Establish Suicide Prevention Coordinator**
- **Establish Neighbor Island positions**

Rationale: Infrastructure includes the people (dedicated staff and networks of partners), financial and other resources that support the injury prevention field. A solid infrastructure benefits the state by helping to reduce the burden of injury. "The strengthening of a well-developed injury program in the state health department is the foundation for state and local injury prevention efforts" (Institute Of Medicine. *Reducing the Burden of Injury*: *Advancing Prevention and Treatment*).

An organizational entity within the DOH having the responsibility and authority, as well as the ability to conduct injury surveillance and prevention programs is fundamental to public health efforts in Hawaii. The ongoing stability of this lead entity is crucial to providing a coordinated focus for injury prevention activities throughout the state.

According to the STIPDA, just as traditional "bricks-and-mortar" infrastructure supports roads and bridges, state injury prevention programs rely on a strong foundation of core capacity, leadership, and coordination (*Safe States, 2003)*. A solid infrastructure based on core funding provides focus and direction for the many aspects of an effective injury prevention program, and makes the best use of limited resources currently available. STIPDA recommends that key positions – in leadership, data collection and analysis, program development, evaluation, and education – be permanent positions (*Safe States, 2003)*. Soft funding or time limited funding causes problems of staff turnover and less continuity. Without stable funding, it is difficult to plan for the future, maintain needed programs, and recruit and retain talented staff needed to address injuries in Hawaii.

STIPDA and IPAC also recommended the establishment of a suicide prevention coordinator and an injury prevention coordinator position for each of the neighbor islands (*An Assessment of the Hawaii Injury Prevention and Control Program* and *Injury Prevention in Hawaii: Status and Progress Review*). Suicide, the leading cause of injury death in Hawaii, exacts an enormous toll from Hawaii's people. The devastating trauma, loss and suffering are multiplied in the lives of family members and friends. A suicide prevention coordinator position in IPCP would focus continued attention on this public health crisis and organize multidisciplinary support. The neighbor islands have fatal injury rates one-third higher than Oahu, yet they have no full time injury prevention personnel. To have a greater impact at the state level, it was recommended that IPCP establish dedicated injury prevention staff for each county.

Data Collection, Analysis And Dissemination

Establish standards for completeness and accuracy of external cause of injury coding (E-coding) for hospitals to achieve and maintain.

Rationale: This recommendation was in STIPDA's assessment of IPCP in 2003 and was strongly re-affirmed by all eight injury workgroups developing the state plan. The groups stated a need for complete and accurate morbidity data to get a better understanding of the nature and extent of the injury problem in their respective injury areas.

Accurate and timely data collection and dissemination provides the basis for tracking external causes, circumstances, and consequences of injuries. This is essential to sound program design and policy development. Data can be used to pinpoint emerging or significant injury problems or trends, understand risk factors, focus attention and resources, and design, monitor and evaluate interventions.

State health departments routinely collect accurate and timely mortality data from death certificates. However, deaths from injuries represent only a fraction of the total number of injuries and are just the tip of the iceberg. Data from hospital admissions and emergency department visits are the most comprehensive sources of non-fatal injury data. These data are critical to providing a more complete picture of injury in Hawaii.

Produce and disseminate annual and specialized injury reports.

Rationale: All workgroups stated the need for annual and specialized data reports to be available in user-friendly formats. This was also a STIPDA recommendation in their report, *An Assessment of the Hawaii Injury Prevention and Control Program, 2003*.

Intervention Design, Implementation And Evaluation

Incorporate injury prevention into Hawaii's Health Education Standards for grades K through 12.

Rationale: This recommendation was a common theme of many workgroups. It was identified as an effective strategy for instilling in children and adolescents injury prevention concepts and behaviors that can be carried into adulthood. Workgroup members recognized that to be effective in the schools, injury prevention education must be developed and taught as part of the Health Education Standards at every grade level.

According to the Council of Chief State School Officers, "Schools are society's vehicle for providing young people with the tools for successful adulthood. Perhaps no tool is more essential than good health." (Council of Chief State School Officers. *Beyond the Health Room*. Washington, DC. 1991). Schools can efficiently reach a majority of children and "teach students the skills needed to promote safety and prevent unintentional injuries, violence, and suicide while at home, at work, at play, in the community and throughout their lives." (Centers for Disease Control and Prevention. *School Health Guidelines to Prevent Unintentional Injuries and Violence*. Morbidity and Mortality Weekly Report [MMWR], 2001; 50, No. RR-22.).

Educational interventions do not often stand alone to be truly effective. According to CDC, effective school-based injury prevention efforts also address policies and procedures, staff development, the physical environment of the school, and the curriculum in a coordinated school health program (MMWR, 2001, No RR-22).

This recommendation is in line with the Healthy People 2010 objective (7.2 b-d) and follows one of the key CDC school health recommendations to prevent unintentional injuries, violence, and suicide; "Implement health and safety education curricula and instruction that help students develop the knowledge, attitudes, behavioral skills, and confidence needed to adopt and maintain safe lifestyles and to advocate for health and safety" (MMWR, 2001, 50, No. RR-22).

Technical Support And Training

Develop a cadre of individuals and organizations who are injury literate, articulate, and active.

Rationale: This recommendation addresses the need to develop: 1) the next generation of injury prevention practitioners and leaders and, 2) the capacity of organizations to incorporate injury prevention approaches within their organizations as well as to address injuries in the broader community.

Injury prevention is a relatively new field. It is critical to enlarge the pool of skilled, competent practitioners able to address the injury problem in Hawaii. Training and technical assistance is one way to enlarge this pool.

Because successful injury prevention strategies rely on collaboration among government agencies, community organizations, and businesses, it is necessary to develop competency in these sectors. Prevention and control efforts must continuously adapt to reflect the magnitude and complexity of injury in Hawaii. The public health approach to prevention is interdisciplinary in nature, that is, not working in isolation but with government agencies, the private sector, and communities through multifaceted strategies. By building solid ground for multidisciplinary collaboration, we can continue to develop the science and practice of injury prevention and make progress in reducing the burden of injury in Hawaii.

Public Policy

Cultivate awareness and advocacy among policy makers and the public in recognizing and addressing injuries as a major public health problem in Hawaii.

Rationale: According to the Institute of Medicine (IOM) report, "Both the general public and policy makers need information on the effectiveness of injury prevention measures in order to make informed decisions and choices" (*Reducing the Burden of Injury: Advancing Prevention and Treatment)*. The challenge is to increase public and legislative awareness of the scope of injury morbidity and mortality and the utility of potential interventions. For example, many people believe that injuries are "accidents" that just happen. This perception often precludes policy makers from identifying injury prevention as a discrete public health issue, limiting the earmarking of state and federal dollars for injury research as well as development of prevention

programs. Lack of awareness also limits support among legislators and the public for effective prevention legislation and injury prevention initiatives.

The IOM Report further indicates that public education and advocacy are key elements of modern public health practice at the state and community levels. Arousing public awareness and concern is vital to counteracting complacency or sluggishness in addressing the magnitude of our injury problem.

Sector Involvement

Foster partnerships with the military to address injury prevention issues in which the military can have impact.

Rationale: Fostering partnerships and collaboration with the military was discussed and strongly recommended in nearly all the workgroups as an important sector to include in statewide injury prevention efforts. Injuries are a significant health problem in the military, especially post 9/11 where they have impact on the availability of trained personnel and overall mission readiness. In addition, the military and their dependents comprise 8% of Hawaii's population (State Department of Business, Economic Development and Tourism (DBEDT). *The State of Hawaii Data Book 2003*), with nearly half (47%) of the active duty personnel 25 years of age or under (DBEDT web site – http://www.hawaii.gov/dbedt).

The workgroups felt that a close, collaborative relationship with the military would provide many advantages: gaining access to a wider population, combining different approaches and expertise, sharing relevant injury data, making better use of resources, and delivering more consistent messages and activities on- and off-base. Examples of large multi-agency collaborations are the "Click It Or Ticket" and impaired driving prevention statewide campaigns.

STIPDA has recognized the importance of coordination and collaboration as the hallmarks of a successful injury prevention program in their document *(Safe States, 2003)*. According to STIPDA, of all areas of public health, injury prevention stands out as the one that requires partnerships with the widest variety of non-health agencies and organizations. In fact, coordination and collaboration were considered so essential to every aspect of state injury prevention programs that STIPDA included it as part of each core component of a model state injury prevention program, rather than as a separate component *(Safe States, 2003)*. (In the earlier edition, *Safe States*, *1997*, coordination and collaboration were listed as a separate core component.) Workgroup members felt strongly that the military needs to be a partner in major injury prevention efforts in Hawaii, as have other entities, such as law enforcement, transportation, and insurance. A multidisciplinary approach to injury prevention is critical since it reflects the multiple, complex causes of injury – as well as the diverse, interrelated solutions that are needed *(Safe States, 2003)*.

Injury Specific Recommendations

Drowning and Other Water Related Injuries

Healthy People (HP) 2010 Objective: Reduce Drownings

	Baseline Rate*	Current Rate*	2010 Target*
National	**1.6 drownings** in 1998	**1.2 drownings** in 2002	**0.9 drownings** Method: better than the best.
Hawaii	**3.0 drownings** from 1996-2000 (average annual rate).	**2.4 drownings** from 2000-2004 (average annual rate).	**0.9 drownings** Method: meet national HP 2010 target.

* Resident deaths per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Minimize Risks Of Ocean And Freshwater Drowning

Develop a beach rating system, which includes comprehensive risk assessments for all beaches in the state.

Rationale: Lifeguard rescues on Oahu average approximately 1,500 per year. The most common reasons for these rescues are related to beach users' inappropriate skill levels.

A beach rating system, similar to the rating system of ski slopes, would be a standardized method of communicating risk to beach users. Such a rating system would allow beach users to choose beaches and activities appropriate to their skill level.

Currently, no objective rating system of the beach and its waters exist. While the use of a rating system for ski slopes has been universally established, Hawaii would be the first location in the U.S. and internationally to field-test this strategy. A beach rating system could also be used in determining needed resources and the deployment of lifeguards to maintain safety for all beach users.

Evaluate existing and promising programs, curriculum and activities to determine their effectiveness in preventing drownings and other water related injuries and to appropriately allocate limited resources

Rationale: Preventing swimming-related ocean drowning and near drowning in natural bodies of water is particularly challenging because few strategies for automatically protecting

swimmers are known. As an island state with an environment conducive to year-round ocean-related activities, Hawaii has an opportunity to provide a leadership role in the evaluation of current prevention efforts to determine their effectiveness and to allocate scarce resources.

While many strategies have been implemented in Hawaii to reduce drowning and other water-related injuries, but few have been evaluated. Strategies identified are: lifeguards at pools and oceans, Junior Lifeguards, the Hanauma Bay safety video, beach safety warning signs, and learn-to-swim programs. Of these, the Hanauma Bay educational intervention was determined to be a priority for evaluation. In addition, certain promising strategies warrant evaluation. These include the use of safety equipment, such as helmets for surfers, fins, and use of jet skis by lifeguards.

Minimize Risks Of Pool Drowning

Support mandatory 4-sided isolation fencing for residential pools.

Rationale: While constant adult supervision of young children in or around water is a key strategy in drowning prevention, supervision is an adjunct, not a substitute, for effective residential pool barriers.

Studies show that 4-sided isolation fencing for residential pools is effective in reducing pool drownings among young children because it restricts entry to the pool from the yard and residence. This barrier is especially important in preventing drowning injuries in young children that commonly occur when children can enter a pool without supervision. Currently, Hawaii has mandatory 3-sided fencing, which doesn't adequately prevent against unintended access to pools. In addition to four-sided isolation pool fencing, other barriers (e.g., automatic door locks and alarms, weight-bearing pool covers) can provide additional layers of protection in preventing drownings when lapses in supervision occur.

Conduct a coordinated educational campaign targeting residential pool owners and pool service providers to promote pool safety and the adoption of safety devices.

Rationale: Residential pool drownings are preventable. However, a gap exists between knowing what is effective and what is being implemented in the community. Most effective intervention strategies combine a strong community-based educational campaign promoting the use of pool barriers with legislative mandates and building codes or county ordinances.

Drowning and Near-Drowning Data

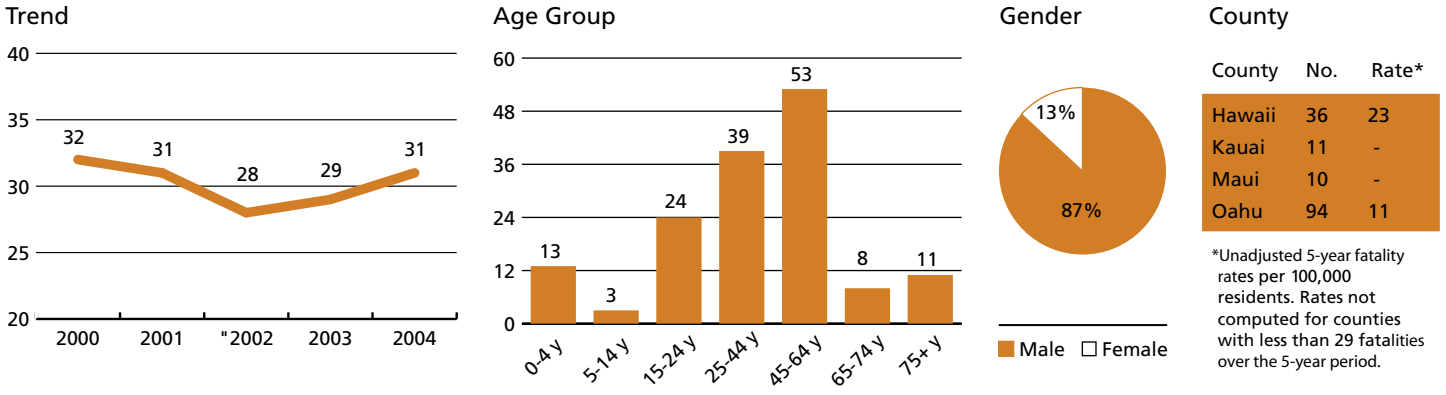
Overview of Drownings

Annual crude rate (1999-2002): 2.6 deaths per 100,000 residents (1.2/100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 2nd highest (AK highest: 4.0/100,000, NY lowest: 0.6/100,000)
Injury ranking in Hawaii (2000-2004): 5th leading cause of fatal injuries, 4th leading cause of unintentional injuries.

Hawaii had the 2nd highest resident drowning rate in the United States, a rate that was twice the average for the rest of the country. If drownings among non-residents were included, it

is possible that Hawaii would have the highest rate, as half (50%) of the victims were non-residents. An average of 30 residents drown each year. If non-residents are included, however, the annual total doubles to 60 victims per year, with a generally increasing trend over the 2000-2004 period. The ages of the victims were very broadly distributed, with no obvious high-risk range. Most (87%) were males. Hawaii County had twice the drowning rate of Oahu (23.1/100,000 residents vs. 10.5/100,000). There were too few deaths to compute rates for Kauai (11 deaths) and Maui counties (10).

Drownings
Hawaii Residents, 2000-2004



Contributing Factors

Over the 2000-2003 period, most (95 of 120, or 79%) of the resident victims drowned in the ocean or saltwater environments. Almost all (94%) were older than 18 years of age, and most (91%) were males. Unintentional immersions (e.g. boat crashes, being swept off rocks, etc.) led to 26% of the ocean drownings. The most common activities related to the drownings were swimming (16%), free diving (12%), and snorkeling (4%). (Victim activity was unknown for 31% of the cases.)

According to autopsy records (1996-2000), personal factors (unrelated to the ocean environment) probably or possibly contributed to almost half (44%) of the ocean drownings of residents off Oahu. Circulatory diseases, most commonly heart disease, caused or contributed to 16% of these drownings, 10% were alcohol related, 10% were drug related, and 5% were related to seizure disorders.

Seven (6%) of the 120 resident drownings over the 2000-2003 period were in swimming pools, including 2 victims who were 1 year-olds. There were also 8 drownings (5%) in freshwater environments, including 2 drownings in the Wailuku River near Hilo.

Near-Drownings

For every resident who drowns, there are approximately 2 near-drownings which require hospitalization, or about 60 per year, and another 504 residents who are treated in emergency departments (ED) for near-drownings each year. (These estimates are 185 hospitalizations and 1,009 ED visits per year if non-resident patients are included.) The highest annual rates for near-

drownings among residents were computed for 15 to 24 year-olds (8.2/10,000). Only 1% (6) of the patients were 65 years of age or older. Most (84%) of the patients were males.

Almost half (44%) of the swimming pool drowning and near-drownings that require an ambulance on Oahu are among children under 5 years of age. Of the 19 lifeguarded beaches on Oahu, Makapuu, Sandy, Waimea, and Hanauma were all in the top 5 for both the number and rate of rescues. Rescue rates differed by almost 20-fold across the beaches, and even more with certain beaches (e.g. Waimea) depending on the season, indicating risk of drowning differs greatly by beach and time of year. The characteristics of those rescued also varied by beach, for example, from mostly younger residents at Nanakuli, to mostly adult-aged non-residents at Hanauma Bay.

Falls

Healthy People 2010 Objective: Reduce Deaths From Falls

	Baseline Rate*	Current Rate*	2010 Target*
National	**4.7 deaths** in 1998.	**5.6 deaths** in 2002.	**3.0 deaths** Method: better than the best.
Hawaii	**5.4 deaths** from 1996-2000 (average annual rate).	**5.8 deaths** from 2000-2004 (average annual rate).	**3.0 deaths** Method: meet national HP 2010 target.

* Resident deaths per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Reduce The Number And Severity Of Falls Among The Elderly.

Enhance public awareness that falls are preventable and promote actions that reduce the risk of injury.

Rationale: National and Hawaii trends show a growing elderly population (65+). The risk and severity of injury due to falls rise significantly in this age group. Although falls can happen to everyone, the rate of injuries from falls among the elderly is vastly disproportionate to the rest of the population. For the elderly in Hawaii, both fatal and nonfatal falls have the biggest impact on death and disability among all injury areas.

A public awareness campaign will bring attention to the prevalence and serious nature of falls to the elderly. It is vital that everyone, especially the elderly, realize that they are susceptible to falls, that falls are preventable, and that steps can be taken to lessen risk and severity.

Seniors may be hindered from taking action to reduce their own risks of falling due to their perceived stigmatization of aging. The public awareness campaign must be sensitive to this concern and shaped accordingly.

Increase availability and accessibility of fall prevention programs statewide for caregivers and the elderly on how to prevent falls and effectively use community resources.

Rationale: Falls prevention programs such as home safety monitoring, exercise, balance/skills building, and medication management are effective in reducing the incidence and severity of falls among the elderly.

Although many programs already exist, they are unable to meet the demand for services, technical assistance, and funding statewide, especially in rural areas and the neighbor islands. Program availability in rural areas and the neighbor islands is often hampered by problems of accessibility. It is often difficult for those seeking services to travel vast distances to receive

them. Moreover, it is usually not cost effective to plan programs for a small number of people spread out over a broad geographic area.

The service providers in this workgroup strongly endorse services being brought to where seniors congregate (e.g., community centers, elderly housing, even McDonalds). By making falls prevention programs more available and accessible to seniors, their goal is to reduce the incidence and severity of falls.

Expand the role of medical and health care professionals in screening, educating, and referring elderly to fall prevention programs.

Rationale: Studies show that physicians play a critical role in preventing falls among the elderly. They are viewed as credible and reliable sources of health information and are influential in directing their patients to appropriate medical services.

Most older adults are not treated by someone versed in gerontology, hence primary care physicians serve as their central point for screening, education, and referrals on a variety of health concerns. Incorporating falls prevention education into a regular office visit would greatly increase the likelihood that patients who are at risk will receive needed services.

Those elderly who have fallen are 2-3 times are more likely to fall again. An affirmative answer to "have you fallen before?" will inform physicians and help them provide quality patient care.

Currently, many physicians and other health care professionals may need to be trained in screening, education, and referral for fall prevention. This is a promising intervention that could greatly decrease the impact of falls, especially among the elderly.

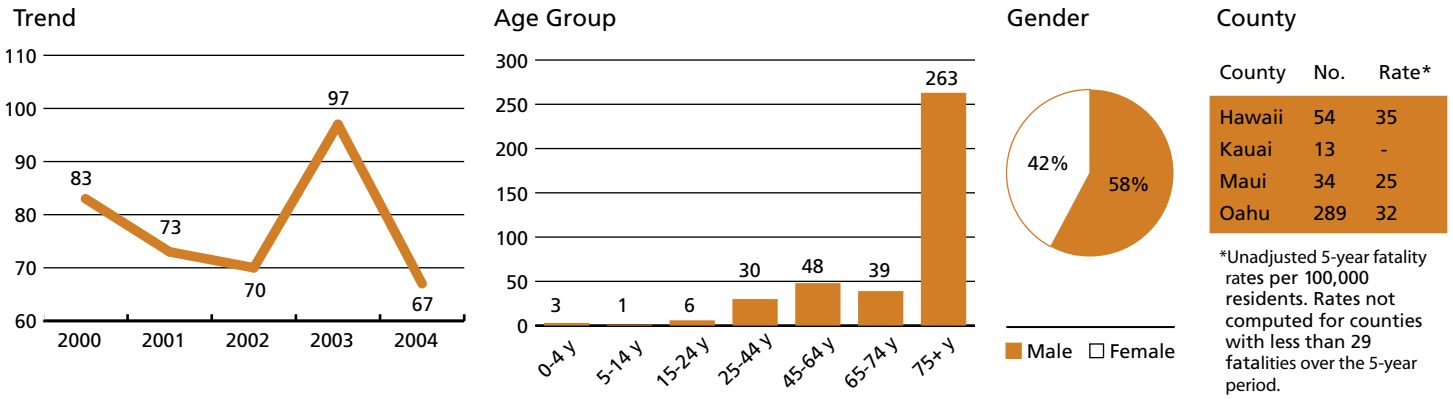
Falls Data

Overview of Fatal Injuries

Annual crude rate (1999-2002): 5.8 deaths per 100,000 residents (5.1/100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 23rd highest (WI highest: 12.2/100,000, AK lowest: 2.6/100,000)
Injury ranking in Hawaii (2000-2004): 2nd leading cause of fatal injuries, leading cause of unintentional injuries.

There was no trend in the annual number of fatal falls among residents, which averaged 78 per year. The 5-year total of 390 deaths made falls the leading cause of fatal unintentional injuries in Hawaii over 2000-2004. Most (77%) of the victims were aged 65 years or older, and the risk of falls increased dramatically with age from 65 years onward. Forty-two percent of the victims were females, the highest such proportion among the main injury categories. Gender was equally distributed (50% female, 50% male) among victims aged 65 years and older.

Deaths from Falls
Hawaii Residents, 2000-2004



Fatal Falls Among Seniors

Falls were by far the leading cause of fatal injuries among senior-aged residents in Hawaii, accounting for more than one-third (36%) of the total. Both the number and rate of fatal falls increased steadily across the older age range: 5-year rates among residents aged 85 and older were almost 15 times higher than rates among seniors aged 65-69 years (68/10,000 residents vs. 5/10,000). Rates among male seniors were higher than rates among female senior residents. Fatality rates among seniors were lowest for Kauai, although there were no significant differences between counties. Data on the cause of the fatal falls among seniors was of poor quality, as 42% were coded as "unspecified" causes. Over one-third (38%) of the deaths were due to falls "on the same level."

Non-Fatal Hospitalizations

For every senior resident who dies from a fall, there are an estimated 41 who require hospitalization for falls, which they ultimately survived, and another 60 who are treated in an emergency department. As with fatal falls, the number and rate of hospitalizations for falls increases dramatically with age over the senior age range. The distribution of gender is different, however, in that most (67%) of the patients are women. Forty-one percent of the patients suffered a fracture, most commonly fractures of the femur (14%). Hospital charges (not including physician charges) average almost $60 million a year in Hawaii, and 61% of that is paid by Medicare/Medicaid. One third (33%) of these non-fatal falls were "on the same level" from "slipping, tripping or stumbling." Sixteen percent were from "one level to another," most commonly from beds (4%), stairs or steps (3%), and chairs (2%). Almost half (45%) of the falls were due to "other" or "unspecified" causes.

Oahu EMS Data

EMS records were manually reviewed for more detail on the causes of falls among seniors. Although causes are probably multi-factorial in nature, an estimated 64% of the falls involved intrinsic, or personal, factors. Extrinsic, or environmental, factors were noted in about one-fourth (26%) of the EMS reports. The most common intrinsic factor was loss of balance, followed by transfer falls (mostly getting up from chairs, or out of beds). About three-fourths of the falls occurred in the home environment, most commonly the yard or other outside areas, or in bathrooms or bedrooms.

Motorcycle

Hawaii 2010 Objective: Reduce motorcycle rider fatalities

	Baseline Rate*	Current Rate*	2010 Target*
National	**0.9 deaths** in 1998.	**1.2 deaths** in 2002.	No comparable HP 2010 objective for motorcycle deaths
Hawaii	**1.5 deaths** from 1996-2000 (average annual rate).	**1.7 deaths** from 2000-2004 (average annual rate).	**0.9 deaths** Method: meet national baseline.

* Deaths (including non-residents) per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Increase Helmet Use

Advocate for a mandatory universal helmet use law.

Rationale: Helmet use is the most effective means of preventing death and reducing the severity of non-fatal head injury in motorcycle crashes. Despite this fact, helmet use in Hawaii continues to be lower than the national average: 43% in 2003 versus the national average of 58%.

Studies have shown that states that have passed mandatory helmet use laws have experienced decreases in death, disability, and cost resulting from motorcycle crashes. There are few laws as easy to implement and enforce, with minimal inconvenience and cost, with near 100% compliance, and which can have a tremendous impact on saving lives and preventing disability.

The policy debate is often based the issue of personal individual freedom versus public health and safety. To pass a helmet use law, it is critical to educate legislators and the public about the social and economic impacts of injuries to unhelmeted motorcyclists.

Reduce Alcohol Involvement In Motorcycle Crashes

Enhance and expand training of county police officers to recognize impaired motorcyclists.

Rationale: Alcohol is a major risk factor in motorcycle crashes. One-third (33%) of the drivers who died in motorcycles crashes were legally intoxicated; nearly half (44%) were reported to have some level of alcohol in their blood at the time of death (2000-2003). According to the UH Community Colleges' Motorcycle Safety Education Program, one reason impaired motorcyclists can often drive without being detected is that DUI recognition for a car driver is different from a motorcyclist. While police officers have been highly trained and successful in recognizing impaired car drivers, special training is needed to recognize impaired motorcycle riders.

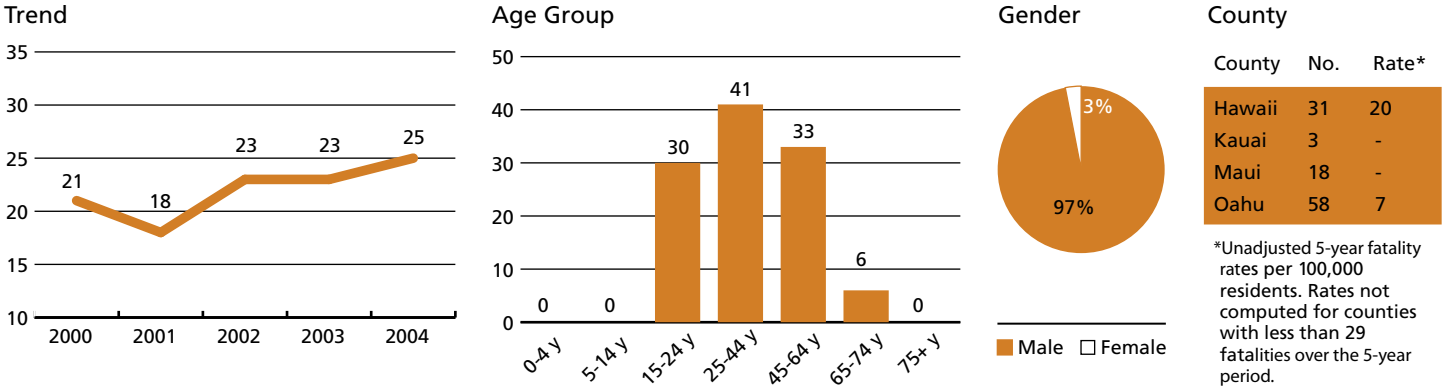
Motorcycle Crash Injury Data

Overview of Fatal Injuries

Annual crude rate (1999-2002): 1.4 deaths per 100,000 residents (1.0/100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 9th highest (SC highest: 1.8/100,000, ND lowest: 0.5/100,000)
Injury ranking in Hawaii (2000-2004): 9th leading cause of fatal injuries, 7th leading cause of unintentional injuries.

A total of 110 residents died from motorcycle crashes in Hawaii over the 2000-2004 period, with no apparent trend over those 5 years. Most of the fatally injured motorcyclists were young adult males; half (55) were males aged 21 to 40 years. Over half (58, or 53%) of the fatalities occurred on Oahu, but higher rates were computed for Hawaii County, whether adjusting for resident population or number of registered motorcycles.

Fatal Injuries to Motorcyclists
Hawaii Residents, 2000-2004



Contributing Factors

Alcohol was estimated to be involved in half (53%) of the fatalities over the 2000-2003 period (excluding the 24% of crashes for which alcohol status was not known.) Almost half (44%) of the fatally injured drivers were estimated to have been drinking before the crash, and one-third (33%) were estimated to have been legally drunk. Alcohol use was particularly common (55%) among drivers who crashed in the nighttime hours of 8:00 p.m. to 5:00 a.m. Only a minority (27%) of the drivers had been wearing helmets at the time of the crash. Almost half (47%) of the crashes did not involve another vehicle but were due to loss of control of the motorcycle. Speeding contributed to 31% of the fatal crashes. A high proportion (13%) of the victims were military personnel. Helmet use was more likely among military personnel than civilian riders (90% vs. 17%), but military personnel were more likely to have been speeding (60% vs. 26%). Alcohol use was comparable between the two groups.

Non-Fatal Hospitalizations

For every person killed in a motorcycle crash, there are an estimated 15 who are hospitalized for non-fatal injuries in Hawaii, and another 38 who are treated in emergency departments. As for fatal crashes, a large proportion (at least 37%) of crashes requiring hospitalizations did not involve another vehicle. About one-third (32%) were due to "loss of control" of the motorcycle. The age and gender distribution of the patients was similar to fatal crashes: half (52%) were between 21 and 40 years of age, and most (87%) were males. Almost one-fifth (18%) of the patients had a traumatic brain injury (TBI). According to Queen's Trauma Registry data, only 32% of the injured riders were wearing helmets. The incidence of TBI among non-helmeted riders was almost twice as high as among helmeted riders. Hospital charges totaled almost $11.4 million per year, an amount that would be approximately doubled if physician charges were included.

Other Data

From Oahu EMS data, the neighborhoods with the highest numbers of motorcycle crashes were Kalihi-Palama, Ala Moana, and the North Shore. Observational studies show helmet use was less than 50% in Hawaii for every year from 1999-2003, less than the national average of 58%. Helmet use is higher on Oahu (5-year average of 47%) compared to Neighbor Islands (28%), but is generally increasing in the latter.

Motor Vehicle Occupant

Hawaii 2010 Objective: Reduce motor vehicle occupant fatalities

	Baseline Rate*	Current Rate*	2010 Target*
National	**11.9 deaths** in 1998.	**11.7 deaths** in 2002.	No comparable HP 2010 objective for motor vehicle occupant deaths
Hawaii	**6.8 deaths** from 1996-2000 (average annual rate).	**6.2 deaths** from 2000-2004 (average annual rate).	**No more than 6.2 deaths**. Identify and reduce disparities among groups.

* Deaths (including non-residents) per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Increase Compliance With Traffic Safety Laws

Increase "high visibility enforcement efforts" of traffic safety laws and publicity of those efforts as a combined strategy.

Rationale: Periodic high visibility enforcement efforts combined with publicity of these efforts is a successful strategy in increasing compliance of traffic safety laws

"High visibility enforcement efforts" include checkpoints and saturation patrols. "Checkpoints" are places where visible enforcement officers are checking for specific violations (i.e. non-use of restraints or impaired driving). "Saturation patrols" are coordinated law enforcement efforts in locations known to have high concentrations of alcohol-related arrests, crashes, injuries or fatalities. The success of these visible enforcement efforts is dependent upon the public's advance knowledge of these efforts because it increases the perceived risk of receiving a ticket or being arrested. Therefore, publicity and media attention are critical prior to, during, and after enforcement activities. One example of a successful effort in Hawaii is the 2004 "Click It or Ticket" campaign, which resulted in Hawaii becoming the first state in the nation to reach 95% seat belt use.

The intent of this recommendation is to have government agencies, community groups, and businesses collaborate in publicizing their focused, visible, intentional enforcement efforts.

Strengthen Leadership In Traffic Safety Advocacy

Develop a statewide task force for traffic safety advocacy.

Rationale: The statewide task force will provide leadership in advocating for effective legislation to improve traffic safety. Other strategies that the task force may implement include: developing a statewide traffic safety action plan based on Hawaii data, developing a public awareness or media campaign, etc. Various representatives from state and county government, military, businesses, faith-based and other community groups are critical to the success of this task force

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in fostering leadership, commitment, and coordination of shared resources among task force members.

The workgroup intends for this taskforce to model the structure and functions of the former Governor's Task Force on Impaired Driving. The National Highway Traffic Safety Administration (NHTSA) supports traffic safety task forces in other states.

Decrease Fatalities In Teen Driver Crashes

Advocate for Graduated Driver's License System for Hawaii.

Rationale: NHTSA encourages states to implement a Graduated Driver Licensing System as a proven strategy to decrease fatalities in teen driver crashes. The highest rates of fatal and non-fatal crashes are among the 15-19 year olds. The problems contributing to high crash rates among young drivers are lack of driving experience and inadequate driving skills; excessive driving during night-time, high-risk hours; risk-taking behavior; poor driving judgment and decision making; drinking and driving; and distractions from other passengers. To address these factors, traffic safety researchers developed a licensing system that would prolong the learning process for young novice drivers. The system consists of three stages: learner's permit, intermediate (provisional) license and full licensure. Young drivers are required to demonstrate responsible driving behavior at each stage of licensing before advancing to the next level. It is a simple effective method that addresses this high-risk age group.

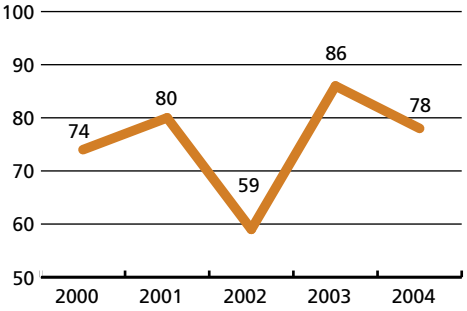
Motor Vehicle Occupant Injury Data

Overview of Fatal Injuries

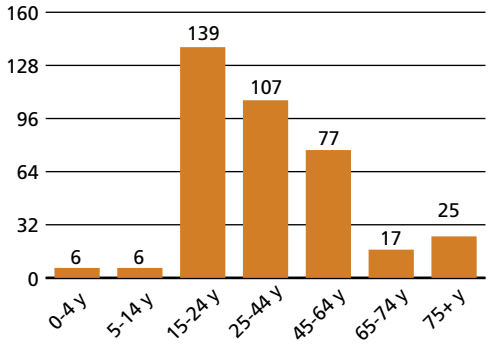
Annual crude rate (1999-2002): 3.1 deaths per 100,000 (6.9 per 100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 45th highest (MS highest: 24.8/100,000, CT lowest: 1.1/100,000)
Injury ranking in Hawaii (2000-2004): 3rd leading cause of fatal injuries, 2nd leading cause of unintentional injuries.

An average of 75 motor vehicle occupants were killed each year in Hawaii, with no significant trend over the 1998-2002 period. Almost half (44%) of the victims were in the 15-29 year age range, and the highest rates were computed for 15-19 year-olds (89 deaths/100,000 residents). Residents aged 14 years or younger had the lowest rates (5/100,000). Most (71%) of the victims were males, although women actually outnumbered men among victims who were 65 years of age or older (55% were women). Although almost half (49%) of the occupants were killed on Oahu, fatality rates were significantly higher for Neighbor Islands, particularly Hawaii County. The rate for Hawaii County was nearly twice that for Maui County, and more than three times the rate for Honolulu County.

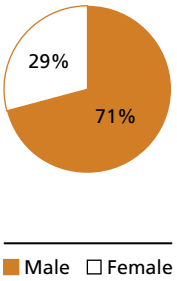
Trend



Age Group



Gender



County

County	No.	Rate*
Hawaii	114	73
Kauai	23	-
Maui	55	41
Oahu	185	21

*Unadjusted 5-year fatality rates per 100,000 residents. Rates not computed for counties with less than 29 fatalities over the 5-year period.

Contributing Factors

Impaired driving had a major role in Hawaii, as alcohol was estimated to be involved in over half (59%) of the fatalities over the 2000-2003 period, (excluding the 27% of crashes for which alcohol status was not known). That proportion is even higher for occupants killed during nighttime (71%) or on weekends (72%). Failure to use restraints was another important risk factor for fatal crashes, as more than half (56%) of all occupants killed in Hawaii were not wearing seatbelts at the time of the crash. Restraint use was particularly low among passengers (31%), and more specifically among backseat passengers (16%). There was also an association with alcohol use, as drivers who were estimated to have been drinking were nearly half as likely to have used seat belts compared to non-drinking drivers (38% vs. 64%). Nearly half (49%) of these fatal crashes involved speeding. That proportion was higher for crashes on Oahu (62%), compared to Neighbor Islands (36%). About half (53%) of these crashes involved only a single vehicle and were due to failure to keep in proper lane, running off the road, speeding, inattentiveness, or driver fatigue.

Non-Fatal Injuries

In Hawaii, for every fatally injured occupant, there are an estimated 12 who are hospitalized, and 71 more who are seen in emergency departments. Injuries were most common among 15-29 year-olds, with highest rates computed for 15-19 year-olds. Hospital charges totaled almost $31.7 million per year, an amount that would be approximately doubled if physician charges were included. An estimated 6,600 patients are treated by ambulance personnel each year in the state, and over 4,800 are transported to hospitals. From Oahu EMS data, the peak time for crashes was between 2:00 p.m. and 5:00 p.m. (27%). The neighborhoods with the highest numbers of injuries were by far Waipahu and Kalihi-Palama (more than 350 per year in each neighborhood). Waianae and Pearl City also had high numbers (more 250 per year in each neighborhood).

Risk Factor Data

According to DOT crash report data, drivers who are 15-18 years of age are at least 4 times more likely to be involved in a crash, compared to drivers 19 years of age and older. Crash rates among 15-18 year-old drivers decreased over the 1998-2001 period, however. According to observational studies in 2003, approximately 89% of front seat occupants in Hawaii use seatbeltsv, and that proportion is fairly constant across counties. Seat belt and car seat usage in Hawaii has increased in response to legislation.

Pedestrian

Healthy People 2010 Objective: Reduce Pedestrian Deaths

	Baseline Rate*	Current Rate*	2010 Target*
National	**1.9 pedestrian deaths** in 1998.	**1.7 pedestrian deaths** in 2002.	**1.0 pedestrian deaths** Method: 50% improvement.
Hawaii	**2.1 pedestrian deaths** from 1996-2000 (average annual rate).	**2.2 pedestrian deaths** from 2000-2004 (average annual rate).	**1.0 pedestrian deaths** Method: meet national HP 2010 target.

* Deaths (including non-residents) per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Create A Pedestrian Friendly Environment

Maintain and upgrade existing crosswalks and walkways; develop new crosswalks and walkways based on pedestrian safety factors such as location and condition.

Rationale: Modifying the physical environment is one of the most effective ways to increase safety for all road users. For both pedestrians and drivers, crosswalks and walkways need to be well maintained and upgraded, if necessary, so that they are clearly visible and well lit during non-daylight hours. Clear visibility of pedestrians at crosswalks and walkways is particularly important since the majority of fatal incidents occur during early morning and evening hours. A data-driven evaluation will help to ensure that the location and condition of existing and new crosswalks and walkways is based on pedestrian safety and need.

As a community, we support the increased use of crosswalks and walkways if they are accessible, available, and convenient to use. Besides pedestrian use, crosswalks act as a traffic calming measure by reducing the speed of drivers and making them more aware of other road users.

For the neighbor islands and rural areas of Oahu, walkways (i.e., non-vehicular multi-modal pathways or cut ways), are particularly important in increasing pedestrian safety. Both state and county must work together to ensure that their development is a priority.

Promote Shared Responsibility Of Pedestrians And Drivers For Road Safety

Conduct a media awareness campaign aimed at changing attitudes and behaviors of drivers and pedestrians to improve road sharing.

Rationale: There is a need to change the perceptions of drivers and pedestrians to share the road responsibly. According to FARS data (2000-2004), drivers and pedestrians are almost

equally at fault. Fifty-three percent (53%) of pedestrians were erroneously in the roadway, and 46% of drivers made errors that led to fatal pedestrian injuries.

Although we depend heavily on motor vehicle transportation in Hawaii, particularly on the neighbor islands, drivers are also pedestrians; both would benefit from friendlier roadways.

A comprehensive multi-media campaign that would reach into communities and include enforcement as a combined strategy would help to reinforce driver and pedestrian responsibility for friendlier roadways.

Incorporate pedestrian safety in the health education standards of the Department of Education's K-12 curriculum.

Rationale: When environmental changes that separate pedestrians from motor vehicle traffic are not possible, changing the behavior of pedestrians and drivers is necessary to prevent injuries. It is particularly important to promote safe pedestrian behavior early on since the highest rates of non-fatal pedestrian injury in Hawaii are among young children, under 15 years of age. The second highest rate of non-fatal injuries are among seniors for whom there are some existing education programs in place.

Current efforts to incorporate standards-based health education into the DOE curriculum presents the opportunity to include consistent teaching of pedestrian safety skills and practices to children throughout K-12. High school drivers' education classes could also include appropriate driving behavior related to pedestrian safety. Teachers would be able to access community resource programs to complement the standards based curriculum.

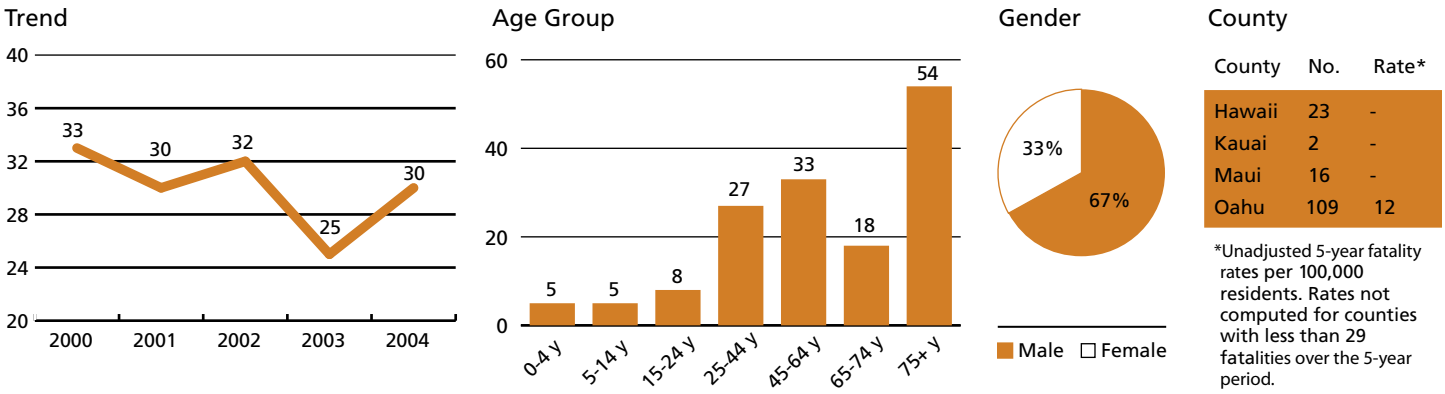
Pedestrian Injury Data

Overview of Fatal Injuries

Annual crude rate (1999-2002): 2.6 deaths per 100,000 (2.1 per 100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 7th highest (NM highest: 3.7/100,000, NH lowest: 0.9/100,000)
Injury ranking in Hawaii (2000-2004): 7th leading cause of fatal injuries, 5th leading cause of unintentional injuries.

An average of 30 Hawaii residents are killed each year in Hawaii, with no apparent trend in the annual number over the 2000-2004 period. Almost half (48%) were 65 years of age or older, and annual rates increased dramatically over the senior age range: 4.3/100,000 residents aged 65 to 74, 9.8/100,000 for 75 to 84 year-olds, and 24.3 for those 85 years and older. Most (73%) of the deaths occurred on Oahu.

Pedestrian Deaths
Hawaii Residents, 2000-2004



Contributing Factors

Almost half (43%) of the crashes occurred during 2 peak times periods: 5:30 a.m. to 7:30 a.m. (26% of the deaths), and 5:30 p.m. to 7:30 p.m. (17%). Most (81%) of those hit during the morning were 65 years or older. Only 15% of the senior-aged victims were hit during nighttime hours (7:30 p.m. to 4:30 a.m.). Alcohol was involved in one-fifth (20%) of the deaths, as 14% of the pedestrians were estimated to have been drinking prior to the crash and another 7% were hit by a driver who had been drinking (excluding the 28% of deaths for which alcohol status was not known). Alcohol use by pedestrians was much more common among victims hit between 7:30 p.m. and 4:30 a.m. (31%), compared to those hit during daylight hours (4%). Alcohol use was also more common among pedestrians hit in Hawaii County (36%) than on Honolulu (11%) or Maui counties (0%).

One quarter (25%) of the victims were hit while in a crosswalk, and 8% while off the road or on the shoulder. The fault of the crash was roughly equally distributed between pedestrians and drivers. About half (53%) of the pedestrians were in the roadway erroneously, most commonly by improper crossing, or "jaywalking" (36%). Similarly, about half of the drivers (46%) made an error which contributed to the crash; most commonly drivers were "inattentive" (25%), or failed to yield the right of way to the pedestrian (22%). Only 11% of the crashes were thought to be related to speeding among the drivers.

Non-Fatal Injuries

In Hawaii, for every pedestrian who is killed, there are an estimated 6 who are hospitalized and another 12 who are treated in emergency departments, with more than one third (39%) of them transported via ambulance. Unlike fatal injuries, the highest rates of hospitalizations and ED visits were computed for children under 15 years of age (50.2/100,000), followed by victims 65 years and older (36.9/100,000). About one-third (29%) of the pedestrians treated for non-fatal injuries were under age 15, but only 7% of those killed were of this age, suggesting age is a critical determinant of surviving pedestrian crashes. Hospital charges for non-fatal pedestrian injuries total $6.5 million per year, or $13 million including physician charges. Oahu EMS data show the highest number and rate of crashes occur in the Kalihi-Palama, Waikiki, Downtown, Ala Moana, and Waianae neighborhoods.

Unintentional Poisoning

Hawaii 2010 Objective: Reduce Deaths Caused by Unintentional Poisonings

	Baseline Rate*	Current Rate*	2010 Target*
National	**3.9 deaths** in 1998	**6.1 deaths** in 2002.	No comparable HP 2010 objective for deaths caused by unintentional poisonings.
Hawaii	**2.8 deaths** from 1996-2000 (average annual rate).	**4.2 deaths** from 2000-2004 (average annual rate).	**No more than 2.8 deaths**. Identify and reduce disparities among groups.

* Resident deaths per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Reduce Misuse Of Medications

Through legislation, improve labeling on prescription drugs to include:

- Diagnosis and instructions to patients;
- Physical description.

Rationale: Medication poisoning results from an overdose of a medication or medication given or taken in error. This recommendation will increase patient safety among all ages, particularly the elderly as one identified high-risk group.

Improved labeling would provide information directly on the bottle where patients will see it every time they take their medication. The information will help patients identify the medication and its purpose (e.g., diagnosis component).

A physical description of a medication may include its shape, color, and markings. Oregon passed the "Accuracy Label Rule," which requires that each prescription label include a physical description (e.g., "round, white tablet") of the medication. This labeling provides a last line of defense against errors for both the counseling pharmacist and the patient. Anecdotal information from this landmark legislation in Oregon shows that this is a promising strategy in decreasing medication poisonings.

Increase Public Understanding Of Poison Prevention

Expand age-appropriate education efforts in poison prevention.

Rationale**:** As with many injury prevention efforts, education is an important component to any poisoning prevention strategy. Currently, poison prevention efforts are implemented on a limited scale. These efforts would be enhanced by partnering with other groups and encouraging them to incorporate poisoning prevention education into their programs to reach age groups at risk for poisoning.

Based on fatal and non-fatal injury data, educational efforts need to focus on poisoning related to drug overdoses in the young adult and middle-aged populations.

Hawaii Poison Hotline calls data suggest that homes are not "childproof" because children continue to have access to poisons. Therefore, targeted efforts should include education about childproofing homes as well as integrating prevention messages into the Department of Education elementary school curriculum. According to Kapiolani Poison Prevention Program, there is a need for educating other caregivers, especially grandparents, who may use medications that do not have childproof capping. In addition, establishing poison prevention and caregiver education programs at community senior centers would address poison prevention for the elderly.

Maximize usage of the 24-hour Hawaii Poison Hotline for poison AND medication/drug information

Rationale: The Hawaii Poison Center was established in 1957 by the pediatric physician community in response to a significant public health problem, unintentional childhood poisonings. Renamed the Hawaii Poison Hotline (with calls answered by the Rocky Mountain Poison Center), the 24-hour hotline is widely viewed throughout the state as a valuable resource to: aid individuals in poison management, provide treatment recommendations to health professionals, answer poisoning questions, and promote poison prevention and community awareness. Less known is the hotline's capacity to provide information on prescription medication and illicit drug poisonings.

The extensive capabilities of the 24-hour Hawaii Poison Hotline are currently underutilized. This recommendation focuses on educating the public about hotline capabilities and maximizing its services. In determining when appropriate resources are needed or when they are deemed unnecessary, there is more appropriate use of medical resources (e.g., 911, Emergency Departments).

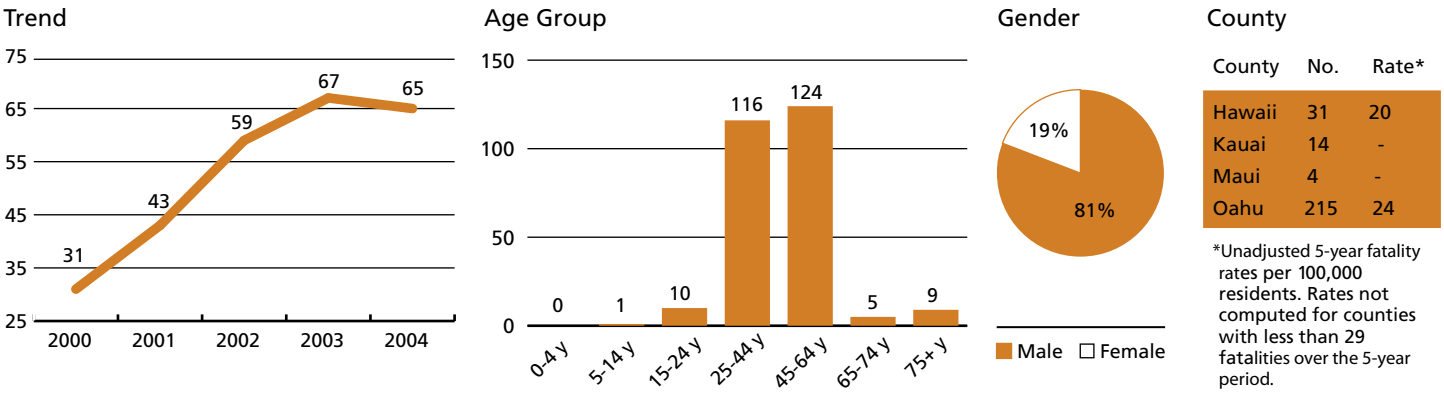
Unintentional Poisoning Data

Overview of Fatal Injuries

Annual crude rate (1999-2002): 3.5 deaths per 100,000 per year (5.0/100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 37th highest (NM highest: 12.9/100,000, RI lowest: 0.9/100,000)
Injury ranking in Hawaii (2000-2004): 4th leading cause of fatal injuries, 3rd leading cause of unintentional injuries.

There was a significantly increasing trend in the annual number of deaths coded as unintentional poisonings among Hawaii residents over the 2000-2004 period. This increase, an approximate doubling of the annual number, did not appear to be due to differential classification with suicidal poisonings or poisonings of undetermined intent. Most (74%) of the victims were 35 to 55 years of age, and most (81%) were males. Drugs and medicinal substances caused almost all (93%) of the poisonings. Altogether, more than half of the victims (57%) were males aged 35 to 55 years of age who were poisoned by drugs or medicinal substances. Narcotics and hallucinogens were the most commonly noted substances (35% of deaths), including heroin, cocaine and morphine. Psychostimulants, which include amphetamine, and tranquilizers caused 22% of the deaths, and most of the remainder (35%) were coded as "other" or "unspecified" drugs.

Unintentional Poisoning Deaths
Hawaii Residents, 2000-2004



County	No.	Rate*
Hawaii	31	20
Kauai	14	-
Maui	4	-
Oahu	215	24

*Unadjusted 5-year fatality rates per 100,000 residents. Rates not computed for counties with less than 29 fatalities over the 5-year period.

Non-Fatal Injuries

For every Hawaii resident who is killed by a poisoning, there are 6 who are hospitalized and 13 who are treated in emergency departments. The age distribution of the patients was much more widespread than that among fatally poisoned victims, with by far the highest annual rates computed for residents under 5 years of age (202/100,000). This was mostly due to ED visits for infants and 1 year-olds. Children aged 5 to 14 years had the lowest rates (24/100,000). Gender was evenly distributed between males (53%) and females (47%), in contrast to victims of fatal poisonings, 81% of whom were male. Hospital charges averaged over $3.6 million per year, not including physician charges, which may double the total charge.

Most (64%) of the poisonings were due to drugs and medicinal substances. Poisonings from psychotropic agents were the most common (18%), particularly those from benzodiazepine-based tranquilizers (7%). Other common poisonings were from heroin, methadone and other opiates (7%), aromatic analgesics (including acetaminophen, or Tylenol) (5%), cardiovascular agents (5%), anticonvulsants (165), and hormones (4%). The remaining 36% of non-fatal poisonings were due to the toxic effects of non-medical substances, most commonly by gas inhalation (8%), corrosives and caustics (6%), or toxicities in foods (5%).

The Hawaii Poison Center received nearly 7000 calls related to unintentional poisonings in 2003. In contrast to poisonings that require hospitalization, and especially fatal poisonings, a significant proportion reported to the Hawaii Poison Center involved very young children; almost half (47%) were poisonings among children aged 5 years or younger. Only 40% were calls for people aged 20 or over. About two-thirds of the calls came from people on Oahu, but the highest rates were computed for residents of Hawaii County (109 calls/10,000 residents). Kauai County had the lowest rates (82/10K). The causes of these poisonings were also very different from those that caused non-fatal hospitalizations, being mostly (77%) due to non-drug or non-medicinal substances. Bites and stings were the most common reason (18%) for the calls, followed by poisonings from cosmetics/personal care products (13%), analgesics (13%), and cleaning products (12%).

Youth Risk Factor Data

According to YRBSS, Hawaii high school students had greater access to illegal drugs at school (1995-2001 average prevalence: 37%), compared to all U.S. high school students (31%). There was also no trend in the proportion of students with access to illegal drugs, which decreased among all U.S. students. Self-reported access to drugs was higher among male students (1995-2001 average prevalence: 43%) in Hawaii, compared to female students (32%). Approximately 3% of Hawaii students reported using any form of cocaine in the previous 30 days, and 7% had used methamphetamine one or more times in their lives. Use rates were 4% and 9%, respectively, for all U.S. high school students.

Suicide

Hawaii and Healthy People 2010 Objective: Reduce the Suicide Rate

	Baseline Rate*	Current Rate*	2010 Target*
National	**11.1 suicides** in 1998.	**10.9** in 2002.	**5.0 suicides** Method: better than the best.
Hawaii	**10.8 suicides** from 1996-2000 (average annual rate).	**10.0 suicides** from 2000-2004 (average annual rate).	**5.0 suicides** Method: meet national HP 2010 target.

* Resident deaths per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Increase Knowledge And Understanding Of Suicide Prevention

Develop and implement suicide prevention training for "gatekeepers."

Rationale: A "gatekeeper" is any individual who interacts with others at work, at play, and in community settings (i.e. other than the medical setting). Gatekeepers can be trained in suicide prevention to identify and respond to persons who are at risk for suicidal behaviors. (U.S. Department of Health and Human Services. *National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001*).

Suicide Prevention training may include how to identify early signs of suicidal behavior, implement timely and effective intervention strategies, identify opportunities to reinforce protective factors, and make appropriate referrals to treatment services.

The workgroup recommended that training be implemented through the school and health systems, and through community-based groups to increase awareness and knowledge of the risk factors and signs of suicidal behavior. Additionally, it is important to develop culturally competent trainings and to support funding for more trainings in the community.

Launch a public awareness campaign.

Rationale: A public awareness campaign aimed at increasing public knowledge of suicide as a serious public health problem and dispelling myths about suicide will support a shift in beliefs and behaviors that allow for early intervention at the community level. The stigma of suicide has been recognized as a barrier to treatment for many people who have suicidal thoughts or have made suicide attempts. Lives can be saved through public understanding that suicides and suicidal behaviors are preventable, and that individuals and groups can play a significant role in suicide prevention.

A public awareness campaign might utilize various media to destigmatize suicide and convey the message that "it is okay to get help". The campaign can educate the community on access

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to care (i.e., where to get help) and increase awareness that suicide is a public health problem and is preventable. Media vehicles may include: electronic - movies, television, radio; print - newspapers and magazines; program materials - newsletters, announcements; proclamations and community events.

Promote and support research on suicide and suicide prevention.

Rationale: Suicide as a field of research is still in its early stages. Therefore, knowledge of factors relating to suicide and suicide attempts is limited. It is vital to increase qualitative and quantitative research to: better identify people "at-risk," increase knowledge of causes of suicide, and develop effective interventions aimed at suicide prevention.

Further recommendations are to explore the possibilities of conducting psychological autopsies and to continue the conduct of population-based surveys.

Broaden Access To Screening And Services

Develop and promote effective clinical and professional practices and policies.

Rationale: Many factors become barriers for persons to access appropriate services and care. Some include: finances, mental health conditions, substance abuse, etc. It is important to develop and strengthen a service system that raises awareness of services available, ensures statewide access for screening and appropriate care to every person as needed, ensures culturally sensitive approaches, and provides flexibility in health insurance reimbursements for mental health services. Promoting effective clinical and professional policies and practices will result in better health to those at risk.

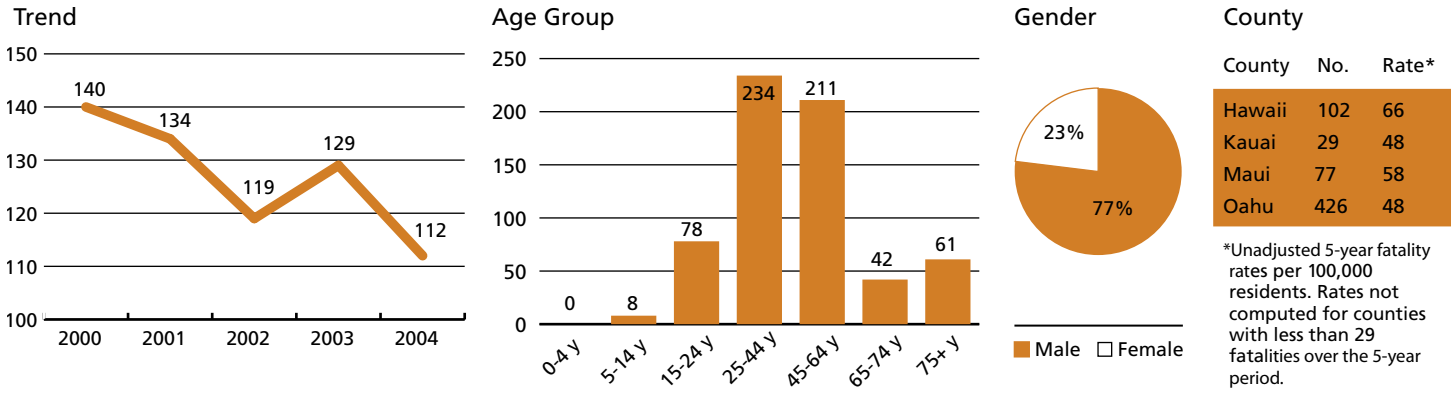
Suicide and Suicide Attempt Data

Overview of Suicides

Annual crude rate (1999-2002): 10.9 deaths per 100,000 residents (10.7 for rest of U.S.)
Hawaii state ranking (1999-2002): 35th highest (NV highest: 20.2/100,000, NY lowest: 6.3/100,000)
Injury ranking in Hawaii (2000-2004): leading cause of fatal injuries

Although suicide was the leading cause of fatal injuries in Hawaii, there was a significantly decreasing trend in the annual rate of suicide among state residents over the 2000-2004 period. Almost all (96%) of the suicide victims were 19 years or older, and two-thirds (67%) were between 21 and 55 years of age. The highest annual rates were among residents aged 75 years and older (14.6/100,000), and 25 to 54 year-olds (14.0/100,000). Male victims outnumbered females by approximately 3-to-1. Rates among Oahu residents (ages 20 and older) were 30% lower, compared to Neighbor Island residents, where Hawaii County residents had the highest rates. The most common mechanism was by hanging or suffocation (45%), followed by firearm use (23%), and poisonings (15%).

Suicides
Hawaii Residents, 2000-2004



County	No.	Rate*
Hawaii	102	66
Kauai	29	48
Maui	77	58
Oahu	426	48

*Unadjusted 5-year fatality rates per 100,000 residents. Rates not computed for counties with less than 29 fatalities over the 5-year period.

Contributing Factors

At least one negative life event was documented in the autopsy records of most (64%) of the victims who died on Oahu in the 1997-1999 period, most commonly serious illness (28%) or the end of a relationship (27%). About one-third (31%) of the victims tested positive for alcohol at autopsy, and heavy alcohol use was found to be more common among younger victims. Illicit drugs were detected among 26% of the victims, where methamphetamine (14%), marijuana (8%), and cocaine (6%) were the most common substances. About two-thirds (62%) of the victims had a documented history of mental illness, and about one-fifth (22%) were known to have made previous suicide attempts.

Non-Fatal Suicide Attempts

For every suicide, approximately 7 Hawaii residents are hospitalized for suicide attempts, and 4 others are treated in emergency departments. (This is the only category in which hospitalizations outnumber ED visits.) The profile of these patients is very different from that of suicide victims: More than half (60%) are female, the age distribution is generally younger (47% are 14-30 years of age), and most (76%) are the result of poisonings, specifically drugs and medicinal substances (74%). Hospital charges totaled over $11 million per year, an amount that would be approximately doubled if physician charges were included.

Youth Risk Factor Data

According to YRBSS, Hawaii high school students had slightly higher self-reported prevalence of considering (24%), planning (19%), and attempting a suicide (12%), and receiving medical attention for an attempt (4%), compared to U.S. students as a whole (21%, 16%, 8% and 3%, respectively). However, each of these risk factors generally decreased over time in Hawaii. Among Hawaii students the prevalence of each of these risk factors was about twice as high for female students, compared to male students. Risk factor prevalence generally decreased across the 9th to 12th grades.

Violence and Abuse

Hawaii and Healthy People 2010 Objective: Reduce Homicides

	Baseline Data	Current Status	2010 Target
National	**6.5 homicides** in 1998.	**6.2 homicides** in 2002.	**3.0 homicides** Method: better than the best.
Hawaii	**3.2 homicides** from 1996-2000 (average annual rate).	**2.6 homicides** from 2000-2004 (average annual rate).	**No more than 2.6 homicides.** Identify and reduce disparities among groups.

* Resident deaths per 100,000 population age adjusted to the year 2000 U.S. standard population.

Recommendations

Promote Community-based Violence Prevention Interventions

Promote and support the development of "full-service" schools.

Rationale: Full-service schools are able to address critical youth issues such as youth violence and substance abuse. Currently, Hawaii has many after-school activities, but would benefit greatly by moving toward full-service schools that are broader in design and more extensively involve parents and other adult members of the community in school life.

The full-service school is "a school center in which health, mental health, social and/or family services may be co-located, depending on the needs of the particular school and community (Joy Dryfoos. *Full-Service Schools A Revolution in Health and Social Services for Children, Youth and Families*). They are often open when youth violence is more likely to occur – before and after the traditional school day, on weekends, and during vacation breaks (Pacific Center for Violence Prevention, Trauma Foundation. *Preventing Youth Violence: Full Service Schools*, Policy Paper).

With young adult males in Hawaii experiencing the highest rates of fatal and non-fatal injuries and involvement in violent crime, the development of full service schools is a strategy that will address the need to start early to prevent youth from becoming involved in violence. Existing full-service programs throughout the country have had significant health, social, and educational benefits for youth, parents, and members of the community *(Preventing Youth Violence: Full Service Schools)*.

Identify approaches used in local and national programs that effectively reduce community violence.

Rationale: This strategy recognizes that those who are affected by or work in violence prevention can best shape solutions that would be effective within their respective communities. There are many programs that model this community-driven approach. An assessment of local and national programs will help to identify those that are effective or promising, and that communities can tailor to meet their own needs.

Increase Knowledge And Understanding Of Violence

Conduct research to better understand violence in Hawaii.

Rationale: Research is critical to understanding the multi-faceted problem of violence, and to designing and developing effective interventions.

More violence prevention research needs to be conducted at the local level, particularly related to Hawaii's cultures.

Existing studies and new research provide opportunities to collect and disseminate violence prevention data and information. By focusing on research in this area, we would further the body of local knowledge about what does and doesn't work in preventing violence.

Violence and Abuse Data

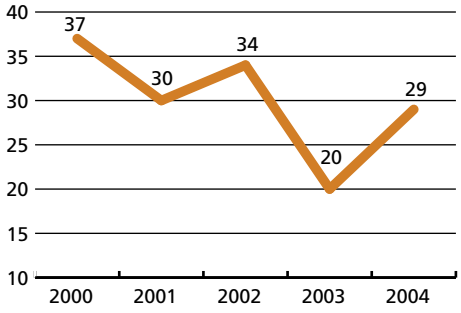
Overview of Homicides

Annual crude rate (1999-2002): 3.0 deaths per 100,000 residents (6.3/100,000 for rest of U.S.)
Hawaii state ranking (1999-2002): 39th highest (LA highest: 12.5/100,000, ME lowest: 1.5/100,000)
Injury ranking in Hawaii (2000-2004): 6th leading cause of fatal injuries.

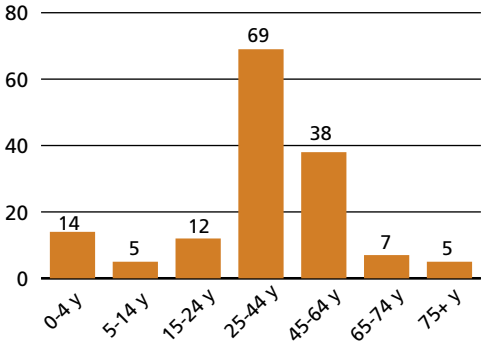
An average of 32 Hawaii residents were murdered each year in Hawaii, with no clear trend over the 2000-2004 period. Half of the victims were 30 to 50 years of age, and this group also had the highest rates of homicide. Five percent (8) of the victims were infants. About two-thirds (69%) of the victims were males. Most (69%) of the homicides occurred on Oahu. There were too few deaths on Neighbor Islands for valid rate comparisons. The most common mechanism of homicide in Hawaii was use of firearms, accounting for 31% of the deaths. That proportion was much higher among homicides in the U.S. as a whole, 64% of which were committed with firearms.

Homicides
Hawaii Residents, 2000-2004

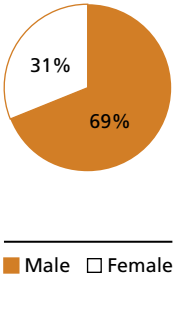
Trend



Age Group



Gender



County

County	No.	Rate*
Hawaii	23	-
Kauai	11	-
Maui	12	-
Oahu	104	12

*Unadjusted 5-year fatality rates per 100,000 residents. Rates not computed for counties with less than 29 fatalities over the 5-year period.

Supplemental Homicide Reports from the FBI were linked to the death certificate data for the 1999-2003 period. SHR reports indicate that at least half of the victims (56%) knew their assailant; only 13% were killed by strangers. Most commonly, victims were killed by an acquaintance outside of their families (30%), although the victim-perpetrator relationship varied by gender. Female victims were more likely to be killed by their intimate partners (38%), or other family members (12%), while male victims were more likely to be killed by extra-familial acquaintances (30%) or strangers (18%). Twenty-five (17%) of the victims were intimate partners of the assailant, including 15 spouses (12 wives, 3 husbands), 1 ex-spouse, 7 girlfriends, and 2 boyfriends. Other victims killed by family members included 9 children killed by their parents, and 5 victims who were killed by other family members. Most (85%, or 11 of 13) of the homicides of victims 2 years of age or younger occurred on Oahu.

Non-Fatal Injuries

For every homicide in Hawaii, there are an estimated 3 residents who are hospitalized for assaults and another 21 who are treated in emergency departments. The highest rates for non-fatal assaults were computed for 15 to 24 year-olds (57.3/10,000 per year), of whom 86% were male. Unarmed beatings were the most common (53%) mechanism of assault; firearms were used in only 0.4% of the assaults. Hospital charges averaged over $11.7 million per year, not including physician charges, which may double the total charge.

Young adults (ages 20-34) also had the highest rates of assault-related injuries that required Oahu EMS treatment (55.7/10,000 per year). Most (83%) of these injuries were graded as "minor," although 56% of the patients were transported to hospitals. Neighborhoods with the highest numbers and rates of assaults were Waikiki (283 per year), Ala Moana (264), Kalihi-Palama (264), Waianae (177), and Downtown (161).

Risk Factor Data

According to 2001 UCR data, Hawaii had a relatively low rate of violent crime (42nd in the nation). Unlike the rest of the U.S., however, violent crime did not decrease in Hawaii over the 1998-2002 period, and the aggravated assault rate increased significantly over that period. The rate of rape in Hawaii was unchanged over the 1993-2002 period and was roughly comparable to that for the U.S. Almost half (44%) of the male arrestees for assault in 2002 were in the 18-29 year age group, with 30% in the 18 to 24 year age group. Only 16% were 45 years or older. The age distribution for male arrestees for rape was much more widely distributed among the 18-44 year age group (77% were in this age range). Rate of arrests for males for assaults was 4 to 8 times higher than for females at every age group, being most divergent in younger ages.

Thirteen percent of the adult respondent to the 2000 Hawaii Health Survey reported they sustained injuries from physical abuse by their parents or other known adult (boyfriend/girlfriend of parent, etc.) during childhood. Three percent reported a violent experience (being pushed, slapped, hit, punched, kicked, etc.) in the last 12 months, and 1.3% reported being injured from intimate partner violence. Reports of child abuse and recent violence were highest in respondents who identified themselves as Hawaiian (21%), and lowest among the Japanese (5%). Unwanted sexual activity was reported by 0.3% of the female respondents and none of the male respondents.

About one-quarter of high school students surveyed in 2001 in Hawaii reported being in at least one physical fight in the previous year, compared to 33% of all U.S. high school students. That reported proportion decreased annually from 33% in Hawaii in 1995 to 26% in 2001. The percentage of students who carried a weapon in the last 30 days decreased from 18% in 1995 to

11% in 2001, while the proportion who were injured by fighting in remained between 4% and 3% over that period. Carrying weapons and fighting in Hawaii was more commonly reported by male students than females. These behaviors were also progressively less reported across the 9th to 12th grade levels. Ten percent of Hawaii students reported being hit, slapped, or physically hurt by their boyfriend or girlfriend in the last 12 months, a proportion that did not vary much by gender.

Appendices

Data Sources And Methods

Unless otherwise noted, the data presented in this plan refers only to injury among residents of Hawaii. This is consistent with national reporting conventions of injury mortality and allows for the comparison of fatal injury rates in Hawaii with rates for the remainder of the country. Also, other population estimates (e.g. age, ethnicity, county, etc.) were available only for residents, so the inclusion of injuries among non-residents would result in an over-estimation of injury rates. The exclusion of non-residents reduces the amount of fatal injuries by about 12%, hospitalizations by 8%, and emergency department visits by 9%. (Non-residents comprise 50% of the drowning victims in Hawaii, so they are included in some of the data in the drowning section.)

The calculation of injury mortality and morbidity rates necessitates the definition of "at risk" populations for the denominator. U.S. Census population estimates were used for comparisons of U.S. and Hawaii fatality rates.[1] Other analyses compared the rate estimates of the four counties within Hawaii, and these calculations relied on census estimates from the State Department of Business, Economic Development and Tourism.[2] The average population over the 2000-2004 period was used for these county-specific rate estimates.

Three mortality rates relating to the Healthy People 2010 Objectives are listed at the beginning of each injury section: the baseline, current status and target. All three rates were computed separately for Hawaii and the U.S. as a whole, using age-adjustment by the direct method against the U.S. 2000 standard population (18 age groups).[3] The number of deaths for the U.S. was obtained from the Web-based Injury Statistics Query and Reporting System (WISQARS)[4] online database on the CDC web site, except for the motor vehicle related deaths which were taken from the Fatal Analysis Reporting System (FARS)[5] of NHTSA. Data from 1998 was used for the U.S. baseline rate, and 2002 for the U.S. current rate. Data for the Hawaii rates was obtained from death certificates for most injury areas, and FARS for motor vehicle related fatalities. The Hawaii baseline rate was based on the average number of fatalities over the 1996-2000 period (adjusted for the average population over this period), and the current rate was based on the average for the 2000-2004 period (adjusted by the average population). Five-year averages were used to account for the random fluctuation in the annual mortality totals in Hawaii. The target rates are the same for both Hawaii and the U.S., and these were taken from the Healthy People 2010 report where available, and created where lacking (e.g. motor vehicle occupant, etc.).

Each of the eight data sections begins with a comparison of injury fatality rates for Hawaii and the remaining United States. These comparisons are based on "crude" rates based of the average annual number of fatalities over the 1999-2002 period, the most recent data available for the U.S. as a whole. Results were similar if age-adjusted rates were computed, but crude rates are presented for their direct interpretability. Data for these comparisons comes from the WISQARS site.

Death certificates were the primary source of detailed injury mortality data in Hawaii. Injury-related deaths were categorized using the CDC recommended framework of E-code groupings[6,7], or other data groupings. Supplemental data was also used for certain injury categories. Data from FARS was linked to death certificates for deaths involving motor vehicles. Records from the Honolulu County Medical Examiner's office were reviewed for details on Oahu drownings during the 1996-2000 period, and for suicides that occurred between 1997 and 1999. Additional data on homicides was abstracted from the Supplemental Homicide Reports by the Crime Prevention and Justice Assistance Division, Office of the Attorney General, State of Hawaii.

Data on non-fatal injuries was obtained from the Hawaii Health Information Corporation (HHIC), which receives data from all acute care facilities in the state. Injury-related records were identified by any diagnosis in the ICD-9CM code series of 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85. External cause of injury codes were used to categorize the injuries.[6] Excluded from analyses were patients who died in hospital settings (to include only non-fatal injuries), or patients who were transferred to another hospital (to avoid duplicate counting of the same injury). Data for injury-related hospitalizations was available for 2003, while emergency department data was from 2002.

Other sources of data used in this report include Honolulu County ambulance report forms from the Emergency Medical Services and Injury Prevention System Branch of the Hawaii State Department of Health (DOH), lifeguard logsheets from the Ocean Safety and Lifeguard Services Division of the City and County of Honolulu, the Hawaii Health Survey of the DOH, traffic observational studies administered by the State Department of Transportation, the Hawaii Poison Center, and the Youth Risk Behavior Surveillance System of the CDC.

1 Resident Population Estimates of the United States by Age and Sex [database on the Internet]. U.S. Census Bureau. Available from: http://www.census.gov/popest/datasets.html.

2 Population Estimate Reports [database on the Internet]. State Department of Business, Economic Development and Tourism web site. Available from: http://www.hawaii.gov/dbedt/.

3 Anderson RN, Rosenberg HM. Age standardization of death rates: Implementation of the year 2000 standard. National vital statistics reports;47(3). Hyattsville, Maryland: National Center for Health Statistics, 1998.

4 Fatal Injuries: Mortality Reports. [database on the Internet]. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control web site. Available from: http://webapp.cdc.gov/sasweb/ ncipc/mortrate.html.

5 Fatal Analysis Reporting System (FARS) Web-Based Encyclopedia [database on the Internet]. National Highway Traffic and Safety Administration (NHTSA) web site. Available from: http://www-fars.nhtsa.dot.gov/.

6 Recommended framework of E-code groupings for presenting injury mortality andmorbidity data (May 15, 2003). Centers for Disease Control and Prevention, National Center for Injury Prevention and Control web site. Available from: http://www.cdc.gov/ncipc/whatsnew/matrix2.htm.

7 ICD-10 Framework: External cause of injury mortality matrix (November, 2002). National Center for Health Statistics web site. Available from: http://www.cdc.gov/nchs/data/ice/icd10_transcode.pdf

Glossary Of Acronyms

BRFSS – Behavioral Risk Factor Surveillance System
CDC – Centers for Disease Control and Prevention
DOH – State Department of Health
DOT – State Department of Transportation
E-code – External cause of injury codes within the ICD-9 system.
ED – Emergency Department
EMS – Emergency Medical Services
FARS – Fatal Analysis Reporting System
HIPP – Hawaii Injury Prevention Plan
HP 2010 – Healthy People 2010
ICD-9-CM - International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10 - International Classification of Diseases, 10th Revision
IOM – Institute of Medicine
IPAC – Injury Prevention Advisory Committee
IPCP – Injury Prevention and Control Program
KIPC – Keiki (childhood) Injury Prevention Coalition/SAFE KIDS Hawaii
MCH – Maternal and Child Health
NHTSA – National Highway Traffic Safety Administration
STIPDA – State and Territorial Injury Prevention Directors Association
YRBSS – Youth Risk Behavior Surveillance System

Bibliography

Aaza S, Sleet DA, Thompson RS, Soisin DM, Bolen JC, Task Force on Community Preventive Services. Reviews of evidence regarding interventions to increase use of child safety seats. *American Journal of Preventive Medicine* 2001; 21 (supplement 4): 31-47.

Christoffel, Tom and Gallagher, Susan Scavo. *Injury Prevention and Public Health: Practical Knowledge, Skills and Strategies.* Aspen Publishers, Inc., 1999.

Committee on Injury Prevention and Control, Institute of Medicine. *Reducing the Burden of Injury: Advancing Prevention and Treatment.* Washington DC, National Academy Press, 1999.

Committee on Poison Prevention and Control, Institute of Medicine. *Forging a Poison Prevention and Control System.* Washington DC, National Academies Press, 2004

Dinh-Zarr TB, Sleet DA, Shults RA, et al., and the Task Force on Community Preventive Services. Reviews of evidence regarding interventions to increase use of safety belts. *American Journal of Preventive Medicine* 2001; 21 (supplement 4): 48-65.

Dryfoos, Joy G. Full-Service Schools: *A Revolution in Health and Social Services for Children, Youth and Families*. San Francisco, Jossey-Bass, Inc., 1994

Hawaii State Department of Transportation, Safe Community Office. Hawaii occupant protection safety assessment, November 4-8, 2002. Assessment conducted November 4-8, 2002.

Hawaii Injury Prevention Advisory Committee. *Injury Prevention in Hawaii: Status and Progress Review*. July 2003.

Krug EG et al., eds. *World Report on Violence and Health*. Geneva, World Health Organization, 2002.

National Center for Injury Prevention and Control Website (http://www.cdc.gov/ncipc), CDC. Injury Fact Sheets.

Pacific Center for Violence Prevention, Trauma Foundation, *Preventing Youth Violence: Full Service Schools*. Policy Paper.

State and Territorial Injury Prevention Directors Association. An Assessment of the Hawaii Injury Prevention and Control Program. Assessment conducted June 16-20, 2003.

State and Territorial Injury Prevention Directors Association. *Safe States, 1997 and 2003 Editions,* Atlanta, Georgia.

State and Territorial Injury Prevention Directors Association. *State Technical Assessment Team State Guide & Materials, Hawaii, June 16-20, 2003*.

Task Force on Community Preventive Services. Increasing child safety seat use, increasing safety belt use, and reducing alcohol-impaired driving. *American Journal of Preventive Medicine* 2001; 21 (supplement 4): 16-22.

U.S. Department of Health and Human Services. *Healthy People 2010*. Washington, DC, November 2000.

U.S. Department of Health and Human Services. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD, 2001.

U.S. Department of Health and Human Services. Youth *Violence: A Report of the Surgeon General*. Rockville, MD, 2001.

U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide*. Washington, DC, 1999.

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