

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State DUNS Number

Number

80993567

Expiration Date

5/9/2014

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

P.O. Box

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

To

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

Last Name

Telephone

Fax

Email Address

Footnotes:

I: State Information

Assurance - 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 Coastal 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	<input type="text" value="Loretta J. Fuddy, A.C.S.W., M.P.H"/>
Title	<input type="text" value="Director of Health"/>
Organization	<input type="text" value="Department of Health"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

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), (c), (d), (e), and (f).

For purposes of paragraph (f) 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

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.

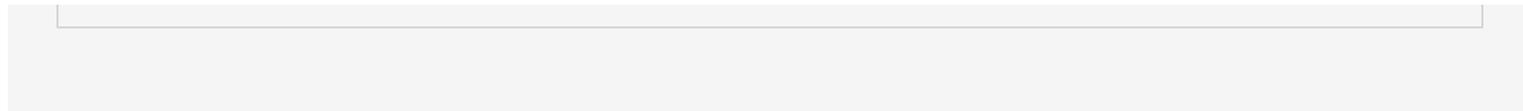
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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	Loretta 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 (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Loretta J. Fuddy, A.C.S.W., M.P.H

Title

Director of Health

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Loretta J. Fuddy, A.C.S.W., M.P.H"/>
Title	<input type="text" value="Director of Health"/>
Organization	<input type="text" value="Department of Health"/>

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

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

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 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, tribal, 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.

Footnotes:

Description of the State Service System

Hawaii, the 50th State, is one of the most remote places in the country. Located in the middle of the North Pacific Ocean, it is one of the most isolated yet populous places on Earth. California is 2,400 miles from Honolulu, roughly a 5-hour flight by air. Six time zones separate Hawaii from the eastern United States. For example, when it is 9:00 am (Eastern Standard Time) in Washington, D.C.; it is 6:00 am in Los Angeles and 3:00 am in Hawaii.

The “Hawaiian 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 seven populated islands located in four major counties: Hawaii, Maui, Oahu, Kauai, Lanai, and Niihau (listed in order of size). Kaho`olawe is not inhabited.

Approximately 70% of the state population resides in the City and County of Honolulu on the island of Oahu, concentrated in the Honolulu metropolitan area. Population growth is largely occurring on the Neighbor Islands (the main Hawaii islands other than Oahu normally referred to locally as being “Neighbor Islands.”) Over 13 percent of Hawaii’s people were estimated to be living in Hawaii County, 11 percent in the tri-island of Maui County (Maui, Molokai, and Lanai); 5 percent in Kauai County (Niihau). In the 2010 Census data, Hawaii’s population grew by 12.8 percent, with the Hawaii and Maui counties experiencing the highest increases of 24.5 percent and 20.8 percent respectively. The islands of Molokai (7,345) and Lanai, aka, Ellis Island (3,135) decreased in population.

Hawaii is composed of a rich blend of races, ethnicities, languages and cultures including Native Hawaiians, Pacific Islanders, Japanese, Filipino, Chinese, Vietnamese, Caucasian, African American, American Indian, Alaska Native, Hispanic, Micronesians, and people of other heritages. Hawaii’s population consists of 50.5 percent males and 49.5 percent females. Hawaii’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. Hawaii also has the largest percentage of persons with two or more races, which constitutes 23.6 percent of the total population.

Hawaii’s population, like other cities on the “mainland” is aging. The median age of Hawaii residents increased from 36.2 to 38.0 over the last decade, higher than the national average of 37.2 percent, while the proportion of children and youth ages 0-19 years decreased. Among the four counties, Kauai County had the highest percentage of older population (65+) at 14.9 percent and Maui County had the lowest percentage at 12.2 percent. 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 78 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.

After the economic downturn, Hawaii's economy has begun to rebound and is showing signs of strength. The economy is poised for steady, positive economic growth. This upward trend is expected to continue into 2014. The lowering of the unemployment rate is encouraging. According to the Bureau of Labor Statistics Current Population Survey, the unemployment rate for Hawaii was 4.5 percent in July 2013¹. The state unemployment rate was 2.9 percentage points lower than the national rate of 7.4 percent.

The unemployment rate in Hawaii is now 2.4 percentage points lower than the 2009 peak. The Department of Labor and Industrial Relations reported that the unemployment rate in Honolulu County fell to 4.2 percent in July 2013 from 4.7 in June 2013. The rate dropped to 6.8 percent from 7.4 percent in Hawaii County, to 5.3 percent from 5.9 percent in Kauai County, and to 4.9 percent from 5.4 percent in Maui County. Oahu is expected to regain all of the jobs lost during the recession, based on state job projections. Further, the State Department of Business, Economic Development and Tourism forecasted Hawaii's real gross domestic product to grow by 2.4 percent in 2013 and by another 2.3 percent in 2014.

Hawaii's poverty rate continues to reflect the impact of the recession with 12.1 percent living in poverty. This represents an estimated 161,600 individuals living in poverty statewide. Over 50,000 or 17 percent of those 18 years of age or younger live in households below the federal poverty level. Like unemployment rates, poverty rates vary across counties: Honolulu 10.3 percent; Maui, 12.8 percent; Kauai 12.9 percent and Hawaii 20.4 percent.

Hawaii'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. The majority of tertiary health care facilities, specialty and subspecialty services are located on Oahu. Consequently, Neighbor Island and rural Oahu residents often must travel to Honolulu for these services. Passenger travel between islands is entirely by air. Air flights are frequent, but comparatively expensive and are quite volatile due to varying fuel costs.

The structure of Hawaii's public services is unique in that, for most operational areas, services are provided and funded through the state. The state's education, health and human services, labor, business and commerce, agriculture, public safety and regulatory functions are provided by state government. Basic services from the four county governments include local law enforcement, criminal justice, emergency response, and infrastructure provision, such as roads and sewers. The counties also provide a few health and human programs.

¹ Source: Hawaii Department of Labor and Industrial Relations (DLIR).

Overview of Hawaii's Behavioral Health System

The Hawaii State Department of Health is committed to protect and improve the health and environment for all people in Hawaii. According to Hawaii Revised Statutes², the department of health within the limits of available funds within the designated programs promotes and provides 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;
- 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.

Single Mental Health Authority (SMHA)

The State's Adult Mental Health Division is considered the single mental health authority. The authority is within the 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 the Developmental Disabilities Division (DDD). ADAD is the only division within the BHA that exclusively contracts for all services. AMHD provides services through the state operated Community Mental Health Centers (CMHCs), the Hawaii State Hospital and contracts for services through thirty (30)

² Hawaii Revised Statutes §334-3

Purchase of Service providers. CAMHD and DDD contract for all services provided beyond case coordination.

Eligibility Criteria for State Mental Health Services

The SMHA restricts services funded via state general or special funds to only adults meeting the SMHA's definition of having a serious mental illness and to children meeting the SMHA's definition of having serious emotional disturbance. The SMHA provides services funded via Medicaid to adults with any mental illness and to children with an Axis I diagnosis. The income cap which individuals are eligible for SMHA services is the Medicaid level. There is also an illness severity requirement for individuals to be eligible for SMHA services. Educationally supportive services are available for students who have complex needs which extend beyond their school-based educational program and require specific support via their Individualized Education Plan (IEP). Support for Emotional and Behavioral Development (SEBD) Program Services are available for Medicaid-eligible youth with an Axis I diagnosis and functional deficits.

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 Administrator meets with the BHA Deputy Director and other three BHA Administrators on an ongoing basis. Recent and continuing collaboration between the AMHD and ADAD focused on providing services for consumers with co-occurring diagnoses; and between AMHD and CAMHD on youth to adult transition, which has been supported by the Data Infrastructure Grants (DIG). Since CAMHD, DDD and AMHD have long-term responsibility for individuals that span these agencies, the three Divisions meet regularly to increase collaboration.

The Developmental Disabilities Division (DDD)

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.

The Alcohol and Drug Abuse Division (ADAD)

The ADAD is the single state agency that manages the Substance Abuse Prevention and Treatment Block Grant for Hawaii. It is the primary source of public funds for substance abuse prevention and treatment services in Hawai'i and oversees funds for substance abuse services

for both adults and adolescents. Some substance abuse treatment services are funded through the Hawaii Medicaid 1115 waiver program called QUEST (Quality Care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided) which is administered by the Department of Human Services. Private health insurance companies and health maintenance organizations provide certain minimum substance abuse benefits as required by Hawaii Revised Statutes (HRS) §431M. ADAD's treatment efforts are designed to promote a statewide culturally appropriate, comprehensive system of services to meet treatment and recovery needs of individuals and families as well as to meet the treatment and to address the prevention needs of communities. Priority admissions are given to pregnant women and injection drug users. ADAD's target population includes adults or adolescents who meet the criteria for substance abuse or dependence.

The Child and Adolescent Mental Health Division (CAMHD)

The CAMHD aims to improve the emotional well-being of children and adolescents while preserving and strengthening their families by assuring early access to a child and adolescent-centered, family-focused community-based coordinated system of care that addresses the child's and adolescent's physical, social, emotional, and other developmental needs within the least restrictive environment.

The 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 a state psychiatric hospital facility for persons with mental illness, including those referred through judicial and the criminal justice system.

The AMHD's mission is to promote, provide, coordinate, and administer a comprehensive mental health system for individuals eighteen years of age and older who have a severe and persistent mental illness. In Fiscal Year 2012, AMHD administered services to 11,062³ adults with severe and persistent mental illness. Services are provided in state operated facilities and through contracts with private providers. The AMHD requires that providers be nationally accredited or certified.

The AMHD includes clinical and administrative lines of authority and oversight responsibility under the leadership of the AMHD Administrator. The Acting AMHD Psychiatry Chief supervises the clinical lines through the statewide services coordinators (SSCs), who have statewide responsibility for the development of services, program standards, and policies and procedures, according to evidence based practices and professional standards. The SSCs 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 SSCs are: 1) Crisis Services, ACCESS Line and Specialized Treatment

³ Hawaii 2012 Uniform Reporting System (URS) Table 2A.

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.

The table below shows the utilization rates for the State Mental Health Authority for FY2012.

Table 1: Utilization Rates, Fiscal Year 2012⁴

Number of Persons Served	12,981
Utilization Rate (adults & children)	9.45 per 1000
Community Mental Health Utilization Rate (adults & children)	9.32 per 1000
State Psychiatric Hospital Residents at the Start of the Year	178
State Psychiatric Hospital Utilization Rate (adults)	.30 per 1000
Percent of Hospital Residents with a Forensic Status at the end of the Year	77%
State Population	1,392,313 ⁵

HEALTH INSURANCE IN HAWAII

Historically, Hawaii has had a large proportion of its population covered by some form of health insurance. In the 1980s, Hawaii's uninsured population was estimated at 5%, and the state was credited as having the lowest uninsured rate in the U.S. This is a legacy from traditional Hawaiian society; the subsequent plantation era where medical care was provided for workers, and the rise of strong labor unions.

Prepaid Health Care Act

The generally accepted principle of broad or universal access to health care is reflected in the passage of the Hawaii Prepaid Health Care Act of 1974. The Act requires employers to provide a group health plan for employees working at least 20 hours a week for at least four straight weeks and earn at least \$542 a month. The law also mandates a minimum set of benefits that must be provided.

Hawaii is the only State with such a requirement and was successful in obtaining a waiver from the federal Employee Retirement Income and Security Act (ERISA), which prohibits state regulation of self-insured employers. The law does not require employers to cover dependents, so families may be omitted from coverage. Recent large increases in insurance premiums over the past few years have raised concerns about the Act and its impact on businesses in Hawaii.

⁴ 2012 CMHS Uniform Reporting System (URS) Output Table

⁵ U.S. Census Bureau, 2012

In 2011, the DOH Administration received legal opinions from the U.S. Department of Health and Human Services and the U.S. Department of Labor that concluded the State of Hawaii could retain the Hawaii Prepaid Health Care Act alongside the federal Patient Protection and Affordable Care Act. Private and public health insurance covered an estimated 90 percent of Hawai'i residents in 2007. Private health insurance covered about 56 percent of residents. Of those people covered by private health plans in Hawai'i, 93 percent were covered through employment-based plans. The number of residents in public health insurance programs remained fairly stable between 1995 and 2007 at about 36 percent of the resident population.

Uninsured

Although the Hawai'i resident population is relatively well insured compared to populations in most other states, direct and indirect problems persist. Many low-income Hawai'i residents remain uninsured and a significant number of full-time and part-time workers remain uninsured. Over 50 percent of the total number of uninsured residents in Hawai'i is employed either part-time or full-time. The statewide uninsured rate was 7.8 % in 2008 compared to 15.4% nationally according to the Census Bureau 2009 Current Population Survey. Hawaii had the second lowest uninsured rate behind Massachusetts. However, this data reflects uninsured rates prior to 2009 when the major effects of the state economic decline occurred. A disproportionate number of uninsured residents reside on the islands of Hawaii, Kauai, and Maui compared to the number of uninsured residents residing on Oahu, where the majority of the state's population is located.

Hawaii Health Connector

Consistent with the rest of the nation, the two dominant types of managed care organizations are health maintenance organizations and preferred provider organizations. Nearly 35% of Hawaii residents with insurance were enrolled in an HMO in 2007. Of these HMO enrollees, one out of three participated with one of the QUEST plans. The financing of health care in Hawaii's private sector is dominated by two health plans: the Hawaii Medical Service Association (HMSA, the Blue Cross, Blue Shield of Hawaii plan) which was founded in 1935, and Kaiser Permanente which began operating in Hawaii in 1958.

Other major insurers in the state are Hawaii Medical Assurance Association (HMAA) and University Health Alliance (UHA). Although there was a significant commercial insurance presence at one time, it has dwindled due to the State's isolation, limited consumer market and aggressive health insurance plan competition. To address Hawaii's shrinking health insurance market and rising health costs, legislation was passed in 2002 to regulate health insurance plans to assure insurance rate increases are not excessive, yet sufficient to keep insurance companies viable in the long-term. Hawaii was one of the last states to pass such legislation.

Hawaii is one of 15 states setting up its own health insurance exchange to match qualified individuals and small businesses seeking subsidized health plans. The Hawaii Health Connector is a private, non-profit organization committed to helping the people of Hawaii live happier

lives by making sure that health insurance is not only easier to purchase but also easier to understand. The program received \$205 million from the federal government to establish the Hawaii Health Connector, to educate the public about the Connector, and to operate it. The Hawaii Health Connector was developed as a result of the Affordable Care Act, and anticipates enrolling as many as 300,000 island residents including 100,000 who are uninsured, by the end of the year⁶. The Connector is due to open for business on October 1st, however, advertisement via radio and newspapers have already begun.

According to Coral Andrews, Executive Director of the Hawaii Health Connector, 75 percent of Hawaii residents, who are considered uninsured, should qualify for subsidies that will make insurance more affordable. A total of 34 community organizations that were recently identified as potentially eligible for \$6.7 million in grant funds to contact the uninsured population and to assist them in signing up for health coverage. A goal is to build a website that will make it easy for customers to compare dozens of health plans, calculate their subsidies, and enroll in a plan of their choice. A multilingual call center is also scheduled to open by September 15 to answer questions. Ms. Andrews opined that if the Hawaii Health Connector is successful in signing up 300,000 people, it could generate \$300 million to \$1 billion in revenue, which could be used to maintain the exchange until 2015.

Medicaid⁷

The Hawaii QUEST Expanded Medicaid (QExA) demonstration project is a section 1115 project administered by the DHS Med-QUEST Division (MQD) that began in August 1994. QUEST has two basic objectives: to expand medical coverage to include populations previously ineligible for Medicaid and to contain costs by shifting from fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage.

Through a Medicaid QUEST waiver in 2006, DHS also expanded services by covering more low income adults, by establishing the QUEST-ACE (Adult Coverage Expansion). At that time, QUEST-ACE offered a limited-benefit package that provided for inpatient and outpatient care, emergency room visits, mental health services, diagnostic tests, immunizations, alcohol and substance abuse treatments, and limited prescription drug coverage. Men and women over the age of 19 without dependent children are eligible whose annual earnings are at or below 200% of the FPL. The program is designed to help adults who could not previously qualify for QUEST due to the 1996 enrollment cap. The waiver also allowed the state to continue to make direct payments to hospitals to offset the costs of caring for the uninsured.

At this time, the State only pays for emergency dental services, such as tooth extractions for adults. In 2013, MQD contracted with Hawaii Dental Services (the Delta Dental affiliate) to administer its dental program. QUEST allows participants to select medical plans from the three current participating providers: AlohaCare, Hawaii Medical Services Association (HMSA),

⁶ Honolulu Star-Advertiser, "Insurance exchange intends to sign-up 300,000." August 15, 2013.

⁷ www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-fs.pdf

and Kaiser Foundation Health Plan. The three QUEST health plans offer additional services for disease management and some plans will offer health promotion programs for enrollees. MQD also implemented a new quality assurance program. Plans receive financial incentives for meeting quality performance standards and are assessed penalties if they fail to meet baseline requirements. As of March 2013, the health plan distribution for QUEST enrollees is: AlohaCare 29.5%, HMSA 54.3%, Kaiser Permanente 9.9%, Ohana 3.3%, and United Healthcare 3.1%.

QUEST Expanded Access

The Medicaid population 65 years or older and disabled of all ages (commonly called the aged, blind, and disabled (ABD) population) was covered under a separate fee-for-service program. In February 2009, the ABD population transitioned into a managed care system through the new QUEST Expanded Access (QExA) program. MQD designed the QExA program to provide service coordination, outreach, improved access, and enhanced quality healthcare services by health plans through a managed care delivery system. QExA health plans coordinate benefits across the continuum of care for this Medicaid population to include acute and primary care, behavioral health, and long-term care services. In 2008, DHS awarded the 3-year QExA contracts to two health plans: Evercare and Ohana Health Plan associated with national health insurers United Healthcare Group and WellCare Health Insurance of Arizona, Inc. Full conversion of Hawaii Medicaid to managed care has enabled the State to contract for Medicaid expenditures with a fixed annual budget. As of March 2013, the health plan distribution for QExA enrollees is: Ohana 53.8% and United Healthcare 46.2%.

Due to the economic downturn, Hawaii Medicaid programs observed an approximately 13% increase in recipients for two successive years. This unexpected growth program combined with federal restrictions under the American Recovery and Reinvestment Act resulted in a budget shortfall and the need to delay two months of health plan capitation payments.

To address a \$75 million budget shortfall, Medicaid reduced eligibility for adults from 200% to 133% and reduced its reimbursement rates. Additional funding became available through an increase in the federal matching rate providing \$15 million. A supplemental appropriation of \$8 million was approved by the Legislature. Savings also came from program integrity measures that included reduction of duplicative enrollment, annual eligibility reviews for adults, fraud reduction, and periodic review of death records provided by the Hawaii State Department of Health vital records.

The eligibility change in July 2012 resulted in 3,600 residents being removed from the QUEST Medicaid Program. Simultaneously, the State increased the limited benefits for 14,000 individuals in the QUEST-ACE and QUEST-Net programs (for those who lost QUEST eligibility or do not qualify for QUEST) to make it consistent with the rest of the QUEST population. As of March 2013, the QExA enrollment was 45,761 and QUEST enrollment was 236,463. Total Medicaid enrollment was 291,244, an overall increase from 2012.

Med-QUEST Behavioral Health Services

Public mental health services for adults with severe and persistent mental illness (SPMI) have been delivered through two major mechanisms in the State of Hawaii. 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 SPMI are administered through the Department of Human Services (DHS). The DHS, which is the Medicaid intermediary, is responsible for providing behavioral health services to all its beneficiaries. MQD provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with serious mental illness (SMI) and SPMI. The DHS contracts for service provision through the QUEST managed care programs with three providers: 1) Kaiser Permanente QUEST, 2) HMSA QUEST and 3) AlohaCare QUEST, which are responsible to provide both behavioral health services and primary care services. Standard behavioral services include: inpatient psychiatric hospitalization, medications, medication management, psychiatric and psychological evaluation and management, and alcohol and drug dependency treatment services.

In an effort to improve integration between medical and behavioral health care, in July 2010, the MQD transitioned all AMHD consumers with QUEST insurance to their QUEST Health Plans. Results of this transition were not without confusion for consumers and providers alike. Therefore, in March 2013, MQD contracted with a Community Care Services (CCS) vendor. Ohana Health Plan was chosen as the pre-paid inpatient health plan administrator. The intent of this integration of services is for individuals to receive physical and psychiatric care from the same organization with the goal of improving overall health outcomes.

The covered behavioral health services are State plan services. The covered specialized behavioral health services include those covered under the section 1115 demonstration project.

The State Plan Standard Behavioral Health Services⁸:

- Acute Psychiatric Hospitalization
- Diagnostic/Laboratory Services
- Electroconvulsive Therapy
- Evaluation and Management
- Methadone Treatment
- Prescription Medications
- Substance Abuse Treatment
- Transportation

State Plan Specialized Behavioral health Services are:

- Assertive Community Treatment (intensive case management and community-based residential programs)

⁸ Med-QUEST Division Behavioral Health Protocol, 2013.

- Bio-psychosocial Rehabilitation
- Crisis Management
- Crisis Residential Services
- Hospital-based Residential Programs
- Intensive Family Intervention
- Therapeutic Living Supports and Therapeutic Foster Care Supports

1115 Demonstration Specialized Behavioral Health Services

- Clubhouse
- Peer Specialist
- Representative Payee
- Supportive Employment
- Supportive Housing

The Ohana Health Plan, also known as, Community Care Services (CCS), will be responsible to case manage, authorize, and facilitate the delivery of behavioral health services to Medicaid eligible adults with SMI/SPMI and who are in the QExA health plans. The transition of consumers to the CCS program will occur in phases; beginning in September 2013 through January 2014. On the other hand, AMHD will continue to provide services for the forensically encumbered, the uninsured and underinsured and provide crisis services statewide.

I. Planning Steps

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

Services for Adults

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 were 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 Hawaii 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.

AMHD's 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.

Community Mental Health Centers

The AMHD state operated Community Mental Health Centers (CMHC) is under the direction of the CMHC Systems Administrator. 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. Each CMHC has a center manager who is responsible for administration of the CMHCs day-to-day activities. Beginning July 1, 2010, designated center managers from each county Hawaii, Kauai, Maui (islands of Maui, Molokai and Lanai), and Honolulu (Oahu) 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 Acting AMHD Psychiatry Chief. 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.

Hawaii State Hospital

The only state psychiatric hospital, the Hawaii State Hospital (HSH), is a branch of the AMHD and is administered under the responsibility of the AMHD Administrator. 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 accredited facility with a current census of 202 filled beds as of August 18, 2013. 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 457 individuals in FY2012.

AMHD's Contractual Relationships

In addition to contracts with thirty Purchase of Service (POS) providers, the AMHD contracts with community hospitals, including Kahi Mohala, the Queen's Medical Center and Castle Medical Center on Oahu and with Hawaii Health Systems Corporation for the neighbor 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 (Kauai). To augment the formal, contractual relationships the AMHD Provider Relations Coordinator holds monthly meetings with the provider community, oriented to both clinical concerns and administrative issues. Additionally, a Provider Manual and Provider Bulletin keep providers abreast of changes within the AMHD system.

Consumer Participation

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 by 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, AMHD Office of Consumer Affairs (OCA), Statewide Clubhouse Coalition, Statewide Peer Coaching Program, Statewide Hawaii Certified Peer Specialist Program, and a number of other committees and groups. The monthly AMHD Chief's Roundtable for consumers provides an opportunity for consumers and family members to make their concerns and needs known to the AMHD Administrator.

Consumers played an integral role in AMHD's Trauma Informed Care Initiative (TIC IT) in 2010 and continue to have 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, consulted in each phase of the redesign and re-launching of AMHD's Hawaii Certified Peer Specialist Training Program. The Office of Consumer Affairs coordinates the Peer Specialist Program. This program is designed to promote the provision of quality peer specialist services and to enhance employment opportunities for

individuals with serious mental illness, substance abuse, and intellectual/developmental disabilities. 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 for consumers.

The updated Hawaii Certified Peer Specialist (HCPS) Training now includes a trauma informed care curriculum. So far, consumer participants have been offered the trauma-specific intervention and Seeking Safety courses. The community-based case management contract scopes will be revised to assure funding for the hiring of HCPS at the completion of their training/internship program. Also added to the renewed HCPS training are: supported education, supported employment, mutual support, recovery principles, and Wellness Recovery Action Plans (WRAP). In addition, plans are underway to fund the program through braided funding and with enhanced supervision to assure successful application of the above practices and principles of peer support services.

Network of Care Program

In an effort to engage with a larger audience of consumers, family members, the Mental Health Transformation State Incentive Grant (MHT SIG), introduced the Network of Care (NOC) program. 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 Hawaii legislature, and make contact with legislators. The NOC system is housed within the Community Mental Health Centers statewide with the goal of being more accessible for consumers and families. Now that the grant has ended, AMHD, through the Mental Health Block Grant funds, is continuing to pay for the equipment and contracts.

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 Kauai, dental health services are provided to Native Hawaiians and to all the under-served people of Kauai by Ho`ola Lahui Hawaii in Waimea and Kapaa.

The State of Hawaii Hospital and Community Dental Services Branch provide dental evaluations and some treatment services to consumers residing in facilities operated by the Department of Health (DOH) including HSH. The Branch also provides dental evaluation and emergency and comprehensive treatment for eligible persons at community based DOH dental clinics located conterminously with the state operated Community Health Centers.

The Aloha Medical Mission's Honolulu Clinic provides 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 Severe and Persistent Mental Illness (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 and disabled persons, is in high demand and often includes a long waiting period. Additionally, a *pro bono* group of dentists provides dental services such as free basic oral health services weekdays at Palama Settlement.

Services in Rural Areas

Services are provided in rural areas through the CMHCs, CMHC, satellite clinics, and the contracted purchase of service provider network. Multiple languages, adherence to traditional Hawaiian and other local cultures, and influences from the mainland majority culture result in unique situations that require appropriate, differentiated treatment processes and responses.

Counties consistently experience shortages of dentists, psychiatrists, psychologists, and social workers. During the 2013 legislative session, the legislature enacted a bill affecting Title V programs by creating a definition for “rural.” As a result, the governor signed Act 144, which makes it possible for certain areas in Honolulu and Maui County to qualify for rural health resources and programs offered through the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy and Centers for Medicare and Medicaid Services. These programs are essential in ensuring access to quality care in Hawaii’s rural areas.

Transportation continues to be a major issue for consumers in rural areas. 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 of 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.

Estimated Serious Mental Illness (SMI) and SPMI Prevalence among Adults by County, FY2012

Table 2: Adult Population, Prevalence and Treated Prevalence By County

County	Adult Population ⁹		Estimated Adult Number of SMI ¹⁰ (5.4%)	Estimated Adult Number of SPMI ¹¹ (2.6%)	Number SPMI Served ¹²	Percent SPMI Served of SPMI Prevalence ¹³
	Number	Percent	Number	Number	Number	Percent
Hawaii	142,799	13.5	7,711	3,713	2,540	68.4
Maui	119,109	11.3	6,432	3,097	1,588	51.3
Kauai	51,868	4.9	2,801	1,349	572	42.4
Oahu	742,707	70.3	40,106	19,310	6,362	33.0
Statewide	1,056,483	100.0	57,050	27,469	11,062	40.3

Hawaii does not formally collect estimates of prevalence of SMI or of 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 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 Hawaii's SPMI adult population is shown in table 1. Application of a 5.4% prevalence percentage to Hawaii's SMI population is also shown. The 2.6% of SPMI is included within the 5.4% of SMI.

State of Hawaii's Treated Prevalence: Hawaii's resident population is comprised of 1,360,301¹⁴ persons statewide in 2012. 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 SPMI, the AMHD served 11,062 adults (unduplicated) in FY2012. AMHD served 40.3

⁹ 18 years and above, Hawaii State Department of Business, Economic Development and Tourism. The State of Hawaii Data Book. Table 1 – Resident Population by Selected Age Groups by County: 2010.

¹⁰ Federal definitions are utilized for Serious Mental Illness and Serious and Persistent Mental Illness (A portion of Serious Mental Illness) and applied to Hawaii's population estimates.

¹¹ Federal definitions are utilized for Serious Mental Illness and Serious and Persistent Mental Illness (A portion of Serious Mental Illness) and applied to Hawaii's population estimates.

¹² FY2012 Uniformed Reporting System Table 2A, Profile of Persons Served; Statewide and by County.

¹³ E.g., 11,062/27,469 = 40.3.

¹⁴ 18 years and above, Hawaii State Department of Business, Economic Development and Tourism. The State of Hawaii Data Book. Table 1 - Resident Population by Selected Age Groups by County: 2010.

percent of those expected to demonstrate SPMI. Although not all these individuals have SMI, it is likely that the Medicaid data would include additional individuals with SMI in addition to those served by the county system.

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

Hawaii County: Hawaii County's land mass of 4,028 square miles is 1.8 times larger than all other Hawaii counties combined. The "Big Island," aptly named is undergoing further population growth that continues to challenge public and private agencies. The total population for Hawaii County is 175,784 based on Census Bureau data for July 1, 2010. The total number of consumers served in FY2012 is 2,540.

Kauai County: In FY2012, 572 persons received services from the AMHD within the CMHC. These services are case management, day treatment, community housing including group home and supported housing services, homeless outreach.

Maui County: Maui has one CMHC, located in Kahului, and two clinics, one on Molokai and one on Lanai. 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. During FY2012, 1,588 persons received AMHD services.

Services for Special Populations

Mental Health Treatment in Jails and Prisons

According to national headlines¹⁵, the rate of suicides over the last 10 years in jails across the country has mental health experts concerned about the care of inmates who are SMI/SPMI and the lack of supervision. In Hawaii, 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 inmates with mental illness and expand mental health treatment programs for inmates, including coping skills and dealing with trauma. At times, inmates are transferred to the HSH by court order for more intensive mental health services.

On the policy level, administrators from multiple organizations form the Interagency Council on Intermediate Sanctions Committee (ICIS). Members of the Committee include the DPS, the Judiciary, the Department of Attorney General, the Department of Health, office of the Public Defender, Hawaii Paroling Board Authority, and the Honolulu Police Department. The ICIS

¹⁵ "Jail Suicides Worry Experts," New York Times, August 19, 2013.

meets monthly to discuss the reduction of recidivism and the prevention of future victimization by adult offenders. The group's goals are:

- Implement a system-wide application of standardized assessment protocols;
- Establish a continuum of services that match the risk and needs of adult offenders;
- Collaborate with communities in developing and implementing the continuum of services;
- Create a management information system capable of communicating among agencies to facilitate sharing of offender information; and
- Evaluate the effectiveness of intermediate sanctions in reducing recidivism.

Older Adults

There is renewed focus on adults aged 50-70 years old in the mental health system. Many elderly adults are on Medicare and experience difficulty finding a psychiatrist because this population tends to use the emergency departments more since physicians are less likely to accept them as patients. There's no easy fix for these types of situations in the islands. The coordination of care, coupled with the high cost living has become more essential. As Hawaii's population ages, the mental health system is now responding by training more people and working towards ensuring that mental health related resources are available for this age group. This has resulted in the 2013 legislature passing SB 310 SD2 HD2 CD1, which establishes an assisted community treatment program in lieu of the involuntary outpatient treatment program for severely mentally ill individuals who meet specified criteria. The Governor recently signed this bill into law.

Through the Hawaii Needs Assessment Report¹⁶, seniors were reported as having the most hospitalizations due to short-term complications of diabetes and mental health hospitalizations. Specific needs of older residents are increasing due to the in-home needs and access to palliative care, in addition to mental health treatment. Therefore, Healthcare Reform will benefit this growing population while lowering premiums and providing better health coverage.

AMHD, in collaboration with the Executive Office on Aging, established the Oahu Geriatric Mental Health Hui (OGMHH). The OGMHH has applied for membership with the National Coalition on Mental Health and Aging, which is pending. 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)
- Consumers and Advocates

¹⁶ HAH Healthcare Association of Hawaii, July 2, 2013.

Activities include:

- Collaborating with the Executive Office on Aging, who publishes a quarterly newsletter, dedicated an article in the press about Aging and Mental Health issues.
- Providing the impetus for the Executive Office on Aging to develop the first statewide plan on Alzheimer's disease and Other Related Dementia.
- With the Newsletter and the Dementia plan completed, focusing its efforts on the issue of "elderly wanderers in the community" and trying to develop a coordinated community response. Information and community input were gathered on a possible "Silver Alert" but based on community input, this was discontinued and other avenues are now being considered.

Veteran's Administration

The AMHD continues to collaborate with the Veteran's Administration on a quarterly 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 Department of Health 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 Veteran's Administration 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.

Due to the high suicide rate among returning veterans, all four branches of the military are focused on suicide prevention. The Department of Defense recently shifted suicide prevention from a medical to a readiness issue under the category of Operational Health and Readiness. All branches now have "readiness" as a top priority and they are addressing the challenges that affect areas of a soldier's life. The military is reaching out to the civilian community to share resources, and collaborate to make sure soldiers can function and transition successfully into civilian life. Other interventions that are implemented are providing services to family members of active military, i.e., by putting therapists in the schools to be an available resource.

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. Persons of diverse sexual orientation and gender identity are accepted at shelters and special accommodations are made to support them in those settings. As part of a LGBTQ's consumer recovery plan, if the consumer needs additional supports than are available in the AMHD service array, they are referred to local gay and transgender community support groups. At present, upon admission, 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.).

Racial and Ethnic Minorities

According to the 2010 U.S. Census, approximately 75 percent of Hawaii's population belongs to a racial or ethnic minority group, i.e. Hawaiians or Pacific Islanders, Black or African Americans, Hispanic or Latino, and Compact of Free Association (DOFA) migrants. The race/ethnic group most commonly reported as experiencing more health problems than average was Native Hawaiians, followed by other Pacific Islanders. It is noted that the rate of poverty is high among persons of certain race/ethnic backgrounds in the state. For the Native Hawaiians and other Pacific Islanders, the poverty rate is approximately 18 percent.

Mental health is also a clear area of need in Hawaii, and access to quality mental health care for racial and ethnic minorities remains an issue. According to the Healthcare Association of Hawaii Needs Assessment Report¹⁷, two mental health indicators exhibit race disparities. The proportion of adults with a depressive disorder was highest for other Asians (16.6%), while the suicide death rate is highest for Native Hawaiian/Pacific Islanders (39.3 deaths/100,000 population). The Health Connector is reporting that there are 8 percent or 89,974 uninsured Hawaiians who may be eligible for health coverage. Since most Hawaiians and Native Pacific Islanders practice "pono pono" or holistic and naturopathic interventions, if they choose to pursue Western medicine, the Affordable Care Act will make it easier for them to get physical and psychiatric care. Due to pre-existing medical conditions is prevalent in this population, physicians and mental health providers will not deny them.

The AMHD served approximately 2,196 or 20% Native Hawaiians and Pacific Islanders (see page 21). With limited resources and staffing, the AMHD has focused on opportunities to integrate the needs of this population into existing programs, planning and policy efforts and by improving collaboration with other state and local partners to provide services for racial and minority groups.

¹⁷ HAH Healthcare Association of Hawaii, July 2, 2013.

Table 3: Number of Persons Served By Age, Gender, Race/Ethnicity¹⁸

Age	Total				American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Pacific Islander	
	Female	Male	Not Available	Total	Female	Male	Female	Male	Female	Male	Female	Male
0-12 Years	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	91	109	1	201	0	0	5	6	0	0	11	17
21-24	192	261	2	455	0	0	11	26	8	6	33	64
25-44	1,528	2,079	3	3,610	5	17	190	286	30	51	369	490
45-64	2,567	3,066	2	5,635	19	17	451	631	39	91	520	598
65-74 years	397	324	0	721	4	0	108	72	3	12	53	27
75+ years	147	77	0	224	0	0	59	28	0	0	10	4
Not Available	51	153	12	216	0	0	0	0	0	0	0	0
Total	4,973	6,069	20	11,062	28	34	824	1,049	80	160	996	1,200

Age	Total				White		More Than One Race Reported		Race Not Available		
	Female	Male	Not Available	Total	Female	Male	Female	Male	Female	Male	Not Available
0-12 Years	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0
18-20 years	91	109	1	201	6	15	2	5	67	66	1
21-24	192	261	2	455	23	41	16	20	101	104	2
25-44	1,528	2,079	3	3,610	323	526	92	142	519	567	2
45-64	2,567	3,066	2	5,635	825	976	140	130	573	623	2
65-74 years	397	324	0	721	141	144	11	8	77	61	0
75+ years	147	77	0	224	31	16	2	1	45	28	0
Not Available	51	153	12	216	0	0	0	0	51	153	12
Total	4,973	6,069	20	11,062	1,349	1,718	263	306	1,433	1,602	19

¹⁸ 2012 URS Table 2A.

Services to the Homeless

As the state struggles to recover from the economic crisis, the homeless situation has worsened, and the number of Hawaii's homeless people is growing at a higher rate than last year. Preliminary results for Honolulu County alone show a 4.7%¹⁹ rise in the homeless population for 2013. Social services and government agencies assisting the homeless in Hawaii have limited resources to address the "crisis." As a result, to address the seriousness of the situation, community stakeholders from different areas are forced to work together to find more permanent, creative solutions to address the issue of homelessness. Top government officials and agencies at the state and county levels are involved, as are nonprofit social service agencies, outreach groups and religious organizations that assist homeless persons with food, health and shelter.

The State of Hawaii, Department of Human Services (DHS), Homeless Programs Branch, in coordination with the Honolulu County, Department of Community Services (DCS), and other homeless service providers and organizations with the Hawaii Continuum of Care (CoC) collaborated to develop the annual survey and statewide "point in time" (PIT) count of homeless persons. Instead of the conventional one night PIT counts, volunteers were able to collect data during a six-day period for the four counties: Oahu, Maui, Kauai and Hawaii. Counts were taken from January 24 to January 29, 2012. The objective of this PIT count was to obtain accurate information on both sheltered and unsheltered homeless²⁰ persons.

The Hawaii 2013 statewide PIT count is not yet available. However, the Oahu PIT count was cited in an article in the Honolulu Star-Advertiser, May 17, 2013. According to the article, 4,556 homeless persons (1,465 unsheltered persons and 3,091 sheltered persons) were identified during the period of January 22 to January 29, 2013; an increase of 11 percent over 2012. Within the unsheltered category are 505 chronically homeless persons²¹, which include the concentration of homeless persons most visible on the streets of Oahu. The article also reported that 78 percent of unsheltered homeless are severely mentally ill, 55 percent are chronic substance abuse users, and 29 percent are both mentally ill and chronic substance abusers. The co-occurring disorders dictate that these individuals need case management, medical treatment, substance abuse treatment and other supportive services in addition to housing.

¹⁹ Honolulu Star-Advertiser, "Officials Still Optimistic Despite 4.7% Rise in Homeless population." Friday, May 17, 2013.

²⁰ Sheltered definition included persons staying in emergency, transitional shelters, or safe havens. Unsheltered definition included persons who stated that they were unsheltered on the night of January 23, 2012 and who are living outdoors or in places not intended for human habitation such as a park or the beach.

²¹ Chronically Homeless – an unaccompanied individual with a disabling condition (diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions), who either has been continuously homeless for at least one year or has had at least four episodes of homelessness in the past three years.

The 2012 statewide PIT count resulted in a total of 6,246²² persons identified as being homeless. Statewide, sheltered homeless accounted for 3,726 persons and unsheltered individuals were 2,520. Of this total, 779 or 38.1 percent were chronically homeless individuals. Caucasians, Hawaiians, Part/Hawaiians and other Pacific Islanders continue to comprise the majority of the homeless in both sheltered and unsheltered categories. According to the PIT count, the homeless population stayed relatively stable (0.9 percent) between 2011 and 2012.

Table 4: Number of Homeless People in Hawaii²³

County	Category	2010	2011	2012	%Change 2011-2012
Oahu	Sheltered Homeless	2,797	2,912	3,035	+4.2%
	Unsheltered Homeless	1,374	1,322	1,318	-0.3%
	TOTAL	4,171	4,234	4,353	+2.8%
Maui	Sheltered Homeless	392	394	420	+6.6%
	Unsheltered Homeless	399	658	454	-31.0%
	TOTAL	791	1,052	874	-16.9%
Kauai	Sheltered Homeless	60	97	101	+4.1%
	Unsheltered Homeless	213	239	301	+25.9%
	TOTAL	273	336	402	+19.6%
Hawaii	Sheltered Homeless	286	229	170	-25.8%
	Unsheltered Homeless	313	337	447	+32.6%
	TOTAL	599	566	617	+9.0%
State	Sheltered Homeless	3,535	3,632	3,726	+2.6%
	Unsheltered Homeless	2,299	2,556	2,520	-1.4%
	TOTAL	5,834	6,188	6,246	+0.9%

The table above shows the total PIT statewide count over a three-year period. The data indicates that the number of sheltered homeless increased by 2.6 percent reflecting increased

²² 2012 Homeless Point-in-Time Count, City and County of Honolulu, Department of Community Services, State of Hawaii, Department of Human Services, Homeless Program Branch Office.

²³ Homeless Point-in-Time Count, 2012, City and County of Honolulu.

shelter utilization; however, some shelters are still not at full capacity. Persons in families continue to comprise a high percentage of the sheltered population; the average shows a 71 percent increase over the past three years. Oahu accounted for 3,035 of the 3,726, or approximately 81 percent, of the state's total sheltered homeless population. Of this number, 534 were in households with children, 2,170 were people in families and 865 were individuals. The PIT report also noted that there are fewer shelter beds available to single individuals and persons in households without children. In Hawaii County, the number of sheltered homeless continues to decrease for the third year in a row. There were 170 sheltered homeless on the island in 2012 versus 229 in 2011.

The counts of unsheltered homeless did not show any noticeable movements. On Oahu the number of unsheltered homeless remained reasonably the same, from 1,318 in 2012, down from 1,322 in 2011. There was a noticeable shift from the Waianae Coast to downtown Honolulu in 2010, which had a concentration of unsheltered homeless of 410 unsheltered individuals (29.8 percent of the island's total unsheltered homeless population); while downtown Honolulu recorded 394 people (28.7 percent). In 2011, the highest concentration of unsheltered homeless was now in the downtown Honolulu (448 people or 33.9 percent) with Waianae accounting for 296 people (22.4 percent). For 2012, the total counts remain stable with 403 or 30.6 percent of unsheltered homeless individuals residing in the downtown Honolulu area and 280 or 21.2 percent residing in the Waianae area.

Two counties, Kauai and Hawaii, saw a significant increase in the total number of unsheltered individuals, 25.9 percent and 32.6 percent respectively, while Maui showed a drop in that population (31.0 percent). Kauai County's overall homeless count increased 19.6 percent from 336 to 402. Overall, the statewide unsheltered homeless count fell by 1.4 percent.

Although the data provides a "snap shot" of the homeless population in the state, the data is not without limitations. Reasons for this are that 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. The data is based on the United State Department of Housing and Urban Development's (HUD) very specific definition of homes – those living in emergency shelters, transitional housing for the homeless, safe havens for homeless individuals and in places not intended for human habitation (unsheltered). Lastly, 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/outreach workers. This can result in different totals and varying assumptions about what constitutes serious mental illness.

The *Projects for Assistance in Transition from Homelessness* (PATH) grant 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.

The Hawaii Department of Health's AMHD is responsible for planning, coordinating, and implementing the PATH Formula Grant Program. Subsequently, the 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 like 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, and included in the AMHD service array is the provision of services for homeless adults living with mental illness.

Number of Homeless Persons with Severe and Persistent Mental Illness Served

Outreach services to persons who are “homeless”²⁴ are provided primarily by service contracts with POS providers jointly funded by the Center for Mental Health Services, 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. During FY2012, 769 homeless individuals were contacted through outreach. However, only 211 or 28 percent of individuals were enrolled in the AMHD system. According to the Consolidated Plan for the State of Hawaii, the state is currently experiencing a shortfall of approximately 35,000 affordable homes for purchase and 17,000 rental apartments.

Solutions to Homelessness

In July 2011, the Governor established the Hawaii Interagency Council on Homelessness (HICH) and tasked the group with developing a statewide 10-year plan to end homelessness. The Governor’s vision for the State is to end homelessness through increased coordination among stakeholders. There are four (4) overarching goals: 1) Retool the homeless crisis response system; 2) Increase access to stable and affordable housing; 3) Increase economic stability and self-sufficiency, and 4) Improve health and stability.

One of the initiatives is the development of an inventory of permanent rentals. Efforts also include helping the chronically homeless through “Housing First,” a policy of getting individuals stable shelter which then makes them more receptive to medical treatment and social assistance. The “Housing First” concept is receiving acceptance among state lawmakers. They believe that housing is needed for those with chronic problems or for those who have recently become homeless. As a result, on May 22, 2013, the Governor released \$48.3 million for public housing statewide. Priority projects were identified by the members of the state legislature.

Also in May 2013, the Mayor of Honolulu outlined an ambitious two-year Housing First pilot project to shelter 100 of Oahu’s most visible and troubled homeless individuals off the streets. The project is based on the “Housing First” model in which resources are focused on getting

²⁴ 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.”

people in housing using the “scattered residence” for the estimated 505 chronically homeless. The cost for this program is estimated between \$3 to \$4.9 million and \$30,000 to \$48,000 per person. The City and County managers plan to house 500 to 600 chronically homeless individuals from the streets.

During the last legislative session, State legislators passed funding for a new program to offer one-way flights to any of the state’s estimated 17,000 homeless persons. Lawmakers appropriated \$100,000 over the next two years for the “return-to-home” program, but that funding could increase if the initiative is viewed as a success.

The state Department of Human Services (DHS) would administer the program, but officials there worry that the program could wind up being abused by those not currently living in Hawaii. There are, however, a few eligibility restrictions. In order to get a free one-way ticket, a person must be participating in the program for the first time and swear he or she is doing so voluntarily. In addition, there is little verification that the person using the one-way ticket will have any better opportunity at their destination, because at that point, Hawaii has shed its responsibility for providing care and services. One way to improve this type of program, as the Director of Community Organizing at the National Coalition for the Homeless opined, is that the program should be run not by law enforcement officials, but by homeless advocacy organizations that have the homeless best interests at heart.

In May 2013, the Hawaii State Department of Health, Alcohol and Drug Abuse Division proposed the *Hawaii Pathways Project* to SAMHSA to strengthen the infrastructure, partnerships, and service systems to provide permanent housing to individuals and families living on Oahu. If funded, the project will assist the chronically homeless individuals with substance use or co-occurring substance use and mental health disorders through assertive outreach, case management, and treatment services. The goals of the project are:

- Provide sustainable, permanent housing to individuals.
- Link individuals to Medicaid and other mainstream entitlements.
- Provide community-based and evidence based treatment for substance use and psychiatric disorders that is client driven and recovery oriented.
- Provide a range of recovery resources and supports including peer navigation and peer support.

Under the Supportive Services for Veteran Families Program (SSVF) program, \$300 million in grant monies has been allocated to assist veterans who are homeless in Hawaii. The Veterans Administration (VA) will award grants to private non-profit organizations and consumer cooperatives who can provide supportive services to very low-income veteran families living in or transitioning to permanent housing.

Funds will provide eligible Veteran families with outreach, case management, and assistance in obtaining VA and other benefits, which may include:

- Health care services
- Daily living services
- Personal financial planning services
- Transportation services
- Fiduciary and payee services
- Legal services
- Child care services
- Housing counseling services

In addition, grantees may also provide time-limited payments to third parties (e.g., landlords, utility companies, moving companies, and licensed child care providers) if these payments help Veteran families stay in or acquire permanent housing on a sustainable basis.

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 departments, the Judiciary Branch, Developmental Disabilities Division, the Child and Adolescent Mental Health Division, Division of 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 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.

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 Trauma Informed Care Initiative (TIC IT) Grant; the University of Hawaii; the Department of Labor Center for Disabilities Studies; and through the Social Security’s Ticket-to-Work program, community stakeholders and providers has been successful. 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. Further, by streamlining program efforts and combining “silos” has resulted in support of creating more training opportunities for consumers, increasing the use of evidence based best practices, and combating homelessness while promoting safe, affordable housing for individuals in the state.

Another example of successful partnering with another program within the Department of Health is with the Office of Health Status Monitoring (OHSM). Over the past several years, the AMHD and OHSM developed a symbiotic relationship to gain a better understanding of suicidal thoughts and behaviors among adults which may help to identify individuals at risk for suicide, to inform the development of screening tools, and to inform AMHD and general practitioners on treatment planning. Consequently, the AMHD partnered with the OHSM to look at causes

of death in the entire AMHD population by contracting with SMS Research and Marketing Services, Inc. This study, through random sampling of consumers currently receiving services in the AMHD system, asked three (3) questions: 1) During the past 12 months, did you ever seriously consider attempting suicide?; 2) During the past 12 months, did you ever make plans about how you would attempt suicide?, and 3) During the past 12 months, how many times did you actually attempt suicide?

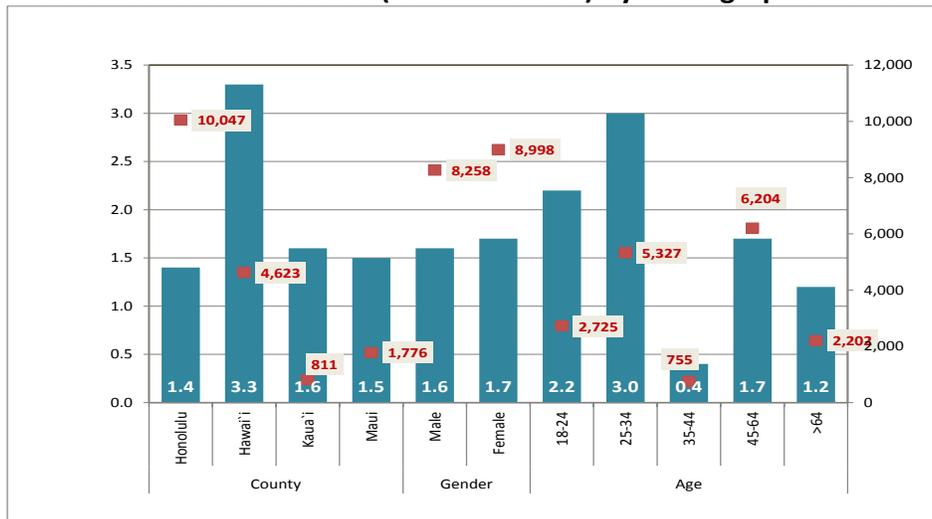
Table 5: Attempted Suicides to Completions

Source of Estimate	Considered	Made A Plan	Attempts	Suicides	Failures / Success
	N	N	N	N	Ratio
US Adults 2008	8,300,000	2,300,000	1,100,000	33,000	33
HHS Average 2007, 2009	22,840	18,279	5,194	131	40

Table 6: Considered Suicide (last 12 months) Exceed Confidence Limits State Average

Variable	Considered Suicide Last 12 Months		
	%	Lower 95% CL	Upper 95% CL
State Adult Average	1.7	1.3	2.2
Below Poverty - Poor <100%	3.9	2.4	6.2
Diabetes	10.3	4.1	23.7
HBC	5.5	2.4	11.8
Lung Cancer	4.8	2.3	9.8
Number of Chronic Conditions >1	7.4	3.0	17.5
Fair-Poor General Health	4.5	2.5	7.9
	5.9	3.6	9.3

Table 6: Considered Suicide (last 12 months) By Demographic Variables



The results of the study as depicted in the tables and graph above, showed the following:

- Compared to adults in the U. S., Hawaii adults have a higher ratio of attempted suicide to completion.
- Below poverty level and health conditions are highly associated with consumers considering suicide.
- Adults considered suicide, for the last 12 months, ranged 1.4 – 2.4 percent from 2001 to 2011.
- Consumers between the ages of 25-34 appear to have attempted suicides to completion.
- Hawaii County compared to the other counties has the highest rate of attempted suicides to completion.

Trauma Informed Care

One of the strengths of AMHD is the Trauma Informed Care Initiative (TIC IT). In 2010, SAMHSA announced that Hawaii was among 22 states who have been awarded a competitive grant to enhance its public mental health services. This is a five-year initiative focusing on universal trauma screening for all service recipients within AMHD's 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 in providing the trauma services and to develop this role 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, training resources have been distributed, and statewide training opportunities have been offered.

Continuity of Care Program

The primary function of this new service is to coordinate a statewide system of services for adults with SMPI and to address AMHD's enhanced mission to focus on "recovery into independence." It promotes continuity of care wherever the consumer intersects with the criminal justice system, admission into AMHD services until discharge (including Hawaii State Hospital (HSH) and the Community Mental Health Centers). This service also 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 statewide. Compliance went from a low of 19% to a high of 84% for case managers' attendance at hospital recovery plan review meetings.

E-ARCH Program

The AMHD Expanded Adult Residential Care Home (E-ARCH) Program was initiated as a continuity of care project to address the rising census at the HSH. The program focused on discharge of patients residing at HSH who did not meet acute psychiatric criteria, yet had no appropriate AMHD funded level of care for discharge. On a case-by-case basis, usually as a result of forensic encumbrance, other facility referrals have been approved for the AMHD E-ARCH Program consumers admitted to Kahi Mohala, Licensed Crisis Residential Services (LCRS), Specialized Residential Services Program (SRSP), and other hospitals including Castle Medical Center, the Queen's Medical Center, and Pali Momi Medical Center.

Currently there are 39 consumers participating in the AMHD E-ARCH Program with an additional two consumers transitioning into the program. There are approximately 25 licensed E-ARCH care givers and five private pay RN case managers contracted with AMHD for this service.

While not eccentric by any means, two main reasons why the AMHD E-ARCH Program stands out as extraordinary include:

Education and Training (to the care giver, their staff and the private pay RN case managers). Through community research and discussion, it was pointed out that there was a lack of education and training on psychiatric care in the E-ARCH setting. The opportunity to address this barrier to discharge comes annually by way of the three-day HSH care giver and private pay RN case manager training. Course topics on therapeutic relationships, boundary setting, psychiatric diagnoses, co-morbidity, community risk assessment, and self-defense are taught by seasoned professionals including psychiatrists, psychologists, nurses and community leaders.

Team Collaboration (Prior to, during, and After E-ARCH admission). There is always an opportunity to talk, to communicate and to explain. Being up front, forthcoming, and proactive is part of the commitment to quality discharges. Hospital and community team members have multiple interaction opportunities, two of which are seen as significant to the placement process. The initial transition meeting and discharge meeting focus on the roots of the discharge plan essentially mapping out the transition process. The goal is to keep the transition to a two week period using either the "go and stay" model or the "back and forth" model.

One ongoing challenge for this program is the need for utilization management and administrative program support. This program has been recognized for its commitment to working with providers and supporting consumers as they move out of the hospital and into a community-based home setting. As the population ages, more geriatric psychiatric care options are needed such as an AMHD funded adult residential care home (ARCH) program and a larger 24/7 operated psychiatric intermediate care facility (ICF), and mobile psychiatry and physician services.

Emergency Room Usage/Criminal Justice Front Door Diversion/Collaboration

The following summary is taken from the 2012 report of the Honolulu Emergency Psychological Services and Jail Diversion Program (HEPSJDP). This program is partially funded with Mental Health Block Grant funds.

The Honolulu Emergency Psychological Services and Jail Diversion Program (HEPSJDP) is a collaborative project of the Honolulu Police Department (HPD), the Hawaii State Department of Health, Honolulu Emergency Medical Services, the Queens Medical Center, Castle Medical Center, Tripler Army Medical Center, and the Institute for Human Services. The program has been funded with federal, state and city resources. This report analyzes pre and post arrest data on mentally ill and emotionally disturbed persons who came into contact with police officers between January 1, 2007 and December 31, 2012. The HEPSJDP was designed to comply with guidance from the US Department of Justice, the US Department and Health and Human Services, Federal case law, Hawaii Revised Statutes, and with policy guidance from the International Association of Chiefs of Police (IACP), the Commission on Accreditation for Law Enforcement Agencies (CALEA), the National Association for Mental Illness (NAMI), Mental Health America (MHA) and the Criminal Justice/Mental Health Consensus Project. The program's mission is to:

- Divert as many mentally ill and emotionally disturbed persons from the criminal justice system into the mental health system as possible without compromising public safety;
- Provide 24/7 consultation to HPD officers on how to respond to, manage, and provide assistance to persons-in-crisis (PICs);
- Train police officers on how to respond to and deal with PICs;
- Provide access to emergency psychological services for any PIC who comes into contact with a HPD officer;
- Coordinate emergency mental health services;
- Provide basic psychiatric screening and medication management for all persons who are arrested; and
- Provide data-based trends analysis on the mental health and criminal justice outcomes of these services.

The HEPSJDP assisted 28,868 individuals, either a pre or post arrest between January 1, 2007 and December 31, 2012. During this period, 10,156 individuals were sent to a hospital on an MH1 for involuntary psychiatric evaluation/treatment; 534 individuals received Crisis Mobile Outreach (CMO) from workers who were sent to the scene of incidents; and 16,129 individuals received medical services while in the cellblock. Over the life of the program, 76% of the individuals involved in an incident that entailed calling the police psychologist without arrest were only seen once. In 2007, approximately 30% of those arrested were of individuals with SMI or severe substance abuse. In 2012, despite a 300% increase in diversions into the mental health system, the percentage of arrests had risen to approximately 44% of all arrests.

A similar program that is funded with the Mental Health Block Grant funds is the Maui Crisis Intervention Team program. This program trains police officers in the tri-island area (Maui, Molokai, and Lanai) to respond to consumers in crisis.

Weaknesses of AMHD's Service System

Lack of Housing

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

Hawaii State Hospital (HSH)

The commitment of staff and management at the HSH 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 an increase in the number of filled beds. While discharges for this 95% forensic population are largely through the court system, analysis nevertheless indicated that emphasis on discharge planning held promise. The focus is on rehabilitative activities, and (PSR). The primary responsibilities for psychiatry, psychology, and 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. Unfortunately, the census at HSH continues to grow. Currently, as of August 18, 2013, there are 202 patients in HSH, with 40 consumers housed in a privately owned community hospital, and four housed in the Hawaii Health System Corporation's county hospitals.

In response to the high rate of admissions at HSH, Governor Abercrombie convened a Special Action Team (SAT) in the summer of 2012. The SAT met over the course of three months, with participation by a statewide panel comprised of representatives from the Governor's office, executive branch departments (Attorney General, Health, Human Services, Public Safety, Human Resources Development, Budget and Finance) the Judiciary, the Offices of the Prosecutors of each county, the Office of the Public Defender, Chiefs of Police of each county, community mental health consumers, providers and advocates. The work of the group was focused on three areas: 1) Personnel/Finance/Procurement; 2) Program Capacity/Clinical Operations; 3) Legal/Judicial. In addition to community based service delivery and interagency collaboration actions, the SAT has four recommendations for statutory changes. One proposed change is a new amendment to Hawaii Revised Statutes (HRS) §704-404 (Examination of defendant with respect to physical or mental disease, disorder, or defect) and three proposed changes are housekeeping measures intended to clarify an amendment made to HRS §704-411 (Legal effect of acquittal on the ground of physical or mental disease, disorder, or defect excluding responsibility; commitment; conditional release; discharge; procedure for separate post-acquittal hearing) during the 2011 Legislative session by Act 99. The four proposed changes are included and incorporated into this single bill. The new proposed change amends

HRS §704-404 to mandate that all public agencies provide records to the court regarding individuals undergoing fitness examinations ordered by that court. The amendment should have resulted in helping to shorten the length of hospitalization at HSH due to delays in receiving required information in a timely manner needed by the courts. Most providers of medical care currently cannot provide their records without consent from the defendant and many defendants do not consent. This amendment would have made the disclosure required by law, and therefore, eliminate other confidentiality legal impediments to releasing the information. This proposal would also made the Judge's order for evaluation to also be an order requiring and assembling information relevant to the evaluation; the impact of this change will be to shorten the length of legal proceedings as the necessary records will be submitted to court in a timely manner, and thereby shorten lengths of stay for patients at HSH. Unfortunately, the bill "died" in committee. Plans are underway to reframe the bill and re-submit it as a new bill in the 2014 legislation session.

Transportation

Travel in the rural areas of Hawaii continues to be problematic. Ground transportation for rural consumers on the island of Hawaii and air travel options for neighbor island air traffic are examples. In the current economic climate, inter-island state travel underwent special scrutiny.

Shortage of Psychiatrists

Hawaii 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, psychiatrists are leaving the state system for more advantageous employment opportunities.

Lack of Consistent Data

The lack of consistent data across the state system has hampered progress in strengthening services and the service delivery infrastructure. Within the AMHD, there are two competing data collection systems that are not integrated. The AMHD is seeking to remedy the situation by implementing the System Improvement Project (SIP). The purpose of the SIP is to integrate contractual data, claims data, utilization data, and electronic health records management into one data system across the AMHD system (CMHCs, HSH, POS providers). Reporting and the ability to track data elements will be enhanced once the system is operable. In addition, sentinel events data, hospital readmissions and consumer costs/expenditures will be captured in this new data base. Unfortunately, the implementation of the project has been delayed due to a lack of equipment.

Hawaii Department of Health, Child & Adolescent Mental Health Division

The Hawaii Department of Health is charged to provide preventative health services for children and youth; provide diagnostic and treatment services for emotionally disturbed children and youth, and provide treatment and rehabilitative services for mentally ill children and youth. Such services shall be delivered at the earliest possible moment after the need for such services is established. All eligible children and youth between the ages of birth and seventeen shall receive the necessary mental health services to ensure their proper and full development. (Hawaii Revised Statutes §321-171). The children's mental health services program is required to coordinate the effective and efficient delivery of mental health services to children and youth, including services provided by private nonprofit agencies under contract to the department of health, and is responsible for the development and implementation of centralized and highly specialized programs for children and youth. Children's mental health services are provided through a combination of public and private services. Direct services such as clinical oversight and intensive case management are provided by the state, while additional services are provided by an array of private providers under contract with the state.

Description of the Child and Adolescent Mental Health Division

The Child and Adolescent Mental Health Division (CAMHD) is led by a CAMHD Administrator and consists of both line and staff offices. The staff offices are maintained at the state level with 82 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 145 positions. 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 information technology initiatives, including the electronic health records system, 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 led 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.

CAMHD Strengths

Commitment to the Hawaii CASSP Principles

Based on the input from youth, families and stakeholders, CAMHD adopted the Hawaii Child and Adolescent Service System Program (CASSP) Principles. Nationally, the CASSP principles (Stroul, B.A. and Friedman, R.M., 1986) were developed based on the original work of Jane Knitzer (*Unclaimed Children*, 1982) to provide a framework for systems of care. Early in the 1990's Hawaii communities and stakeholders reviewed and adapted the CASSP principles to ensure the principles are culturally and linguistically relevant to our community.

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

- *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). 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.

Ethnicity of Child and Adolescent Mental Health Division Staff		
Black	3	1.5%
Chinese	9	4.5%
Filipino	19	9.6%
Hawaiian	5	2.5%
Japanese	52	26.3%
Korean	2	1.0%
Mixed, Other than Part-Hawaiian	3	1.5%
Other and Unknown	16	8.1%
Part Hawaiian	37	18.7%
Puerto Rican	3	1.5%
Samoaan	1	0.5%
Caucasian, Portuguese	48	24.2%
TOTAL	198	100.0%

CAMHD Clinical Model. To ensure appropriate, effective and efficient treatment, CAMHD maintains clinical oversight of each youth served. Each youth is assigned a Mental Health Care Coordinator who will facilitate the planning, coordination of services and monitoring of treatment through consultation with the Branch Clinical Lead.

Clinical Lead. Within each Branch, a Clinical Psychologists and Child Psychiatrists provide clinical direction to the treatment provided to youth through their collaboration and consultation with the youth’s assigned Care Coordinator. Clinical review by a psychologist or psychiatrist helps to assure that the services authorized are appropriate to address the youth’s difficulties and that they meet “Medical Necessity” criteria. Each youth will be assigned a

“Clinical Lead” – either a CAMHD psychologist or psychiatrist - who will oversee their care and authorize services. The Clinical Lead’s involvement may also include consulting with the service provider to help with planning treatment and designing interventions for the youth in order to assure efficient, effective care.

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. Parent Partners are also available to provide peer support to parents. Contracts are responsible for coordination of services that re provided within their agency and regular communication about their services to the CAMHD MHCC.

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.

Primary Diagnosis of Child and Adolescent Mental Health Division Youth		
Adjustment Disorders	106	5%
Anxiety Disorders	167	9%
Attentional Disorders	283	15%
Disruptive Behavior Disorders	512	27%
Mental Retardation	23	1%
Miscellaneous Disorders	93	5%
Mood Disorders	273	14%
None Identified	404	21%
Pervasive Developmental Disorders	23	1%
Substance Related Disorders	45	2%
TOTAL	1929	100%

Data-Driven

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 CAMHDs

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.

Health Information Technology

Over the past few years, 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 increase access to professional services from anywhere across the Telehealth network. Training sessions can also be hosted throughout the state using the videoconference system.

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. 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. CAMHD does not provide services that are appropriate for youth with moderate or severe intellectual disabilities or severe autism spectrum disorders. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. CAMHD requires all its providers to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. 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. 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.

CAMHD currently has two SAMHSA system of care grants with which we are striving to improve services and Hawai'i's system of care.

Project Kealahou

Project Kealahou (navigating pathways to healing) focuses on improving the lives of girls who have experienced significant trauma. Project Kealahou is working to establish a trauma-informed system of care to help Hawai'i's ethnically and culturally diverse girls overcome difficulties in their lives. The grant collaborates with Hawaii's child-serving agencies, communities and families to help the girls build and nurture healthy relationships that will allow them to reconnect with their families, communities and themselves.

Project Kealahou provides:

- Support and mentoring – provides one-on-one support and mentoring for girls, assists them in setting and accomplishing personal goals, and offers opportunities for them to develop peer mentoring skills to help others.
- Youth activities – social and cultural group activities to promote connection to place, community, family and self.
- Girls Circle – A structured support group designed to foster self-esteem. Girls Circle encourages girls to maintain connections with peers and adult women, and allows for self-expression through sharing and creative activities, such as drama, journaling and art.
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – An evidence-based treatment that helps girls and their caregivers heal the impact of trauma.

Project Laulima (many hands working together)

The purpose of Project Laulima is to develop more integrated and comprehensive services to children and youth with co-occurring mental health needs and developmental disabilities. Project Laulima works to improve access and service quality. Project Laulima brings together the Developmental Disabilities Division and Child and Adolescent Mental Health Division of the DOH, the Department of Education, the Department of Human Services, and several family and youth organizations to improve collaboration and coordination to meet the multi-agency needs of children and youth with both mental health needs and developmental disabilities. Project Laulima will focus on the development of new policies and programming, and providing service accountability. The grant will support capacity building efforts, including community outreach activities, workforce development and comprehensive training initiatives.

Hawaii Department of Health – Early Intervention

The Department of Health Early Intervention Section (EIS) is a federal and state-mandated program that provides services to support the development of infant and toddlers from birth to three years of age. Information and support are provided to parents to increase their knowledge about and ability to support their child's development. The Hawaii Health Department is the lead agency for the implementation of Part C, Individuals with Disabilities Education Act (IDEA) for the State of Hawaii. The Early Intervention Section is responsible to ensure that Hawaii meets all the requirements and regulations of Part C of IDEA. Services are provided to assist a child in five developmental areas: physical, cognitive, communication, social

and/or emotional and adaptive. To be eligible for services, a child must be developmentally delayed or biologically at-risk, which would include a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay if early intervention services are not provided. Eligible children are provided a care coordinator, and are offered services such as assistive technology, audiology, family support/education, health services, vision services, nursing, nutrition, occupational therapy, physical therapy, speech and language therapy, social work, specialized teach, psychological support, and transportation.

Hawaii Department of Education

Generally, the charge of the state education agency (SEA) is to monitor and enforce compliance with state and federal mandates, including IDEA, and to monitor and enforce compliance and to provide leadership and guidance through technical assistance to ensure that local educational programs are compliant and of high quality. Traditionally local education agencies (LEAs) provide the implementation of programming that leads to meaningful educational outcomes for students and their families. The Hawaii Department of Education performs the function of a local education agency (e.g., operating program services) while also maintaining oversight and technical assistance responsibilities as the state education agency. Hawaii's public schools form a single, statewide district that spans six islands and seven geographic districts: Central, Honolulu, Leeward and Windward on Oahu; and Hawaii, Maui (including Molokai and Lanai islands) and Kauai (including Niihau Island). Each complex consists of a high school and the elementary and intermediate/middle schools. There are 287 public schools, 31 of which are charter schools.

Hawaii's unique location in the Pacific Ocean established our islands as the military hub of the Pacific. With Air Force, Army, Coast Guard, Marines, and Navy base installations located on Oahu, Kauai, and the Big Island, and the Pacific Component Commands headquartered on Oahu, Hawaii supports the 300,000 plus service personnel and their families. About 15,000 military dependents, representing about 8 percent of the total student enrollment, attend public schools.

In the 2011-2012 school year, 212,345 students were enrolled in public and private schools, grades K to 12. Nearly 16 percent of Hawaii children were enrolled in private schools (34,132). The majority of students (84.2%, 181,213) of students were enrolled in Hawaii's public schools.

Ethnicity of Hawaii Public School Students 2011-2012²⁵

Black	5,111	2.80%
Hispanic	6,654	3.70%
Native American	1,155	0.60%
Native Hawaiian	50,165	27.70%
Chinese	6,012	3.30%
Filipino	39,619	21.90%
Indo-Chinese	2,178	1.20%
Japanese	16,740	9.20%
Korean	2,217	1.20%
Other Asian	462	0.30%
Asian two or more	210	0.10%
Guamanian/Chamorro	430	0.20%
Micronesian	5,888	3.20%
Samoan	6,284	3.50%
Tongan	1,022	0.60%
Other Pacific Islander	583	0.30%
Pacific Islander two or more	25	0.00%
White	27,248	15.00%
Portuguese	2,590	1.40%
White two or more	3	0.00%
Multiple, two or more	6,617	3.70%
TOTAL	181,213	100.00%

Aligned with IDEA legislation, Hawaii public schools offer a continuum of alternative placements where students receive special education or related services, including regular classes, special classes, special schools, home instruction and instruction in hospital settings. With the 2004 IDEA reauthorization, Hawaii added a provision for supplementary services such as a resource room or the provision of itinerant instruction in the regular classroom placement. Hawaii's education system takes great effort to provide special education and related services at the student's neighborhood or home school.

The largest (48%) disability category group served by Hawaii's special education system of students ages 6-21 is Specific Learning Disability. Typically in other states, Speech and Language Impairment category is the second largest group, but in Hawaii the second largest

²⁵ Office of the Superintendent Systems Accountability Office, Department of Education. (2013). *2012 Superintendent's 23rd Annual Report. (RS 13-1271)*. Honolulu: Hawaii Department of Health.

disability category group is Other Health Impairment, comprising 15% of the special education population. In December 2009, 17,502 students ages 6-21 in Hawaii were served under IDEA²⁶. Eight percent (1,420) of students ages 6-21 served under IDEA had an Emotional Disturbance; seven percent (1,167) of students served were under the Developmental Delay category, six percent (1,042) were under Autism, and seven percent (1,244) were served under Mental Retardation.

Hawaii'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.

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.

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.

²⁶ Benitez, D., Meinders, D., Kubinec, J., & Reynolds, V. (2011). *Hawaii Department of Education Special Education Review*. (p. 16). Sacramento: WestEd Center for Prevention and Early Intervention.

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

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.

The purposes of the CCCs are to:

- function as community-based planning and evaluating groups
- provide support and training to parents of special needs children
- provide solutions to concerns raised by community members or refer to proper authority for resolution
- identify any gaps in service delivery and offer possible solutions
- provide feedback to policy makers regarding the effect of policies on service delivery in the local community

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.

- provide system advocacy activities to support, sustain and maintain the quality of services needed in the local community
- serve as a direct link to the Departments of Education and Health and other child serving agencies regarding consumer and community satisfaction

Hawaii Department of Human Services

Hawaii Children's Insurance Program

Hawaii's free public health insurance programs are QUEST and QExA, managed by the Department of Human Services. For children and youth to be eligible, they must be 0 to 19 years old, meet household income level up to 300%, and qualify as U.S. citizens, lawful permanent residents, refugees, or citizens of the Marshall Islands, Federated States of Micronesia, or Republic of Palau. Covered services include regular check-ups, emergency care, immunizations, prescription medicines, doctor visits, eyeglasses, counseling and dental care. A child is covered for one year if he or she stays in the household and doesn't get other health insurance. At the end of one year, a letter is sent to the family to renew their QUEST or QExA health insurance. Although the DHS Med-QUEST data on eligible recipients do not include a separate category for children, in 2010, there were 152,235 children who were eligible for Early & Periodic Screening, Diagnosis & Treatment (EPSDT) for Children.²⁷

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. If more intensive services than those available through the Medicaid Health Plan arise, the youth is referred to the CAMHD system. 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.

²⁷ Management Services Office Research Staff . (2013) State of Hawaii Department of Human Services. Databook, Honolulu: Author.

II: Planning Steps

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

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.

Adult Mental Health Division

To identify unmet needs and service gaps within the adult population receiving mental health services, the AMHD engaged in a comprehensive needs assessment process during the spring of 2013. The process included a series of focus group meetings in each county for stakeholders to respond to a list of pre-determined questions. The on-line survey was designed to solicit broad feedback from stakeholders about AMHD in order to better understand the strengths of the system, service needs, and challenges encountered by consumers, providers, system partners across the state. The process for obtaining community input in determining state priorities met two needs: 1) for each county to develop county plans, which meets state statutory requirements, and 2) to get an environmental scan of the AMHD system for development of its 5-year Strategic Plan.

Statewide Themes

- Clubhouses
 - Strength in many communities.
 - It is a cost effective service, but not available to many because of the eligibility criteria.

- Eligibility Criteria/Access Services
 - Lack of clarification of eligibility to get into AMHD services.
 - It is difficult to get young adults who need mental health services into the AMHD system.
 - There is often a gap from the time of eligibility determination to the time of actual linkage to services; during this time, the service authorization expires.
 - Perception is the only way to get mental health services is to get arrested.

- Service Authorization/Utilization Management
 - Continued issues with perception of limits on case management units; cumbersome process for extra unit authorization.
 - Case managers do not have enough time to work with consumers, especially when there are emergencies and a lack of psychiatry.
 - Many case managers are not applying for extra hours because they are not being reimbursed.
 - When UM makes referrals to provider agencies, little information and background about the consumer is provided with the authorization.

- ACCESS Line/Crisis Response
 - Callers are put on hold; ACCESS does not know the local programs (neighbor islands), there is often no answer, no call-back, and calls frequently are routed to voicemail messages.
 - Access line is called by the hospital ERs, but mostly without success; there is often no responses.
 - ACCESS operators insist on talking directly to a client who must say they are in crisis; this is a barrier to getting people help.
 - Homeless individuals don't have phones.
 - Need crisis response where someone will listen; can't get to speak with a person especially when you need a quick response.

- Service Needs/Gaps in Services
 - Services for elderly SMI or TBI /SA
 - Shortage of detox beds
 - Meaningful and productive things for people like vocational and educational support
 - Support for young adults.
 - Need case management for discharges (specific to transitions).
 - Streamline process for adding more case management services and beyond when people are homicidal/suicidal.
 - 24-hour programs
 - Homeless/at-risk for homeless
 - Transportation
 - Group homes – if a person acts out behaviorally, they are often discharged
 - Not enough outpatient “prescribers”

Practice/Systemic Challenges

- Need support of caregivers and families pre-crisis that involves planning ahead, intact support.
- Gap in services between CAMHD & AMHD.
- AMHD continues to operate separately from primary health care. Psychiatrist and primary care provider do not integrate their care or coordinate their services.
- M.Ds do not communicate among each other at the client level – as a result substance abuse is a revolving door.
- Deeper understanding about consumers is needed.
- The ERs are over-utilized.

Insurance: Impact on Consumers

- With changes in insurance coverage, people lost connection with their agencies who could not take more clients because they were capitated.
- The process is complicated and no one is responsive to the concerns/questions of consumers.
- Health plans are having difficulty in finding many of the consumers, so they are disenrolled.

Priority Recommendations

- Improve ACCESS line. Consider separating call lines for suicide/risk crises and eligibility.
- Provide accessible urgent care for people with serious mental health issues.
- Improve the crisis system; provide crisis services that are accessible and responsive.
- Provide better case management for transitions.
- Patient navigators are needed throughout the system.
- Develop a more proactive system vs. a reactive system.
- Consider providing more 24-hour supervised residential services.
- Increase access to detox services.
- Work with insurance companies and MQD to simplify insurance processes.
- Consider expanding eligibility criteria.
- Separate forensic from the mental health system. People who are not mentally ill come into the mental health system from the courts.
- There is a need for more primary care working with psychiatry.

The AMHD is in the process of updating its ACCESS Line and expanding its eligibility criteria. Therefore, the following priority areas, goals and strategies are identified to address the other listed recommendations.

Children’s Mental Health

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), the table below estimates there to be about 12,545 SED youth in the state of Hawai’i.

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)

The Annie E. Casey Foundation’s KIDS COUNT Data Center¹ estimated that in 2007, 30,000 children in Hawaii have one or more emotional, behavioral, or developmental condition. According to the Centers for Disease Control and Prevention², 13%-20% of children living in the United States experience a mental disorder in a given year, and surveillance during 1994-2011 has shown the prevalence to be increasing. Attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), autism spectrum disorders (1.1%), and Tourette syndrome (0.2% among children aged 6–17 years).

The Child and Adolescent Mental Health Division (CAMHD) conducts an annual evaluation of the population served, the service provided, outcomes of services and the associated costs of service provision. CAMHD’s Research, Evaluation and Training Office uses a variety of sources for its data. The primary source of information is the Child and Adolescent Mental Health Management Information System (CAMHIS), which supports registration of youth with CAMHD, authorization of services, electronic billing for services, and child status monitoring functions. System information was collected from independent databases maintained by various offices within CAMHD. The CAMHD Administrative Services Office maintains the databases for manual billing information and contracts, and provides analysis and reporting based on the Department of Accounting and General Services (DAGS) Financial Accounting and Management Information System (FAMIS). The Clinical Services Office maintains a database of youth placed in out-of-home settings based on weekly provider census reports. The Performance Management Office maintains a database of sentinel events based on incident reports submitted by providers. The CAMHD Research, Evaluation and Training Office (RET) was responsible for merging and validating information from these databases.

In FY2012, CAMHD registered 1,954 youth into its system, with a subset of 1,230 requiring procured services from our array of services. This was a slight increase from last year, and hopefully indicates a slowing of the decline CAMHD has experienced over the past several years. The youth from all islands were represented, with the largest population (37%) served by the Hawaii Family Guidance Center on Hawaii Island (affectionately known as “The Big Island”). Forty percent of the youth were served by the four community-based Family Guidance Centers on the most populous island of O’ahu. Nine percent and eight percent of youth were served by the Maui and Kauai Family Guidance Centers, respectively. According to the Annie E. Casey Foundation’s KIDS COUNT Data Center³, 69% of Hawaii’s children age 0-17 live on Oahu, 13% on the Big Island, 12% on Maui County and 4% on Kauai.

¹ Retrieved August 8, 2013, from The Annie E. Casey Foundation, KIDS COUNT Data Center, <http://datacenter.kidscount.org>

² Centers for Disease Control and Prevention. Mental Health Surveillance Among Children—United States, 2005-2011. MMWR 2013;62(Suppl 2):pp.1-3.

³ Retrieved August 8, 2013, from The Annie E. Casey Foundation, KIDS COUNT Data Center, <http://datacenter.kidscount.org>

According to KIDS Count, in 2010, 4.3% of the children under age 18 on the Big Island are without health insurance, 2.9% on Maui County, 1.9% on Oahu, and 1.3% on Kauai. These percentages, multiplied by the number of youth age 0-17 in 2010 by county, indicate that a little over 7,000 youth in Hawaii do not have health insurance.

The average age for youth served by CAMHD is 14.2 years. Despite various initiatives toward earlier detection and intervention, the age of admission in CAMHD has been persistently high at 14.1 years with no progress over time. Sixty-two percent of the youth served at CAMHD are male, while 38% are female. The ethnic distribution is 61% Multi-racial; 15% White; 13% Native Hawaiian or Pacific Islander; 9% Asian; 2% Black and 1% American Indian or Alaskan Native. While the majority of youth present with co-morbid conditions, the most frequent primary diagnoses are disruptive behavior disorders (33%), 20% mood disorders, 18% attentional disorders, 12% anxiety disorder and 1% pervasive developmental disorders.

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 FY2012:

Geographic Region	Registered Youth	Youth with Procured Services
Honolulu	218	154
Central Oahu	141	107
Windward Oahu	139	93
Leeward Oahu	291	216
Hawai’i	732	447
Maui	185	113
Kauai High End	160	82
Statewide TOTALS	1,866	1,212

*Family Court Liaison Branch’s statewide population is not included.

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.

Priority 1: To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.

Homelessness

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.

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 ADHD⁴.

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

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).

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.

⁴ 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.

Priority 2: To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.

Early 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.

The Healthy People 2020 Mental Health and Mental Disorders Objective 11.2 is: "Increase the proportion of primary care physicians who screen youth aged 12 to 18 years for depression during office visits."

Transition-Age Youth

Of concern to Hawaii's State Council on Mental Health, Hawaii does not have a good support system for youth who transition out of the child-serving system. It is estimated that approximately 400 youth age out of CAMHD each year, yet, due to eligibility criteria, less than 1% will transition to the adult mental health system. Block grant funds were used to support the educational, 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. In the past, block grant funds were successfully used to assist youth with the resources they need to achieve the goals in their transition plans. Youth were 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 assured that the purchases were appropriate to the goals in the transition plan, and accompanied the youth to purchase the items or pay the fees. Although CAMHD supports the empowerment of youth, in these instances, the youth were not allowed to handle the financial transactions, as the federal law prohibits cash payments to recipients.

Special Population

According to a National Alliance on Mental Illness fact sheet⁵, the effects of stigma against gay, lesbian, bisexual, or transgender (GLBT) youth may make them more vulnerable to mental

⁵ Bostwick, W.B., "Mental Health Risk Factors Among GLBT Youth" (Arlington: National Alliance on Mental Illness, 2007), available at <http://www.nami.org>.

health problems such as depression, anxiety, substance abuse and suicide.⁶ The fact sheet goes on to say that multiple studies have demonstrated that GLBT youth consistently face intense victimization in school settings and that 22% of GLBT youth reported they did not feel safe at school. Ninety percent of LGBT youth surveyed reported being harassed or assaulted during the past year, compared with 62% of non-LGBT youth.⁷ A 2009 survey of middle and high school students found that 85% of LGBT teens experienced being verbally harassed at school because of their sexual orientation and nearly two thirds experienced being harassed because of their gender expression.⁸ Bullying is one of several factors that put immense strain on LGBT teens' mental health. Fear of rejection from family members, anti-LGBT messages heard in places of worship and in the media, and the chronic stress associated with having a stigmatized and often hidden identity serve to exacerbate the mental health issues affecting LGBT youth. A recent review of the literature suggests that rates of suicide attempt among LGB youth are 20%-40% higher than among non-LGB youth.⁹

Recently, the Safe Spaces [Super] Committee was formed at CAMHD to create an LGBTQ inclusive, safe and affirming system of care. The committee is a dynamic group of LGBT and ally staff, providers, service system partners, youth, and family members dedicated to improving the lives of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) people in the system of care. They will be working to promote the use of inclusive language, encourage accepting attitudes, embrace diversity, and provide education to the system of care and the greater community. The committee recently created a survey to measure CAMHD staff's attitudes and understanding about LGBT issues. Using the information from the survey, they will develop educational materials and trainings and will distribute professional articles about working with the LGBT population. A longer term goal will be to update policies and procedures and forms to include the spectrum of sexual orientations and gender identities.

Supporting Parents in Directing Care

According to CAMHD's 2013 Consumer Survey findings, participation in their child's mental health treatment was the second most predictive factor in consumer satisfaction.¹⁰ Also, CAMHDs 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 to support CAMHD's family partner organization that represents families in the mental health system and whose parent partners engage parents in advocacy

⁶ Hart, T.A., Heimberg, R.G. (2001). Presenting problems among treatment-seeking gay, lesbian, and bisexual youth. *Journal of Clinical Psychology*, 57, 615-627.

⁷ Harris Interactive and GLSEN (2005). *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers*. New York: Gay, Lesbian and Straight Education Network.

⁸ Maza, C, Krehely, J. (2010). How to Improve Mental Health Care for LGBT Youth: Recommendations for the Department of Health and Human Services. Center for American Progress. Retrieved August 19, 2013 at <http://www.americanprogress.org>

⁹ Kitts, R. L. (2005). Gay adolescents and suicide: Understanding the Association. *Adolescence*, 40, 621-628.

¹⁰ Cultural sensitivity was the most predictive factor.

Jackson, D. and Keir, S. (2013, August). Youth Services Survey for Families (YSS-F): Consumer Survey, 2013. PowerPoint presentation at the State Council on Mental Health, Honolulu, HI.

and participation in treatment. A long-term goal will be for the parent organization to be self-sustaining through reimbursement of peer support services. 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 is available on a local, culturally-sensitive, and family-friendly website: www.helpyourkeiki.com. Mental health information will also be provided in 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.

Priority 3: To find primary prevention—universal, selective and indicated prevention activities and services for persons not identified as needing treatment.

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. Initiatives and efforts to reduce stigma and increase knowledge of mental health in the community is ongoing. CAMHD will continue to support the Children's Mental Health Matters Campaign Committee's public awareness activities. Their "Wear One, Share One" program teaches fifth and sixth grade students about what friendship means, how we can befriend others, and the importance of including rather than excluding others. The "Wear One, Share One" initiative has gained national attention. In October 2013, members of the Children's Mental Health Matters Campaign Committee will be conducting a presentation on the initiative at the Annual Conference on Advancing School Mental Health. The conference is hosted by the Center for School Mental Health and the IDEA Partnership, sponsored by the National Association of State Directors of Special Education. The theme of the conference is "What Works in School Mental Health: Collaboration from the Inside Out" and will reach clinicians, educators, administrators, youth and family members, researchers, primary care providers, advocates, and other youth-serving professionals. The Children's Mental Health Matters Campaign Committee also submitted a proposal on the "Wear One, Share One" initiative to the National Federation of Families for Children's Mental Health annual conference in November 2013.

Through the Committee's and CAMHD's staff efforts, the importance of children's mental health is promoted at local health fairs, at events across the state during Children's Mental Health Awareness Week, and at the annual Children & Youth Day at the State Capitol, which is hosted by the State Legislature and draws tens of thousands of Hawaii's families.

Youth Suicide Prevention

In Healthy People 2020, Mental Health and Mental Disorders Objective 2 is: “Reduce suicide attempts by adolescents.”

For years, Hawai‘i high school students had a high self-reported prevalence of seriously considering suicide, making a plan, and attempting suicide. According to the Hawaii Youth Risk Behaviors Hawaii School Health Survey 2011:

- 14.9% of youth were bullied electronically in the past year
- 29.5% felt sad or hopeless almost every day for two or more weeks in a row so that they stopped doing some usual activities in the past year
- 15% made a plan about how they would attempt suicide in the past 12 months, compared with 12.8% nationally
- 8.6% attempted suicide in the past 12 months, compared with 7.8% nationally.

Because of this, the Department of Health Injury Prevention and Control Section, supported by block grant funds, is collaborating with the Prevent Suicide Hawai‘i Taskforce and affiliated community organizations in each county to support suicide prevention gatekeeper trainings. Through the established trainer network and ongoing educational activities, the health department and its partners are building community capacity to ensure that at-risk youth have access to gatekeepers skilled in providing early intervention. The state is beginning to show progress. The percentage of high school students who report attempting suicide in the previous 12 months decreased from 13% in 2009 to 8.6% in 2011. During the same period, the national rate increased from 6 percent to 8 percent.

Priority 4: To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services statewide.

Improving Outcomes and Quality

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 CAMHDs Telehealth system, which is now almost fully operational. A Telehealth Coordinator was hired to coordinate and monitor use of the videoconferencing system and assist clinicians with using the electronic health record to document consultative and therapeutic interactions with the appropriate Medicaid Current Procedural Terminology (CPT) and Evaluation and Management (E&M) codes.

Increase Evidence-Based Clinical Care

One of CAMHD's strategic goals is to take advantage of the clinical expertise among staff. CAMHD is currently moving forward in developing systems and practices that incorporate clinical oversight by CAMHD Clinicians. Staff psychiatrists and psychologists will be improving the quality of client care by being more directly involved in individual cases and encouraging more use of evidence based services.

The statewide Evidence Based Services Committee, which has multidisciplinary and cross-agency membership, is dedicated to identifying evidence based programs and practices that are effective in improving mental health outcomes for children and adolescents. The work of the EBS Committee has been of immense benefit to CAMHD, and was instrumental in bringing CAMHD into the national limelight for its ground-breaking accomplishments. Through the EBS Committee, the professional relationship between the EBS's two leading agencies, CAMHD and the University of Hawaii Department of Psychology, was strengthened into a strong collaboration, which continues until today. Multiple initiatives between the University of Hawaii and CAMHD have helped to identify and operationalize efforts to improve clinical outcomes for the youth, as well as efficiencies in CAMHD operations.

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Evidence Based Practices

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

Promote the utilization of Evidence Based Practices (EBPs) in the delivery of services to eligible SMI/SPMI individuals.

Strategies to attain the goal:

Develop a service delivery system that utilizes five(5)to seven(7) EBPs to AMHD consumers, i.e., supported employment, supported housing, integrated dual diagnosis treatment (IDDT), illness management and self-directed recovery IMSR and medication management.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number/percent of trainings for staff on EBPs.
Baseline Measurement:	
First-year target/outcome measurement:	Develop baseline for the number of EBPs provided.
Second-year target/outcome measurement:	Increase the number of EBPs provided by 5%.
Data Source:	
	<div style="border: 1px solid black; padding: 5px; margin: 5px 0;">Fidelity and outcome data.</div>
Description of Data:	<div style="border: 1px solid black; height: 20px; margin: 5px 0;"></div>
Data issues/caveats that affect outcome measures::	

Indicator #: 2

Indicator: Number/percent of EBPs implemented according to the CMHS Toolkits.

Baseline Measurement:

First-year target/outcome measurement: Develop baseline for the number of EBPs provided.

Second-year target/outcome measurement: Increase the number of EBPs provided by 5%.

Data Source:

Fidelity and outcome data.

Description of Data:

Fidelity monitoring is included in CMHS's Toolkits for EBPs.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number/percent of consumers receiving EBPs.

Baseline Measurement:

First-year target/outcome measurement: Develop baseline for the number of EBPs provided.

Second-year target/outcome measurement: Increase the number of EBPs provided by 5%.

Data Source:

Fidelity and outcome data.

Description of Data:

Data will be collected from the community mental health centers.

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Safety and Wellness

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

Increase the number of consumers living independently.

Strategies to attain the goal:

Develop an AMHD Housing Plan.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number/percent of trainings provided to consumers, case managers, and providers.

Baseline Measurement:

First-year target/outcome measurement: In FY2012, 4,625 eligible consumers lived independently; in FY2014, increase the number by 5%.

Second-year target/outcome measurement: Increase the FY2012 number by 5%.

Data Source:

AMHD' Client Level Data

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Decrease the number of consumers evicted or terminated from AMHD Community Housing.
Baseline Measurement: Collect data from housing providers in FY2014, which will become the baseline measurement.
First-year target/outcome measurement: Quarterly reports from housing providers indicating the number of consumers evicted/terminated or at risk for termination.
Second-year target/outcome measurement: Decrease the FY2014 figures by 5%.
Data Source:

AMHD's Client Level Data.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Update the "Making It Home" AMHD Housing Manual on being a good tenant and provide trainings to consumers, case managers and public housing staff.
Baseline Measurement: Use Base measurement on FY2012 data in URS Table.
First-year target/outcome measurement: In FY2012, 4,625 eligible consumers lived independently; in FY2014, increase the number by 5%.
Second-year target/outcome measurement: Increase the FY2014 figures by 5%.
Data Source:

Client Level Data.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 4
Indicator: Decrease the number of SMI/SPMI individuals who are homeless.
Baseline Measurement: Use Base measurement on FY2012 data in URS Table of individuals living independently.
First-year target/outcome measurement: In FY2012, 4,625 eligible consumers lived independently; in FY2014, increase the number by 5%.
Second-year target/outcome measurement: In FY2015, increase the FY2014 by 5%.

Data Source:
Client Level Data.

Description of Data:
Numbers reported in URS Tables.

Data issues/caveats that affect outcome measures::

Priority #: 3
Priority Area: Provide Mental Health Services to Eligible Consumers
Priority Type: MHS
Population SMI
(s):

Goal of the priority area:
Develop a 5-Year Comprehensive Strategic Plan for the Adult Mental Health Division by summer 2014.

Strategies to attain the goal:
Develop a plan that guides the Division in providing coordinated services to SMI/SPMI individuals.
Engage system partners and stakeholders in the process.
Develop performance indicators to measure the success of the Plan.

Utilize data to inform policy and program decisions for improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Quarterly performance indicator results.
Baseline Measurement:
First-year target/outcome measurement: Complete plan.
Second-year target/outcome measurement: Develop and monitor performance indicators.
Data Source:

MHSIP Survey results.
QOLI Survey results.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Dashboard progress of the Plan.
Baseline Measurement: Results from the first year will be the baseline measurement.
First-year target/outcome measurement:
Second-year target/outcome measurement: Develop and monitor performance indicators.
Data Source:

MHSIP Survey results.
QOLI Survey results.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Behavioral Health and Primary Care

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

Integrate Behavioral Health into Primary Care for SMI/SPMI individuals.

Strategies to attain the goal:

Determine the immediacy of needs for the SMI/SPMI individuals based on their Axis III diagnosis.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Numbers of crisis calls through the ACCESS Line statewide.

Baseline Measurement:

Develop baseline data for the first year.

First-year target/outcome measurement:

Collect number of crisis calls that involves CMO and are primary care related.

Second-year target/outcome measurement:

Number of crisis calls from FY2014 are decreased by 5%

Data Source:

ACCESS Line quarterly report.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Hire Peer Specialists t statewide to run the Network of Care system to assist consumers in understanding their medical conditions.

Baseline Measurement: Use FY2014 data as baseline measurement.

First-year target/outcome measurement: Develop baseline for the number consumers Peer Specialists assisted.

Second-year target/outcome measurement: Number of consumers increased by 3% that Peer Specialists assisted.

Data Source:

Quarterly reports from Peer Specialists, who are overseeing the Network of Care system.

Description of Data:

Peer speicalists will be hired to cover eight community mental health computers. They will be required to keep a list of consumers they assisted.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Strengthen the CMHCs on primary care knowledge base to increase the integration of behavioral health and primary care.

Baseline Measurement: Use FY2014 data as baseline measurement.

First-year target/outcome measurement: Baseline data from FY2014 chart reviews.

Second-year target/outcome measurement: Chart review results increased by 5%.

Data Source:

Chart review results from random sample of consumers' charts.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.

Priority Type: MHS

Population (s): SED, Other (LGBTQ, Rural, Criminal/Juvenile Justice, Homeless, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

2,000 homeless youth outreach contacts in FY2014

Strategies to attain the goal:

Contract with a provider for outreach services to homeless youth.
Contract with a provider for outreach services to homeless/beach families.
Contract with the judiciary to provide mental health assessments and supports to youth in the juvenile justice system.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of homeless youth outreach contacts
Baseline Measurement:	1880 homeless youth outreach contacts
First-year target/outcome measurement:	2,000 homeless youth outreach contacts
Second-year target/outcome measurement:	2,000 homeless youth outreach contacts
Data Source:	

Annual report from Hale Kipa contract.

Description of Data:

Number of homeless youth outreach contacts

Data issues/caveats that affect outcome measures::

Provider staff turnover.

Indicator #: 2

Indicator: Number of homeless/beach family outreach contacts

Baseline Measurement: 100 homeless/beach family outreach contacts

First-year target/outcome measurement: 100 homeless/beach family outreach contacts

Second-year target/outcome measurement: 100 homeless/beach family outreach contacts

Data Source:

Catholic Charities contract annual report.

Description of Data:

Number of homeless/beach family outreach contacts.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 3

Indicator: Number of mental health assessments of juveniles in the Juvenile Client Services Branch

Baseline Measurement: 31 mental health assessments

First-year target/outcome measurement: 30 mental health assessments

Second-year target/outcome measurement: 30 mental health assessments

Data Source:

First Circuit Court contract annual report.

Description of Data:

Number of mental health assessments of juveniles in the Juvenile Client Services Branch

Data issues/caveats that affect outcome measures::

Delays in procurement and contract processes at each of the government agencies.

Priority #: 6

Priority Area: Fund treatment and support services not covered by Medicaid, Medicare or private insurance for low income individual that demonstrate success in improving outcomes and/or supporting recovery.

Priority Type: MHS

Population SED

(s):

Goal of the priority area:

Provide parent-to-parent services to families of youth with emotional and/or behavioral challenges.

Strategies to attain the goal:

Provide parent-to-parent warmline services

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of parent-to-parent warmline contacts
Baseline Measurement:	100 parent-to-parent warm line calls
First-year target/outcome measurement:	100 parent-to-parent warm line calls
Second-year target/outcome measurement:	100 parent-to-parent warm line calls

Data Source:

Hawaii Families as Allies contract annual report

Description of Data:

Number of parent-to-parent warmline calls

Data issues/caveats that affect outcome measures::

Agencies does not currently have staff or resources to collect unduplicated data.

Priority #: 7

Priority Area: To fund primary prevention--universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.

Priority Type: MHP

Population Other (Children/Youth at Risk for BH Disorder, General public)

(s):

Goal of the priority area:

To educate practitioners and the general public about promoting mental health

Strategies to attain the goal:

To conduct public awareness activities, suicide gatekeeper training, and to integrate behavioral health screening and referral in primary care.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of parent educational material distributed
Baseline Measurement:	200 parent educational material distributed
First-year target/outcome measurement:	500 parent educational material distributed
Second-year target/outcome measurement:	500 parent educational material distributed

Data Source:

CAMHD staff who participate in children's mental health awareness day activities, and Children & Youth Day at the Capitol

Description of Data:

Number of parent educational material distributed

Data issues/caveats that affect outcome measures::

Identification and purchase of appropriate educational materials, and identification of staff willing to conduct these volunteer activities

Indicator #:

2

Indicator:

Number of sites participating in integrating behavioral health into primary care

Baseline Measurement:

0 primary care sites have integrated behavioral health

First-year target/outcome measurement:

2 federally qualified health centers will have integrated behavioral health into primary care

Second-year target/outcome measurement:

2 federally qualified health centers will have integrated behavioral health into primary care

Data Source:

Hawaii Primary Care Association contract annual report

Description of Data:

Number of sites participating in integrating behavioral health into primary care

Data issues/caveats that affect outcome measures::

None

Indicator #:

3

Indicator:

Number of individuals trained in suicide prevention

Baseline Measurement:

160 individuals trained in suicide gatekeeper training

First-year target/outcome measurement: 160 individuals trained in suicide gatekeeper training

Second-year target/outcome measurement: 160 individuals trained in suicide gatekeeper training

Data Source:

Injury Prevention Suicide Prevention contract annual report

Description of Data:

Number of individuals trained in suicide gatekeeper training

Data issues/caveats that affect outcome measures::

Retirement of key personnel in the Suicide Prevention Program and Suicide Prevention Task Force.

Priority #: 8

Priority Area: To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services on a nationwide basis

Priority Type: MHS

Population SED

(s):

Goal of the priority area:

Improve access to health information technology to improve clinical decision making

Strategies to attain the goal:

Develop clinical decision making tools within the electronic health record

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of new clinical progress reports

Baseline Measurement: 1 clinical decision making tool is partially available for use in the field

First-year target/outcome measurement:

Two clinical decision making tools or clinical progress reports are available for use in the field

Second-year target/outcome measurement:

Four clinical decision making tools or clinical progress reports are available for use in the field

Data Source:

CAMHD Research, Evaluation and Training Office

Description of Data:

Number of new automated clinical progress reports

Data issues/caveats that affect outcome measures::

The development of new clinical decision making tools, and the training on the use of the tools may require additional resources (personnel and funds).

Footnotes:

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment*							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ <input type="text"/>	\$ <input type="text"/>	\$ 53,600,000	\$ <input type="text"/>	\$ <input type="text"/>
6. Other 24 Hour Care		\$ <input type="text" value="202,617"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ 25,000,000	\$ <input type="text"/>	\$ <input type="text"/>
7. Ambulatory/Community Non-24 Hour Care		\$ <input type="text" value="451,000"/>	\$ <input type="text"/>	\$ <input type="text" value="300,000"/>	\$ 49,732,014	\$ <input type="text"/>	\$ <input type="text"/>
8. Mental Health Primary Prevention		\$ <input type="text" value="125,000"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		\$ <input type="text" value="106,801"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
10. Administration (Excluding Program and Provider Level)		\$ <input type="text" value="250,000"/>	\$ <input type="text" value="1,021,523"/>	\$ <input type="text" value="2,057,614"/>	\$ <input type="text" value="15,692,978"/>	\$ <input type="text"/>	\$ <input type="text"/>
11. Total	\$	\$ 1,135,418	\$ 1,021,523	\$ 2,357,614	\$ 144,024,992	\$	\$

* Prevention other than primary prevention

Footnotes:

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$200,000
Specialized Outpatient Medical Services			\$100,000
Acute Primary Care			\$
General Health Screens, Tests and Immunizations			\$100,000
Comprehensive Care Management			\$
Care coordination and Health Promotion			\$
Comprehensive Transitional Care			\$
Individual and Family Support			\$
Referral to Community Services Dissemination			\$
Prevention (Including Promotion)			\$110,000
Screening, Brief Intervention and Referral to Treatment	100		\$20,000

Brief Motivational Interviews			\$
Screening and Brief Intervention for Tobacco Cessation			\$
Parent Training			\$
Facilitated Referrals	2000		\$90,000
Relapse Prevention/Wellness Recovery Support			\$
Warm Line			\$
Substance Abuse (Primary Prevention)			\$5,000
Classroom and/or small group sessions (Education)			\$
Media campaigns (Information Dissemination)	500		\$5,000
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$
Parenting and family management (Education)			\$
Education programs for youth groups (Education)			\$
Community Service Activities (Alternatives)			\$
Student Assistance Programs (Problem Identification and Referral)			\$
Employee Assistance programs (Problem Identification and Referral)			\$
Community Team Building (Community Based Process)			\$

Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$
Engagement Services			\$355,000
Assessment			\$
Specialized Evaluations (Psychological and Neurological)	30		\$35,000
Service Planning (including crisis planning)			\$50,000
Consumer/Family Education	100		\$180,000
Outreach	100		\$90,000
Outpatient Services			\$
Evidenced-based Therapies			\$
Group Therapy			\$
Family Therapy			\$
Multi-family Therapy			\$
Consultation to Caregivers			\$
Medication Services			\$
Medication Management			\$

Pharmacotherapy (including MAT)			\$
Laboratory services			\$
Community Support (Rehabilitative)			\$400,000
Parent/Caregiver Support			\$
Skill Building (social, daily living, cognitive)			\$
Case Management			\$
Behavior Management			\$
Supported Employment			\$100,000
Permanent Supported Housing			\$
Recovery Housing			\$300,000
Therapeutic Mentoring			\$
Traditional Healing Services			\$
Recovery Supports			\$
Peer Support			\$
Recovery Support Coaching			\$

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$250,000
Personal Care			\$
Homemaker			\$
Respite			\$
Supported Education			\$
Transportation			\$
Assisted Living Services			\$
Recreational Services			\$
Trained Behavioral Health Interpreters			\$
Interactive Communication Technology Devices			\$250,000
Intensive Support Services			\$
Substance Abuse Intensive Outpatient (IOP)			\$
Partial Hospital			\$
Assertive Community Treatment			\$

Intensive Home-based Services			\$
Multi-systemic Therapy			\$
Intensive Case Management			\$
Out-of-Home Residential Services			\$
Children's Mental Health Residential Services			\$
Crisis Residential/Stabilization			\$
Clinically Managed 24 Hour Care (SA)			\$
Clinically Managed Medium Intensity Care (SA)			\$
Adult Mental Health Residential			\$
Youth Substance Abuse Residential Services			\$
Therapeutic Foster Care			\$
Acute Intensive Services			\$
Mobile Crisis			\$
Peer-based Crisis Services			\$
Urgent Care			\$

23-hour Observation Bed			\$
Medically Monitored Intensive Inpatient (SA)			\$
24/7 Crisis Hotline Services			\$
Other (please list)			\$471,474
Data Collection/Reporting, and Enrollment and Provider Business Practices, Homeless Activities for Adults			\$471,474

Footnotes:

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ 520,000
MHA Planning Council Activities	\$ 18,000
MHA Administration	\$ 62,000
MHA Data Collection/Reporting	\$ 275,000
Enrollment and Provider Business Practices (3 percent of total award)	\$ 63,881
MHA Activities Other Than Those Above	\$ 100,000
Total Non-Direct Services	\$1038881
Comments on Data: MHA Data Collection/Reporting includes: Data Infrastructure staff's salary, MHSIP Consumer Survey; Survey Collection on suicide.	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

IV. Narrative Plan

C. Coverage M/SUD Services

Beginning in January 2014, Medicaid-eligible individuals with a diagnosis of SMI/SPMI and who are enrolled in the behavioral health system, will receive mental health services through the CCS program (the pre-paid inpatient health plan administrator). Through this integrated program model, consumers will receive physical and psychiatric care from the same organization in hope of improving overall health outcomes. The AMHD will continue to provide mental health services for the forensically encumbered, the uninsured and underinsured and continue to provide crisis services statewide.

Since the CCS program and the AMHD will be working with the same purchase of service providers in the state, through quarterly provider meetings as well as meetings with the Department of Human Services (DHS), there will be discussions to identify barriers consumers are experiencing to services through the CCS program. Information will then be provided to DHS and the Hawaii Health Connector Board.

The Insurance Commissioner will retain full regulatory jurisdiction over plans. The Department of Commerce and Consumer Affairs (DCCA) will also play a role, albeit undefined to date. As of this writing, no detailed monitoring process has been identified. Complaints or violations relating to mental health parity will be heard by the DCCA and the Regulated Industries Complaints Office. The monitoring and review process is currently under development.

In October of 2012 Governor Neil Abercrombie announced the State of Hawaii had selected the HMSA Preferred Provider Plan as the State's Essential Health Benefits (EHB) benchmark. This plan has been working in and for Hawaii for a long time and is considered the "gold standard." Essential health benefits must be included in all plans sold on the state-run exchange, known as the Hawaii Health Connector.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

IV. Narrative Plan

D. Affordable Insurance Exchange

The State Medicaid agency Med-QUEST Division (MQD) is in the process of replacing its 25-year-old eligibility system with the Kauhale (community) On-Line Eligibility Assistance (KOLEA) program. By October 1, 2013, all medical assistance programs administered by the MQD, and advanced premium tax credits (APTC)/cost-sharing reductions (CSR) administered by the Hawaii Health Exchange (Hawaii Health Connector) will be implemented in KOLEA. The financial assistance programs and Supplemental Nutrition Assistance Program (SNAP) will be implemented by December 2015. The current system (HAWI) has no capability to accept applications on-line. KOLEA, on the other hand, will support the application process through a user portal. As an option, individuals interested in insurance may pre-screen themselves and their households for insurance assistance eligibility. Individuals deciding to apply for assistance may apply on-line or use current methods of mail, fax, and drop off to one of the MQD offices. Assuming information is complete; KOLEA conducts electronic verifications and whenever possible, makes real-time eligibility determinations. If a determination is not possible, the case pends with a notice to the applicant to provide the necessary information or clarification. Individuals determined to be Medicaid-eligible are then allowed to make plan selections. Individuals who are determined APTC/CSR eligible will be prompted to choose a qualified health plan through the Hawaii Health Connector. The plan selections are then all routed to the Connector to generate the plan enrollment files. User's accounts can then be used to conduct self-service plan selection, report household changes, and to provide supporting verification documents. Beneficiaries may also use the portal to receive their notices or request an appeal. Certified Marketplace Assisters such as application counselors, Navigators, and Connector customer service vendors will be able to assist homeless individuals in the community and will use a portal separate from individuals to complete and submit applications. HPP will work closely with MQD to assure that the system is efficiently qualifying all clients for Medicaid eligibility (and other benefit programs) in a streamlined manner. Information will be collected about timelines from application to eligibility determination for each individual who applies for eligibility. Performance data will be presented to the HICH and the MQD Director. Data will be requested from MQD regarding performance metrics including timelines from application to eligibility determination. Within the AMHD, staff is not involved in the Health Connector Navigator Program, nor do they enroll consumers. However, staff within the CMHCs on each county is aware of the Navigator staff and are able to call them if needed to assist consumers.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

IV. Narrative Plan

E. Program Integrity

Adult Mental Health Division

Given the age of the current eligibility system and the requirements to meet the mandatory Medicaid provisions of the Patient Protection and Affordable Care Act (ACA), by October 1, 2013, the Hawaii Department of Human Services (DHS) decided to replace its eligibility system. This Concept of Operations (CONOPs) document describes the current eligibility system and the proposed replacement system and is intended for anyone who is interested in DHS' approach. Consistent with the intended audience, the document is purposefully broad and general providing a summary of the existing eligibility system and a high level description of the proposed system for accepting applications and processing eligibility determinations for medical assistance, including advanced premium tax credits (APTC) and cost-sharing reductions (CSR) administered by the state's exchange. Persons who are interested in more detail should refer to the documents posted on the federal Centers for Medicare & Medicaid Services' (CMS) Collaborative Application Lifecycle Management Tool (CALT). Readers are reminded that this document reflects a point in time description that was developed during the Concept Phase of the System Lifecycle. As such, it is subject to change as additional work is completed during the design and construction phases of the project.

The current eligibility system, Hawaii Automated Welfare Information (HAWI) system is nearly 25 years old and is operating on outdated technology. Based on an assessment conducted in 2012, it was determined that HAWI would require substantial modernizations and upgrades in order to meet the mandatory ACA requirements. Given the amount of required work, it was determined that it would be nearly impossible to meet the October 1, 2013 due date without a substantial investment of resources. DHS also determined that even with substantial resources devoted to the project, it would not be cost-effective. With the availability of new technology and federal funds at a 90/10 match, the Department decided to procure and implement a new eligibility system.

The new eligibility system, known as the Kauhale (community) On-Line Eligibility Assistance (KOLEA), will eventually replace HAWI. Initially, and by October 1, 2013, all medical assistance programs including Medicaid administered by DHS and APTC/CSR administered by the Hawaii Exchange will be implemented in KOLEA. The financial assistance programs and Supplemental Nutrition Assistance Program (SNAP) will follow and be implemented by December 2015. Eligibility for additional programs such as employment support, child welfare, and adult services may be considered for later implementation into KOLEA.

In Hawaii, DHS is the single state Medicaid agency. Organizationally, within DHS, the Med-QUEST Division (MQD) administers and conducts the day-to-day functions for all medical assistance programs, the Medicaid program being the largest. MQD also administers the Children's Health Insurance Program (CHIP) program as a Medicaid expansion program. Consistent with federal requirements, the MQD maintains the State Plan and State Plan

Amendments, and administers the state's approved 1115 demonstration waiver for managed care known as Hawaii QUEST for individuals and families who are not aged, blind or disabled, and QUEST Expanded Access (QExA) for individuals who are aged, blind or disabled.

There is a common paper application form for all medical assistance programs, but a separate, simplified paper application form is used for pregnant women and children. Currently, in HAWI there is no capability to accept applications on-line, and applications must be filed hard copy. Applications are accepted by mail, fax, and in-person. Upon receipt, applications are entered into HAWI and MQD eligibility workers determine eligibility for the appropriate category. There are basic eligibility requirements, such as residency, citizenship or qualified alien, and social security numbers and financial requirements such as income and assets which differ by "coverage groups" - children, pregnant women, families, the elderly, the blind, the disabled, and non-pregnant childless adults. Depending on the type of eligibility, once an individual is determined eligible, he or she is enrolled in a health plan or covered by fee-for-service. Medical services are delivered through health plans while dental services are covered through fee-for-service. Nearly all beneficiaries receive their medical care from a health plan and only a small number of individuals receive care through the fee-for-service program. Once enrolled, beneficiaries choose their primary care provider from the health plans' provider networks.

As mentioned previously, HAWI is the Department's integrated eligibility system that supports Hawaii's current Medicaid and Medicaid expansion programs as well as the Financial Assistance programs such as Temporary Assistance to Needy Families (TANF) and SNAP. It is a legacy system nearly 25 years old that was transferred from Oklahoma and subsequently modified for Hawaii. Because it is built on older technology, HAWI cannot readily accommodate requirements set forth by new legislation nor respond to information requests on a timely basis. It is inflexible and difficult to maintain, and manual workarounds are prolific. In some instances, HAWI does not support automated eligibility determinations and benefit calculations, which requires staff to manually apply rules and maintain spreadsheets off-line. In general, HAWI does not align with current industry standards and best practices.

As noted previously, KOLEA will support the application process through a user portal. As an option, individuals interested in insurance may pre-screen themselves and their households for insurance assistance eligibility. Individuals deciding to apply for assistance may apply on-line or use the current methods of mail, fax, and drop off to one of the MQD offices. If applying on-line, individuals must first create user accounts. Assuming information is complete; KOLEA conducts electronic verifications and if possible, makes "real-time" eligibility determinations. If a determination is not possible, the case pends with a notice to the applicant to provide the necessary information or clarification. The system generates notices either electronically or on paper, depending on the applicant's or beneficiary's identified preference. Individuals determined to be Medicaid-eligible are allowed to make plan selections (rosters are generated overnight by HPMMS). Individuals who are determined APTC/CSR eligible are allowed to browse and make QHP plan selections. The QHP plan selections are routed to the Connector to generate the plan enrollment files.

The same user accounts may be used to conduct “self-service” to select plans, report household changes, and to provide supporting verification documents. Beneficiaries may also use the portal to receive their notices or request an appeal.

The KOLEA system must support the eligibility determination of all federal and state medical assistance programs including the insurance assistance programs administered by the Connector. It should have a web portal to support users and allow them to apply for assistance and make changes post eligibility. It must have a single configurable rules engine so that changes can be made easily and with minimal IT support. In addition to providing portal access to individuals, the system must provide access to application assisters and marketplace assisters including application counselors, navigators and out-stationed eligibility workers.

The system must support verifications from the federal data services hub and other data sources and conduct predeterminations whether annually or as a result of household changes, or as batch processing for age (e.g., 18 turning 19 or 64 turning 65 or other changes such as the end of a postpartum period). The system must generate notices and produce reports on an ad-hoc and scheduled basis. For eligibility workers, the system must support data input, and provide alerts and other mechanisms to manage cases.

Individuals who want to conduct anonymous pre-screening for assistance will be asked four to five questions such as citizenship, number of adults, number of children, and annual household income. Based on the entries, the system will return a preliminary determination of whether the household may be eligible for assistance and ask the user if he or she wants to complete an application. If the answer is “yes,” the individual will be requested to create a user account with a user name and password. The system will use the federal data services hub to conduct I.D. proofing. Once a user account is established, the applicant may use the portal to create an application. The individual may save and update the application. If there has been no activity on the application for 30 days, the system will delete the application. As soon as sufficient information is available, the KOLEA system checks that the applicant is not already a beneficiary of an assistance program. If the applicant is a beneficiary, the system will prompt the user for other intended actions (such as adding or removing an individual from the household or changing household information such as address, phone number or income). If the applicant is not a beneficiary but known to the system, the system will assign the same client I.D. number.

Marketplace assisters such as application counselors, navigators, and Connector customer service vendor must be “certified” in order to serve in one of these capacities. The Connector is developing the certification program that includes training on protecting and maintaining confidential information. The names of the certified agencies, companies, etc. will be provided to DHS to establish user accounts for these assisters. While in the community and assisting individuals face-to-face, assisters will use a portal separate from individuals to complete and submit applications. The Connector customer service vendor that will be providing the call center functionality will use the same portal to provide assistance over the telephone.

Individuals may apply on-line, but may also choose to file a hard copy application. DHS has offices on the islands of Oahu (2), Hawaii (2), Maui and Kauai and applications may be mailed or

faxed to the island serving the applicant. Additionally, with the implementation of KOLEA, DHS will also accept applications via e-mail. Applications received in the office will be date and time stamped to preserve the application date and entered into KOLEA. Similar to the on-line application process, the DHS worker, prior to entering an application, will verify whether the person is known to the system. If the applicant is known to the system, the same client I.D. number and case number will be retained and any new information from the application is used to update the individual and case information. If the applicant is not known to the system, KOLEA will automatically assign new client and case I.D. numbers.

KOLEA will have interfaces to the federal data services hub and the state data services hub and will verify information submitted on the application. Refer to the DHS MQD MAGI-Based Eligibility Verification Plan for information on the specific data that is verified. If any of the information obtained from the data services hub results in a discrepancy, the system will prompt the individual to validate the data. For some entries such as address, people in the household, etc., the system will accept the applicant's information. For other entries such as citizenship, alien status, social security number, if the verifications are conflicting or cannot be performed electronically, the applicant must provide additional documentation. Depending on the type of verification required, the application will either pend for review or continue processing. If a determination can be made, the system will make an "automatic" determination. If it is not possible (e.g., income not provided), the system will generate a notice identifying the required information and due date. If the information is provided within the required timeframe, the system will continue to determine eligibility. If the required information is not provided within the required timeframe, the system will deny the application and provide notice with the denial reason. Applicants may authorize other individuals to act on their behalf.

The AMHD has a program integrity plan for use of Block Grant funds. Through the MHBG Oversight Committee which includes: the AMH Administrator, the AMHD Medical Director, the CMHC System Administrator, the Public Health Administrator Officer, the Accountant assigned to the MHBG funds and the AMHD Planner. The committee is responsible for the alignment of projects/proposals with SAMHSA's target population and initiatives, as well as to ensure that project leads adhere to state procurement laws. Expenditure reports are presented to the committee to ensure that funds are encumbered and expended with the closing of the cycle to which funds should be expended.

Child and Adolescent Mental Health Division

The Child and Adolescent Mental Health Division (CAMHD) implements the following practices to assure program integrity:

- The Child and Adolescent Mental Health Performance Standards is a contractual set of quality and safety standards that every contracted provider must follow. The Performance Standards outline requirements for every Level of Care in the system. Included in these standards are a description of the specific services offered, admission

criteria, continuing stay criteria, discharge criteria, and exclusionary criteria. Additional guidelines include staffing requirements, clinical standards, and requirements for documentation.

- CAMHD has a Performance Management Section that annually reviews and evaluates client and family outcomes for each of the mental health services provided. The Performance Management Section also monitors program performance and staffing issues between evaluation periods. CAMHD has an ongoing, collaborative relationship with each provider agency to support the clinical standards of the services offered to clients and their families.
- CAMHD has a Clinical Services Office that works with contracted providers to expedite the admission and, at times, discharge of clients who are receiving services. In order to meet the needs of the community, CAMHD will (and has) expanded contracted bed limits to provide additional services as needed.
- CAMHD requires each Community-based Residential Program to provide integrated substance abuse and mental health treatment to clients who are in need of these services. This integrated approach to behavioral health services is an integral part of the out-of-home service array that CAMHD offers.
- CAMHD works in collaboration with the Department of Justice, Department of Health - Developmental Disabilities Division, and Department of Education to provide integrated services to clients who are adjudicated or who have an Individualized Education Program (IEP) plan.
- CAMHD reviews, monitors and provides facility certification for every provider program to help ensure client and program safety.
- The Department of Human Services reviews, evaluates and provides licensure for every CAMHD Transitional Family Home statewide to ensure client and program safety.
- CAMHD conducts process evaluations of block grant project activities 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. The reports provide encounter data, utilization, performance measures, as well as anecdotal information to provide a contextual perspective. CAMHD's Fiscal Office conducts budget reviews each time contracts are issued and negotiated. All claims are matched against the appropriate documentation and expenditure reports.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Adult Mental Health Division

The AMHD does not have a formal system to track and disseminate information on evidence based practices (EBPs). However, many staff members are well versed in some practices such as: Supported Employment, Supported Housing, Integrated Dual Diagnosis Treatment (IDDT), Illness Management and Self-Directed Recovery (IMSR). Unfortunately, the data from these practices are not shared throughout the system, or is used to guide policy decisions, or to guide performance within the system.

The AMHD is planning to provide training and technical assistance on EBPs to help inform care and educate policy makers. AMHD will review SAMHSA's National Registry of EBPs and Practices to formally include them in the 5-Year Strategic Plan.

Once EBPs are developed and providers are trained, AMHD may consider including these requirements in provider contracts.

Child and Adolescent Mental Health Division

Commitment to Effective, Evidence-Based Practices

Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data. CAMHD's array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. The CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services. All treatment planning for psychosocial and pharmacological intervention should stem from careful consideration of the most current research. In addition, agencies are encouraged to gather and evaluate their own data on child outcomes and functioning to further inform clinical decisions and the design of appropriate interventions. See the following links for the

(a) CAMHD Biennial Report:

<http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs013.pdf> and

(b) the evidence-based child and adolescent psychosocial intervention matrix from the American Academy of Pediatrics

<http://www.aap.org/commpeds/doch/mentalhealth/docs/CR%20Psychosocial%20Interventions.F.0503.pdf>

Definition of Evidence-Based Practice

CAMHD reimburses its contracted providers for the provision of evidence-based treatment approaches. Evidence-based practices include all those treatment strategies and interventions for which observable, objective data exist demonstrating positive effects. Using evidence-based treatment means using interventions that have been shown to work. CAMHD contracted providers are expected to utilize data about an individual youth's progress along with the best available information about "what works" in planning and revising treatment. The data (or evidence-bases) showing the positive effects of mental health treatment practices can take one of four major forms, listed below in order of their relative strength. Information about the evidence base for various practices should be utilized throughout the course of treatment to make clinical decisions. Higher priority should be given to more reliable or stronger forms of evidence in making treatment decisions.

i. General Services Research

General service research is data typically found in peer-reviewed scientific journals (e.g., in the form of randomized clinical trial outcomes), and summarized in reports such as the Blue Menu:

<http://www.aap.org/commpeds/dochs/mentalhealth/docs/CR%20Psychosocial%20Interventions.F.0503.pdf> and Practice Element Profiles in the latest CAMHD Biennial Report:

<http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs013.pdf>. Defined this way, evidence-based practice can include large brand-named packaged protocols (e.g., Multisystemic Therapy), broad-based therapeutic approaches (e.g., Cognitive-Behavioral Therapy) and discrete clinical techniques or practice elements (e.g., Caregiver Psychoeducation). When there is limited or weak published research evidence about a particular approach, but it appears promising, the strategy is often referred to as a "best practice."

ii. Case-Specific Historical Information

Case-specific historical information is case-specific data from repeated clinical interactions in the form of standardized (e.g., Ohio Scales, CAFAS, BASC, ASEBA) or idiographic (individualized) assessment strategies (e.g., MTPS ratings, mood or SUDS ratings, etc.). The usefulness of such data increases as the number of routine assessment points increases over time, and the data can be displayed graphically to help demonstrate strategies that are helpful to an individual youth on a case-by-case basis.

iii. Local Aggregate Evidence

Local aggregate evidence is case-specific data aggregated across numerous youth into meaningful composite units, such as treatment facilities. Such evidence includes not only positive clinical outcomes (e.g., a specialty facility may have high rates of success with youth with severe substance abuse concerns), but also critical incidents (e.g., a certain facility may

have higher than average elopement rates, and care should be taken before youth at risk for elopement are placed there). These types of data are sometimes referred to as practice-based evidence.

iv. Causal Mechanism Evidence

Memory, judgment, and professional knowledge of team members regarding the various causal mechanisms associated with the developmental psychopathology and treatment trajectory associated with a youth. Many times, such expertise is sought to help construct interventions for youth who have received empirically supported treatments but have not yet met treatment goals. Say for example, that a team has an agreed-upon case conceptualization that a youth's treatment for her trauma is not progressing adequately because the youth has an overall poor sense of control over her environment. Therefore, in addition to exposure-based strategies, the team recommends that extra care should be taken for cognitive restructuring and parenting strategies that help the youth exert personal control over her environment. Given potential information processing biases and other concerns associated with human memory and judgment, care should be taken when relying on this evidence-base and the other forms of data above should first be strongly considered.

As outlined above, the term "evidence-based practice" extends well beyond brand-name packaged programs such as Multisystemic Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care. As outlined in this definition, the term "evidence" can and should take on many forms.

Threshold

The CAMHD analyzed its own local data to determine the appropriate and effective length of stay guidelines for each service in its array. By using local aggregate outcome data as entered by CAMHD and its providers, CAMHD has determined the most appropriate time frames for each level of care as stated in the service reauthorization section for each service specific standard.

CAMHD analyzed the Child and Adolescent Functional Assessment Scale (CAFAS) and Monthly Treatment and Progress Summary (MTPS) data from the past two years to determine the time frame in which the majority of youth showed maximum improvement based on these measures. This time frame serves as the threshold for which a second level of review is needed in order to continue the service, since only a minority of youth showed continued improvement beyond this point in time. The thresholds are used to guide treatment time frames based on available data, but are not meant to be absolute end points in any treatment service. Treatment beyond any given threshold must have a UR team review to ensure the youth will continue to benefit from further treatment.

Branch Utilization Review Team

Each CAMHD branch holds a regular Utilization Review (UR) Team meeting. The UR team includes all supervisory clinical staff (Clinical Psychologist, Child Psychiatrist, and Mental Health Supervisors) and the branch Quality Assurance Specialist. Minimally, this group monitors all branch youth receiving Hospital Based Residential services and all youth whose length of stay in any level of care has exceeded the threshold for that service. These thresholds are described in the service reauthorization section of each service standard and are based on CAMHD system data about youth improvement over time in each level of care. The role of the UR team is to assure that there is a clear clinical rationale for continuing the service and that all continuing stay criteria are being met. The UR team provides support to the youth's assigned Clinical Lead and Care Coordinator in generating and considering possible alternative options when a youth/family are making little progress despite lengthy treatment in a given program or level of care.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

IV. Narrative Plan

G. Quality

Adult Mental Health Division

The AMHD will continue to collect data on the National Outcome Measures (NOMS) as set by SAMHSA. For example, Increase Access to Services, Reduce Utilization of Psychiatric Inpatient Beds-30 days, 180 days, etc. For the State NOMS, goals, objectives, measures and transformation activities will be developed in the context of the AMHD 5-year Strategic Plan.

AMHD's Purchase of Service Providers will continue to submit Quality of Life (QOLI) interview surveys for consumers at admission, every six months, and at discharge.

The AMHD in collaboration with providers will continue to annually administer the Mental Health Statistical Improvement Program (MHSIP). The most current SAMHSA survey tool with Hawaii specific questions is used and the sample size allows each provider's results to stand independently. The survey is administered both by mail and in-person interviews. The goals of the survey are to: 1) increase consumer participation by 100%; 2) increase response rate, and 3) increase responses on eight domains by 5%. For FY2012, survey results from the MHSIP survey were:

- Hawaii Specific Questions: 93%
- Appropriateness: 92%
- Access to Services: 90%
- Satisfaction: 90%
- Treatment Planning: 84%
- Functioning: 80%
- Treatment Outcomes: 79%
- Social Connectedness: 72%

Child and Adolescent Mental Health Division

The Child and Adolescent Mental Health Division has identified four priority areas for the mental health block grant. These priority areas are aligned with the provisions in the Affordable Care Act. To track progress on the measures, CAMHD has identified the following milestones:

Priority Area 1: To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.

Priority Type: Mental Health Services

Population: Serious Emotional Disturbance

Goal of the Priority Area:

- 2,000 homeless youth outreach contacts made in FY2014.
- 100 homeless/beach family outreach/counseling contacts made in FY2014.
- 30 mental health assessments of juveniles in the Juvenile Client Services Branch, First Circuit, conducted in FY2014.

Strategies to attain the goal:

- CAMHD will continue its contractual arrangement with Hale Kipa to provide outreach services to homeless youth. The purpose of the contract is to provide outreach services to any youth in the City & County of Honolulu, less than eighteen years of age, without shelter and in need of support services, including mental health services, to stabilize their living situation.
- CAMHD will continue its contractual agreement with Catholic Charities Hawaii to provide outreach services to homeless families. The program is focused on assisting homeless children and families living on the beaches of the Waianae Coast of the island of Oahu, who are primarily individuals of Native Hawaiian decent.
- CAMHD has partnered with the Family Court on the provision of mental health assessments of youth in the juvenile justice system. According to the Agreement, Family Court of the First Judicial Circuit may contract with mental health professionals to provide mental health assessment services, prioritizing first those youth who are not otherwise eligible for mental health assessment services from any other state agency or private insurance plan. Youth are provided mental health assessments and a proportion of them are found to be in need of mental health services.

Priority Area 2: To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals that demonstrate success in improving outcomes and/or supporting recovery.

Priority Type: Mental Health Services

Population: Serious Emotional Disturbance

Goal of the Priority Area:

- A model of integration of pediatric behavioral health care at two Federally Qualified Health Centers will be developed in FY2014.
- 100 Parent-to-parent warm line calls in FY2014

Strategies to attain the goal:

- CAMHD will continue its contract with the Hawaii Primary Care Association to develop pilot integration projects at two community health centers. The two community health centers should begin screening for mental health issues in children and will turn to CAMHD for consultation and referral.

- CAMHD will continue its contract with the Hawaii chapter of the Federation of Families for Children’s Mental Health, Hawaii Families As Allies. Hawaii Families as Allies is contracted to provide support to families of youth with emotional and/or behavioral challenges in navigating the system of care through statewide parent-to-parent support.

Priority Area 3: To fund primary prevention—universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.

Priority Type: Mental Health Prevention

Population: Other

Goal of the Priority Area:

- 500 Parent educational materials distributed in FY2014
- 100 Individuals will be trained in suicide gatekeeper training in FY2014

Strategies to attain the goal:

- CAMHD will participate in public awareness activities, such as the annual Children’s Mental Health Awareness Day, and the Children & Youth Day at the State Capitol.
- CAMHD will continue its contract with the Department of Health Injury Prevention & System Branch to implement a youth suicide prevention program.

Priority Area 4: To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services on a nationwide basis.

Priority Type: Mental Health Services

Population: Serious Emotional Disturbance

Goal of the Priority Area:

- Two (2) types of clinical progress reports for clinical decision making will be automated and available for use in the field in FY2014.

Strategies to attain the goal:

- CAMHD will continue it’s initiatives in Health Information Technology to incorporate clinical decision making tools within the electronic health record.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

IV. Narrative Plan

H. Trauma

Adult Mental Health Division

The State Department of Health's AMHD developed a draft policy to include screening of clients for a personal history of trauma. Due to staffing changes the development of this policy is on hold. However, the SAMHSA-funded Mental Health Trauma Grant, Trauma-informed Care Initiative (TIC IT), will work in partnership with AMHD to develop this policy. Currently, there is no policy to connect individuals with trauma histories to trauma-focused therapy. Through TIC IT, work began in the Community Mental Health Centers (CMHCs) to screen consumers for trauma. Consumers who screen positive for trauma and possible Post-Traumatic Stress Disorder (PTSD) and/or substance abuse will be offered trauma-focused therapy, Seeking Safety. There is also a request for proposal (RFP) to provide trauma screening and trauma-focused therapy via contracted agencies. This RFP is under review. In addition, there are no policies that promote the provision of trauma-informed care. However, through the TIC IT, statewide training is occurring for AMHD's CMHC staff in trauma-informed care, utilizing SAMHSA's definition and principles. Through the TIC IT, the AMHD offers Lisa Najavit's, Seeking Safety, which is evidence based, trauma-specific intervention. Clinical staff at the CMHCs and several contracted agency clinical staff have been trained in Seeking Safety.

Child and Adolescent Mental Health Division

CAMHD's standards for Mental Health Evaluations include a requirement that every initial assessment must include a trauma screening instrument such as the UCLA PTSD Index. This standard applies to all contracted evaluations and to those performed by CAMHD psychologists. The standard is codified in the *Child And Adolescent Mental Health Performance Standards* ("Orange Book"), which became effective July 1, 2012.

CAMHD policies generally require individualized treatment planning and efforts to meet the needs identified in Mental Health Evaluations. We have trained a small cadre of providers in an evidence-based trauma treatment for children and adolescents, Trauma-Focused Cognitive Behavior Therapy, and are preparing to offer another round of this training. CAMHD also promotes the use of a modular approach to treatment, including the use of evidence-based practice elements (i.e. safety planning, relaxation skills, cognitive coping, exposure, writing a trauma narrative) that are associated with effective trauma treatments. We do not have a written policy regarding trauma-focused therapy.

CAMHD also has a policy regarding seclusion and restraint that is based on the principles of trauma-informed care, and has trained extensively on this topic. Safety planning regarding a person's triggers, warning signs, preferred ways of calming down, etc. is a regular part of our treatment planning process, and we have a standard safety plan that providers are encouraged to use. However, we do not have a written policy regarding trauma-informed care.

CAMHD annually co-sponsors the IVAT (Institute on Violence, Abuse and Trauma) “Hawaii Conference on the Prevention, Assessment and Treatment of Trauma” – a three day event with a variety of offerings for providers at all levels of expertise. CAMHD sponsored a year-long “learning collaborative” on TF-CBT and are planning to offer another learning collaborative beginning in November 2013. This has been made possible by our SAMHSA system of care grant that focuses on treatment of girls with significant exposure to trauma.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

IV. Narrative Plan

I. Justice

Written and submitted by Hawaii's Planning Council

The State does not have a plan to enroll individuals involved in the criminal and juvenile justice systems in Medicaid. Some are now covered under the QUEST program. The Juvenile Justice System currently does not have plans to enroll individuals in Medicaid for services. The Oahu Criminal Justice System uses the Level of Service Inventory (LSI-R), an assessment tool to determine level of supervision and risk factors that would need to be addressed to minimize risk for recidivism. Court officers complete social summaries on all adjudicated youth and intake services completes initial screenings on pre-adjudicated youth, and then make referrals as needed.

For those, fortunate to be diverted to specialty programs (Jail Diversion Program, Mental Health Court, Drug Court, etc.), other assessment tools are used to determine eligibility, and treatment planning needs. There is coordination, however, between the Jail Diversion Program and the Criminal Justice System, between the Mental Health Court and the Adult Mental Health Division (AMHD). There is also coordination between the Department of Public Safety, AMHD and the Institute for Human Services (IHS) Re-entry Project.

For juveniles there are treatment court programs (Juvenile Drug Court, Family Drug Court) and the Juvenile Detention Alternative Initiative Program. For youth served by both the Family Court and the Child and Adolescent Mental Health Division, there is collaboration between agencies and a pilot wraparound initiative funded by the Casey Family Program which is serving 10 youth involved in multiple systems. Additionally, there are treatment court programs (Juvenile Drug Court, Family Drug Court) and the Juvenile Detention Alternative Initiative Program.

For the adult general population in the criminal system with a mental illness or substance abuse issue, NO. For those fortunate to be diverted to specialty programs such as Oahu Community Correctional Center, Mental Health module, Jail Diversion Program, Mental Health Court, Drug Court, etc.), YES. The First Circuit, Adult Client Services Branch, supported by the Council of State Governments and Justice Center (Federal grant), held a one day conference "Building Effective Supervision and Provider Collaboration Forum" for adult probation/parole officers and mental health and substance abuse community providers. The collaboration forum was held on November 8, 2013 on Oahu. The participants have requested future collaborations between criminal justice personnel and community providers. At this time, limited trainings are available. In the past, AMHD held yearly "Best Practices Conferences" that would focus on forensic mental health. The last one was held in 2009.

Adult Mental Health Division

The AMHD will continue to address diverting justice involved persons from incarceration. This is a top strategic priority for the state. Through the Forensics Task Group, the focus is on ensuring that individuals who have contact with the criminal justice system around misdemeanor or non-violent felony offenses are diverted from the HSH and receive services that are community-based.

Administrators from multiple organizations form the Interagency Council on Intermediate Sanctions Committee (ICIS). Members of the Committee include the Department of Public Safety, the Judiciary, the Department of Attorney General, the Department of Health, office of the Public Defender, Hawaii Paroling Board Authority, and the Honolulu Police Department. The ICIS meets monthly to discuss the reduction of recidivism and the prevention of future victimization by adult offenders. The group's goals are:

- Implement a system-wide application of standardized assessment protocols;
- Establish a continuum of services that match the risk and needs of adult offenders;
- Collaborate with communities in developing and implementing the continuum of services;
- Create a management information system capable of communicating among agencies to facilitate sharing of offender information; and
- Evaluate the effectiveness of intermediate sanctions in reducing recidivism.

Child and Adolescent Mental Health Division

Family Court Liaison Branch

CAMHD's Family Court Liaison Branch (FCLB) provides mental health treatment linkages between the Family Court, Hawaii Youth Correctional Facility, and Detention Home. The Family Court Liaison Branch provides screening, assessment, evaluative, diagnostic, treatment and consultative services to youth involved with the juvenile justice system that have mental health challenges. Their staff works with families and the juvenile justice system to design and implement evidence-based individualized service/treatment plans that are appropriate to the mental health needs of the youth. FCLB coordinates with Hawaii Youth Correctional Facility (HYCF) Parole Officers to manage the transitions of youth as they exit from HYCF prior to their entry into the community. If applicable, youth are referred for in-home or out-of-home services in the community. However, services for young people involved in the juvenile justice system are somewhat limited. More options in the community are needed to address transition to adulthood, mentorship programs and vocational programs.

CAMHD's Family Court Liaison Branch continues to strengthen communication between the Judiciary (Detention Home), Department of Education, Department of Health and Department of Human Services (Hawaii Youth Correctional Facility) to ensure the delivery of appropriate services for youth in a seamless and collaborative manner. Family Court Liaison Branch is an active partner in the many initiatives to divert youth from the juvenile justice system or to

improve the conditions for youth in the juvenile justice system, such as the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI).

Judiciary

Hawaii's Judiciary is a partner in the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI). The purpose of JDAI to reduce overcrowding in juvenile detention centers, reduce costs and improve conditions of confinement without jeopardizing public safety or court appearance rates. JDAI uses a data driven process to identify who is being detained and whether a community-based alternative would work instead. JDAI is based on eight (8) core, interconnected strategies that address why juveniles are unnecessarily or inappropriately detained. The Casey Foundation provides JDAI sites with a comprehensive set of "tools" and technical assistance to advance juvenile justice reform.

The eight (8) core strategies of JDAI that Hawaii is committed to are as follows:

1. Interagency collaboration of key juvenile justice stakeholders to coordinate and plan reform activities.
2. Reliance on data to understand issues, problems, and how resources are allocated. Data will guide program and policy decisions.
3. Use of objective criteria to guide objective detention admissions.
4. Alternatives to detention increase options available for youth yet ensure they are held accountable for their behavior and the community is protected.
5. Expedited case processing to decrease lengths of stay and accelerate the case resolutions.
6. Analysis of special detention cases and developing strategies for managing difficult populations of youth who are detained unnecessarily.
7. Reduce racial disparity in the detention population.
8. Monitor the conditions of confinement in Hale Ho'omalua (Detention Home) to identify problems that need correction. The emphasis is on maintaining safe and humane conditions of confinement.

The Detention Home will need to adopt and implement comprehensive physical assault, intimidation, abuse, sexual misconduct, and harassment policies and procedures. Without appropriate training and safeguards, detained youth may be at risk for harm. Of particular concern are those who are discriminated against or harassed because of their race, LGBT, or other status. Physical violence and threats exist for both boys and girls but is predominately an issue for the boys' population. Incident Reports and Grievances document that youth have requested to be moved when they felt uncomfortable or to avoid altercation with another youth and that their request was granted.

According to the Department of Human Services Office of Youth Services (OYS), the primary purpose of the Hawaii Youth Correctional Facility (HYCF) is to provide safe and secure housing for the most violent and dangerous juvenile offenders who pose a threat to the community. A variety of counseling, treatment, and educational services are available for the youth within the facility. 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.

CAMHD's Project Kealahou is working with the HYCF to enhance gender specific programming for incarcerated girls. Advocates and counselors from Project Kealahou work directly with the girls who have been the victims of trauma. Additionally, Project Kealahou provides trauma-informed training for the Youth Correctional Officers to enhance their sensitivity to trauma-related issues and to broaden the skill base and knowledge and of those who work with the female population.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

IV. Narrative Plan

J. Parity Education

Written and submitted by Planning Council

As an advisory body, the Council plans to assist with the state's education and awareness efforts through several different avenues. For example, we are in the process of establishing a website for the Council which we hope will afford the general public with important updates about our state's efforts to ensure that insurance coverage for substance abuse and mental health disorders is provided in such a way that is equal to the treatment coverage afforded to other chronic health conditions. The Council also recently approved the final draft Council's brochure, that while the brochure does not speak directly to the issue of parity, it does provide contact information for the general public to find out more about the Council and the Adult Mental Health Branch. In addition, the monthly Council meeting brings together a broad range of individuals who represent state agencies, community partner providers and family members. The monthly agendas typically cover the issues of parity related to our vulnerable population and the expectation is that Council members "carry the water" back to their respective agency, thereby educating their colleagues about relevant issues.

The Council membership is representative of a broad range of public-private collaboration. Essentially, through our work on the Council and in the community, Council members serve as the liaison between the state's efforts and wider community initiatives that focus on issues of parity. There is no Council member who does not understand the importance of ensuring parity across the board and for whom this is not of paramount importance. As a Council, the membership is clear about the need to advocate for parity. Parity is social justice.

As mentioned above, the Council is in process of establishing a website. Through that website we hope to make available the Council's meeting schedule, minutes and any relevant community event that might be of interest to those impacted by mental illness. In addition, the Council recently completed a series of public focus groups. The results of the focus group discussions helped to identify emerging issues and helped to provide a safe environment for family members, those suffering with mental illness and providers to share their experiences, perceptions and recommendations. The information gleaned from those discussions will serve to inform strategic planning. Our goal is to implement focus group discussions once per year.

Child and Adolescent Mental Health Division

CAMHD is negotiating business agreements with Med-QUEST providers around psychiatric and psychological services. CAMHD's system of care is Hawaii's de facto "standard of care". As the Affordable Care Act proceeds, there may be opportunities to expand services to youth with private insurance and to the public.

Through an agreement with the state Medicaid agency, CAMHD is able to provide and be reimbursed for psychotherapy services.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

IV. Narrative Plan

K. Primary and Health Care Integration

Adult Mental Health Division

The DHS Med-Quest Division, DOH BHA, and the Hawai'i Primary Care Association (HPCA) established a workgroup (i.e., the State Plan Option Collaborative) in 2011 to explore State Medicaid options for integrating physical and behavioral health home services for individuals with SMI and SPMI. The CMS' Integrated Care Resource Center (ICRC) provided technical assistance on different management and financing models to support integration efforts. On November 20, 2012, the DHS made available its approved draft application for its Quest Expanded Section 1115 demonstration project for public review and comment. As described in the application, the DHS will encourage Quest Integrated (QI) health plans to pursue a shared risk and shared savings program with accountability organizations. In addition, the State's Patient Centered Health Organizations will expand on network supported patient-centered medical homes. Current plans for integration may change based on prospective CMS guidance. On May 25, 2012, the DHS submitted a demonstration proposal to CMS for developing a single, integrated care management system for Medicare and Medicaid enrollees (MMEs). Pending final approval, the proposal outlines enrollment methods, description of supplemental benefits and ancillary services, and available medical and support services that meet network adequacy requirements and standards for both Medicare and Medicaid.

In June 2013, the DOH entered into a collaborative agreement with Kalihi-Palama Health Center (KPHC), a private, non-profit, FQHC to embed primary care services in two state-operated CMHCs on the island of Oahu. This pilot initiative, referred to as the Living Well Hawai'i Project, aims to provide comprehensive and culturally-informed services that are consistent with patient-centered medical home and Medicaid health home standards and expectations. The goal of the Living Well Hawai'i Project is to improve the physical health status of people with SPMI and comorbid, chronic medical conditions. It is expected, based upon past research and evaluation efforts, that providing access to culturally competent, integrated, comprehensive, collaborative care will substantially improve the quality and health outcomes of care for those services. The Living Well Hawai'i Project welcomed its first consumer at one CMHC in August 2013. Services are scheduled to begin at the second CMHC in January 2014.

Members of the HPCA were actively involved in the planning and implementation of the Living Well Hawai'i Project. In addition, the HPCA is currently assisting the State with drafting the Medicaid Health Home State Plan Amendment.

In 2006, the Hawai'i State Legislature passed Act 295 (Hawai'i Revised Statute [HRS] 328 J1 – J15) which prohibits smoking in all enclosed or partially enclosed areas, including but not limited to all healthcare facilities operated in the State of Hawai'i. In addition, the DOH Tobacco Prevention and Education Program trained behavioral health care staff throughout 2012 and 2013 on treating tobacco dependence using different interventions endorsed by the Mayo Clinic Nicotine Dependence Center. Training was customized for child/adolescent and mentally ill tobacco users and their unique challenges.

In 2002, all CMHC and contracted POS case management providers began systematically collecting quality of life data using a modified version of Lehman's Quality of Life Interview (QOLI). CMHC and POS providers continue to collect QOLI for all consumers receiving services at baseline, 6 months following the first baseline assessment, and every 6 months until discharge. In October 2012, the AMHD modified the QOLI to include 2 screening questions about tobacco use. The two questions aim to establish prevalence rates of tobacco use among adult consumers served by the AMHD.

CMHC and POS case management providers are expected to establish and coordinate medical care for all consumers, including those with no primary care provider (PCP). Coordination of care includes acquiring and recording information on comorbid medical conditions. Almost all CMHC and POS providers have the capability to run frequency tables to establish prevalence rates of chronic, comorbid medical conditions among those served by the SMHA.

The Living Well Hawaii Project employs a staged enrollment process to prioritize and actively recruit consumers who meet any of the following criteria: (1) no assigned PCP, (2) actively use tobacco, and/or (3) diagnosed with hypertension, hyperlipidemia, diabetes, and/or obesity. Consumers who meet any one of these criteria are asked by trusted members of their treatment team (e.g., peer specialists) to participate in the pilot. Consumers who agree to participate in the Living Well Hawaii Project receive a comprehensive medical evaluation by the project's PCP (M.D. or APRN-RX), which includes a battery of assessments to determine whether their lipids, weight, blood pressure, glucose levels, HDL and LDLs are within normal limits. The project's Integrated Care Management Team meets shortly after receiving lab results to consider a range of treatment options with the consumer, including referrals to specialists, motivational interviewing leading to patient activation, health education, and self-management tools and programs.

Child and Adolescent Mental Health Division

Recent neurobiological research indicates that children's cognitive, emotional and physical development is linked to one another. This has prompted the recognition of the importance of early developmental screening and interventions and issuance of related anticipatory guidance by pediatricians. The American Academy of Pediatrics' Bright Futures practice guide promotes addressing developmental and mental health needs of children based on age and stage of development. The potential benefits for a better-integrated approach to delivery of mental health services include early identification of emotional and behavioral problems, a coordinated approach to care, enhanced resources available to children and families, improved monitoring, and a collaborative approach to crisis management.

In 2011, the Child and Adolescent Mental Health Division issued a Request for Proposals for innovative projects to integrate behavioral health into primary care settings. Proposals were received from the Hawaii Primary Care Association and the University of Hawaii, John A. Burns

School of Medicine, School of Psychiatry. The proposals were found meritorious and contracts were awarded.

Since this would be demonstration models, the Hawaii Primary Care Association's contract allows wide latitude to develop two pilot projects. Based on the needs and opportunities at the Federally Qualified Health Centers (FQHC), Hawaii Primary Care Association is allowed to employ various strategies to integrate children's mental health services at the FQHCs. Major strategies might include consultation, co-location and collaboration. The consultative model may entail primary care providers consulting with CAMHD using telemedicine or other means. Co-location may entail periodic on-site mental health clinics at the FQHCs. Collaborative care models can include cross-disciplinary training, case conferencing, co-management of care and care coordination.

The Hawaii Primary Care Association (HPCA) began the project in late 2012. Their tasks are to identify potential FQHCs and initiate two pilot integration projects. At the pilot sites, HPCA will facilitate routine screening for children's mental health issues, coordinate the development of a consultation and referral system, identify and provide training opportunities, and assist with problem solving, such as issues regarding the sharing of health information.

The University of Hawaii, John A. Burns School of Medicine (JABSOM), Department of Psychiatry has yet to begin its services. JABSOM's contract provides that two sites be identified and that JABSOM provide education to the primary care clinics on identifying signs and symptoms of mental illness, use of proper terminology and de-stigmatizing language, evidence-based screening and assessment tools, and diagnosis and treatment of common mental illness. JABSOM must also provide direct services including the review and follow-up on evaluations and psychiatric consultation to the primary care providers, and the coordination of care.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

IV. Narrative Plan

L. Health Disparities

Adult Mental Health Division

Two particular sub-populations that are vulnerable to disparities in access, service use and outcomes are the chronically homeless and the native Hawaiian/Pacific Islander populations, and both these groups are among the sub-populations AMHD will continue to focus on through programmatic approaches. The Department of Health's current strategic plan highlights as its first foundation the elimination of disparities and improvement of health of all groups throughout Hawaii, with specific objectives and strategies to improve access, affordability and quality of care. AMHD has responsibility to address and reduce disparities among vulnerable populations through the leadership of the Housing Services Coordinator and the Special Populations Services Coordinator. The AMHD's approach to health disparities for the population spans from working through its primary care/health home integration efforts to address people who tend not use mental health services so they can obtain early treatment, to catching chronic disease earlier for the SPMI population. Further plans to assure the delivery of services reduce disparities are linked to implementation literature which suggests the stage of "Innovation" to respond to client, service, or community unmet needs can occur only after fidelity to the evidence-based service has been reached, which is a key focus of mental health service provision in Hawaii. Within Hawaii, changes have been made, for example, to the Illness Management and Recovery protocol to make it more culturally responsive to the ethnic groups who live in Hawaii. Similar changes were made to the WRAP protocol as part of Hawaii's Mental Health Transformation- State Incentive Grant's Adult Proof of Concept study. The methods used to accomplish this, appreciative inquiry involving service recipients and cultural guides, generally change the style and manner in which interventions are presented but leave its structure and operations intact. AMHD will also draw on expertise within the Department of Health, Office of Health Equity (OHE) which assists in design of processes that assure service approaches address disparity-vulnerable sub-populations.

Child and Adolescent Mental Health Division

According to a National Alliance on Mental Illness fact sheet¹, the effects of stigma against gay, lesbian, bisexual, or transgender (GLBT) youth may make them more vulnerable to mental

¹ Bostwick, W.B., "Mental Health Risk Factors Among GLBT Youth" (Arlington: National Alliance on Mental Illness, 2007), available at <http://www.nami.org>.

health problems such as depression, anxiety, substance abuse and suicide.² The fact sheet goes on to say that multiple studies have demonstrated that GLBT youth consistently face intense victimization in school settings and that 22% of GLBT youth reported they did not feel safe at school. Ninety percent of GLBT youth surveyed reported being harassed or assaulted during the past year, compared with 62% of non-GLBT youth.³ A 2009 survey of middle and high school students found that 85% of LGBT teens experienced being verbally harassed at school because of their sexual orientation and nearly two thirds experienced being harassed because of their gender expression.⁴ Bullying is one of several factors that put immense strain on LGBT teens' mental health. Fear of rejection from family members, anti-LGBT messages heard in places of worship and in the media, and the chronic stress associated with having a stigmatized and often hidden identity serve to exacerbate the mental health issues affecting LGBT youth. A recent review of the literature suggests that rates of suicide attempt among LGB youth are 20%-40% higher than among non-LGB youth.⁵

In 2011, the Hawaii Judiciary conducted a self-assessment⁶ of Hawaii's Juvenile Detention Facility as part of its Juvenile Detention Alternatives Initiative. The assessment found that there are no automatic policies for housing or programming of gay, lesbian, bisexual, or transgender youth on the basis of their actual or perceived sexual orientation. Staff makes special housing or programming decisions for such youth on an individual basis in consultation with the youth and documents the reasons for the particular treatment. The facility administrator or designee reviews each decision. Based on the findings of the self-assessment, it was recommended that the housing and programming for LGBT youth, especially transgender youth, be individualized and rely on consultation with medical and mental health staff.

Recently, the Safe Spaces [Super] Committee was formed at CAMHD to create an LGBTQ inclusive, safe and affirming system of care. The committee is a dynamic group of LGBT and ally staff, providers, service system partners, youth, and family members dedicated to improving the lives of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) people in the system of care. They will be working to promote the use of inclusive language, encourage accepting attitudes, embrace diversity, and provide education to the system of care and the greater community. The committee recently created a survey to measure CAMHD staff's attitudes and understanding about LGBT issues. Using the information from the survey, they will develop educational materials and trainings and will distribute professional articles about working with

² Hart, T.A., Heimberg, R.G. (2001). Presenting problems among treatment-seeking gay, lesbian, and bisexual youth. *Journal of Clinical Psychology*, 57, 615-627.

³ Harris Interactive and GLSEN (2005). *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers*. New York: Gay, Lesbian and Straight Education Network.

⁴ Maza, C, Krehely, J. (2010). How to Improve Mental Health Care for LGBT Youth: Recommendations for the Department of Health and Human Services. Center for American Progress. Retrieved August 19, 2013 at <http://www.americanprogress.org>

⁵ Kitts, R. L. (2005). Gay adolescents and suicide: Understanding the Association. *Adolescence*, 40, 621-628.

⁶ *Hale Ho'omalua Juvenile Detention Facility: A Self-Assessment of the Conditions of Confinement*. (2012). Honolulu: State of Hawaii Judiciary, available at: http://www.courts.state.hi.us/docs/news_and_reports_docs/2012_Self_Assessment_Report.pdf

the LGBT population. A longer term goal will be to update policies and procedures and forms to include the spectrum of sexual orientations and gender identities.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that 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:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

IV. Narrative Plan

M. Recovery

Adult Mental Health Division

A cornerstone of the recovery concept is the active participation of consumers in all avenues of the service system supporting the growth of independence and empowerment that leads to consumer recovery. Thus, the AMHD encourages consumers to be involved in self-directing their care. The AMHD has developed a Recovery (Treatment) Planning policy and procedure, which guides individualized recovery planning and encourages staff to focus their efforts on recovery when assisting consumers.

One of AMHD's priority statements developed was to continue to implement and refine an integrated, consumer-centered; recovery-based behavioral health system that provides culturally informed and evidence-based treatment and services and thereby have developed activities for consumers to include but are not limited to participation in one's treatment plan; provision of recommendations and comment relative to review, planning, and evaluation of services; and serving on the Service Area Boards on Mental Health and Substance Abuse, as well as the State Council on Mental Health. AMHD also embraces the concepts and values of self-determination, which emphasizes participation and achievement of personal control for individuals served through the public mental health system. These concepts and values stem from a core belief that people who require support through the AMHD system has the freedom not only to define the life they seek, but to be supported to direct assistance they require in pursuit of that life.

The realization of recovery is also dependent upon reduction of barriers that foster the discrimination and stigma of mental illness. Consequently, AMHD conceptualizes on a spectrum the services and policies that move consumers toward self-direction in their recovery of independence. AMHD encourages consumers to participate in trainings on self-determination, self-advocacy, peer provided services, WRAP planning and leadership development to reach their goal of independence and direct their own recovery both within and, eventually, outside the public mental health system of care.

Services that support consumers in their self-direction of their services and recovery include:

- Recovery (Treatment) Planning;
- Clubhouse Services (including Transitional Employment and Supported Education);
- Supported Employment Programming;
- Peer provided supports (Peer Coaching, Peer Specialists, Peer Educators, Network of Care Workers Representative Payee services); and
- Work Incentives Training.

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, AMHD Office of Consumer Affairs (OCA), Statewide Clubhouse Coalition, Statewide Peer Coaching Program, Statewide Hawaii 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 Administrator.

The AMHD is in the process of developing a Utilization Plan for Housing which tracks lengths of stay, effectively manages the housing inventory to include tracking levels of care to move consumers along the continuum of care and housing needs.

The Hawaii State Hospital provides a Transition to the Community Program, which utilizes psychosocial rehabilitation practices in which consumers are prepared to transition from the inpatient settings to the community. Through the community based clubhouses in the CMHCs, consumers are encouraged to participate in the supported employment work opportunities while receiving psychosocial rehabilitation supports.

Child and Adolescent Mental Health Division

Involvement of Individuals and Families

CAMHD has instituted measures to ensure family member involvement in the system of care. CAMHD partners with the statewide family organization, Hawaii 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 6 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.

A few years ago, Hawaii Families as Allies 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 Marshallese on its staff. After orientation and training, the half-time Parent Partner began to work on establishing community relationships and translating materials into his native languages.

Hawaii Families as Allies' youth council, Hawaii Youth Helping Youth (HYHY), is composed of youth with emotional or behavioral challenges from across the state. They meet to share their individual experiences and develop an advocacy agenda and an action plan. Examples of the youth council's activities include working with a state senator to introduce an anti-stigma and anti-bullying bill. The youth council's public awareness activities included developing posters and brochures in line with their previously-produced public service announcements and distributing them to schools, clinics, and providers. The youth conduct surveys in schools about bullying and one year found that, of the 131 surveys completed, over 50% felt bullied and depressed about the situation and 80% felt it was important to get help for emotional distress. HFAA recently established a youth council on the island of Hawaii, with plans to establish youth councils for each county.

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

IV. Narrative Plan

N. Evidence Based Treatment

Adult Mental Health Division

The AMHD plans to set-aside five percent of its MHBG allocation to implement evidence based projects. This dollar amount is approximately \$40,000. However, additional dollars may be required to fund a possible test pilot project using the Assertive Community Treatment (ACT) type of model. The target population is the chronically homeless individuals who experience mental and substance disorders. AMHD in collaboration with the Institute of Human Services is planning to design a test program to incorporate ACT services.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

IV. Narrative Plan

O. Children and Adolescents Behavioral Health Services

Written and Submitted by Planning Council

The Child and Adolescent Mental Health Division (CAMHD) provide contracted mental health and substance abuse services to eligible youth. The service array includes both in-home and out-of home services and functions to improve the lives of youth and families in the state of Hawaii. The array of services includes three evidence-based services – Family Functional Therapy, Multi-systemic Therapy, and Multidimensional Therapeutic Foster Home. CAMHD's Intensive-In Home Services can be tailored to the specific needs of the youth and families. A relatively new in-home treatment services targets the needs of youth and young adults who need to work on developing a range of skills to prepare for independent living. The out-of-home service array includes several Community-Based Residential Programs (CBR), Transitional Family Homes, and Hospital-Based Residential programs for the more acute needs of youth. The CBR's in the CAMHD system work with youth and families to address the behavioral and emotional and/or family problems which prevent the youth from taking part in family and/or community life. All CBR programs are specialized to specific treatments, and all are required to treat mental health and substance abuse symptoms.

Monitoring activities are many-fold in CAMHD and with its collaborating stakeholders. At the big picture level, an Interagency State Quality Assurance Meeting is held monthly. This meeting focuses on collaboration at the interagency level. Various reports at the division level aggregate data at demographic, cost, utilization, performance, and outcome performance. Outcome data on how youth are responding to treatment services are collected with the Child and Adolescent Functioning Assessment Scale and the Monthly Treatment Progress Summary. We are in the process of implementing the Ohio Scales throughout our system.

The CAMHD has established Child and Adolescent Mental Health Performance Standards that are updated and revised with each contract cycle. The most recent occurred revision occurred in July of 2012, and will be effective until June 30, 2018. These performance standards were developed as part of a contractual agreement between CAMHD and its contracted providers for the delivery of behavioral health services to youth and families. The guidelines spell out the core components of the current system – i.e. Commitment to Hawaii CASSP Principles, Commitment to Interagency Collaboration and Coordination, Commitment to Evidence-Based Practices, Commitment to Performance Management, and a Commitment to Access and Continuity of Care. Individualized service planning is directed by a Coordinated Service Plan (CSP) that supports the use of medically necessary evidence-based interventions in the least restrictive environment. CAMHD service planning is an individualized and ongoing process that is youth guided and family/guardian centered. The CSP goals revolve around the youth's increasing independence. The contracted provider of services creates a Mental Health Treatment Plan (MHTP) which includes strategies to address the following six areas: Living arrangement/personal management; vocational/educational; mental health/medical;

community/social experiences; financial support; and employment. CAMHD has collaborated with different groups in the following projects:

- a. Interagency State Quality Assurance Meeting – Brings stakeholders from other child-serving agencies/divisions to the table to discuss and task prioritized activities that need to be addressed.
- b. Project Kealahou – Governing council has involvement from all child-serving agencies.
- c. Project Laulima – Involvement from all child-serving agencies.

Three evidence-based services are provided to our children and families through contracted providers of MST, FFT, and MDTFC. CAMHD provides periodic training on evidence based practices for mental and substance abuse prevention and intervention.

On an annual basis CAMHD publishes an aggregated report on service utilization for youth with mental, substance use and co-occurring disorders. In addition, a bi-annual performance report is published with other child-serving agencies on cost, service utilization, outcome measures, and quality indicators. Through CAMHD committee structure and electronic health records, aggregated data can be reviewed and strategically addressed. Initiatives are currently under way that will enhance the time lag that is current in our system. CAMHD is moving towards a more real-time data structure that can be used by clinicians.

Child and Adolescent Mental Health Division

1. CAMHD has a team comprised of program monitoring, research and evaluation, clinical services and the evidence-based services committee. Together they gather statewide, programmatic and individual consumer data which is fed back to stakeholders to further the quality of care.
2. CAMHD has a data driven clinical model where targets, evidence-based interventions and progress are tracked over time and inform clinical decisions. This data comes in the form of the Monthly Treatment Progress Summary (MTPS), Child and Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Service Intensity Inventory (CASII). The Ohio Scales will soon be employed and the MTPS transitioned from a monthly data source to a per contact source.
3. CAMHD meets with the Department of Education, Department of Human Services, Judiciary, and Department of Health – Developmental Disabilities Division on a regular basis through the statewide Quality Assurance Committee. CAMHD has sponsored the wraparound initiative which is collaboration between Office of Youth Services, Department of Human Services, Department of Education, University of Hawaii and CAMHD. CAMHD's Project Laulima is an initiative that has partnered with the Developmental Disabilities Division. CAMHD's Project Kealahou is a partnership between CAMHD, the Judiciary, Office of Youth Services and private entities.

4. CAMHD has and will continue to offered statewide trainings on evidence-based treatments, sponsor evidence-based services conferences, and provide orientations to our existing packaged evidence-based programs.
5. The above mentioned performance tracking includes service costs by youth, program and statewide array.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will 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 opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, 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 be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which 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. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

IV. Narrative Plan

P. Consultation with Tribes

Hawaii has many interracial groups that the Behavioral Health System engages with; however, the closest definition for tribal affiliations would be the Native Hawaiian population. As such, this group is involved in planning efforts to ensure individuals with mental illness receive services in a timely manner and are treated with respect and dignity irrespective of race or culture.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

IV. Narrative Plan

Q. Data and Information Technology

Adult Mental Health Division

The progress on developing client-level data:

- Through the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI), several trainings have occurred to instruct data staff to develop the infrastructure for reporting client level data.
- Last fiscal year the Behavioral Health Administration was able to report client level data.
- Some challenges that were experienced during this transition were:
 - Cross-walking the in-house data to SAMHSA's requirements.
 - Reporting criminal justice data based on the Quality of Life Indicator that is consumer reported, and which may not be very accurate.
 - Difficulty in aligning the CAMHD with the AMHD data set.
 - New statisticians were recently hired in Behavioral Health and this may add additional challenges for them to understand the system and requirements.

Technical Assistance needs would be for SAMHSA to provide more face-to-face trainings.

Child and Adolescent Mental Health Division

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked 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, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this 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 emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

IV. NARRATIVE PLAN

R. Quality Improvement Plan

Adult Mental Health Division

The continuous quality improvement (CQI) program was suspended due to a lack of staff. Due to the economic downturn, many employees lost their positions to a reduction in force or through termination. Further, several vacant positions were frozen and administrators were unable to hire new staff. In the AMHD, the Performance Improvement staff that oversaw the CQI program was decimated through retirement and resignations. The remaining staff was able to continue to monitor providers due to Medicaid requirements. The Office of Consumer Affairs continued to receive and resolve complaints and grievances from consumers.

Currently, under new leadership in the AMHD, plans are underway to develop a 5-year Strategic Plan. Within the next month, there will be Robust Process Improvement (RPI) training for supervisors and managers. This program has been adopted by healthcare organizations to improve quality and sustain high sustained levels over prolonged periods of time. The RPI approach consists of a unique blend of tools including Lean, Six Sigma, and change management. Specific risk points and contributing factors involved in process failures are identified then solutions are developed and targeted to the specific causes.

The AMHD is also in the process of developing a 5-year Strategic Plan to guide policy and keep its system accountable. As a result, a CQI plan will be developed during the process. Target date of completion is summer of 2014.

Child and Adolescent Mental Health Division

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

IV. Narrative Plan
S. Suicide Prevention

The 2012-2017 Hawaii Injury Prevention Plan is listed. The Suicide Plan that covers the State of Hawaii is on pages 31-35.



Hawai'i Injury Prevention Plan 2012-2017

Injury Prevention Advisory Committee
Injury Prevention and Control Section

Hawai'i State Department of Health
Emergency Medical Services and Injury Prevention System Branch

Dear Community Colleagues,

We are pleased to present you with the *Hawai'i Injury Prevention Plan 2012-2017* that serves as a guide for reducing the eight leading causes of injury in Hawai'i. This document builds on the previous *Hawai'i Injury Prevention Plan 2005-2010* and is the result of a collaborative effort between the Hawai'i State Department of Health (DOH), Emergency Medical Services and Injury Prevention System Branch (EMSIPSB); the Injury Prevention Advisory Committee (IPAC); and other community partners. In the gap period between the end of the previous plan and inception of the new plan, the initial plan continued to guide the work of the DOH Injury Prevention and Control Section and community partners.

Here in Hawai'i, we have made great strides in preventing injuries through the cooperative efforts of government agencies, voluntary and professional organizations, and numerous other community partners. There is much more we must do, however, to further reduce the burden of injury.

Injury prevention remains an under-recognized and under-funded area of public health. Now more than ever, we must leverage our resources to join the best knowledge and practices with strong partnerships to effectively prevent injuries, thereby reducing pain and suffering, and saving Hawai'i millions of dollars each year. We must work together to raise public awareness, build community capacity for injury prevention efforts, make changes to the physical environment, and implement policy and organizational practices that prevent injuries.

On behalf of the Injury Prevention Advisory Committee and the Hawai'i State Department of Health, we invite you to join us in achieving the recommendations set forth in this plan. Please contact us through www.nogethurthawaii.gov or call the Injury Prevention and Control Section on O'ahu at (808)733-9320.

Working together, we can accomplish what none of us can do alone.



Bruce McEwan, PhD
Chair
Injury Prevention Advisory Committee



Loretta J. Fuddy, ACSW, MPH
Director of Health
Hawai'i State Department of Health

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Injury Prevention is a Public Health Priority in Hawai'i

Injuries in Hawai'i are responsible for more deaths from the first year of life through age 39 than all other causes combined, including heart disease, stroke, and cancer. Among residents of all ages, injury is the fourth leading cause of death and disability. The vast majority of injuries, however, are non-fatal and can lead to a range of outcomes, including temporary pain and inconvenience, disability, chronic pain, or a complete change in lifestyle.

During an average week in Hawai'i:

- ▶ 13 residents die from an injury
- ▶ 115 are hospitalized
- ▶ Nearly 1,530 are treated in emergency departments

While the greatest impact of injury is in human suffering, the financial cost is staggering. In Hawai'i, injury-related hospitalizations cost an estimated \$364 million annually.

Ten leading causes of death among Hawai'i residents, by age group, 2007-2011

	<1	1-14y	15-24y	25-34y	35-44y	45-54y	55-64y	65+y	all ages
1	Perinatal conditions 292	Unintentional injuries 52	Unintentional injuries 212	Unintentional injuries 196	Unintentional injuries 257	Malignant neoplasm 923	Malignant neoplasm 2,081	Heart disease 8,911	Heart disease 11,170
2	Congenital anomalies 70	Malignant neoplasm 23	Suicide 125	Suicide 124	Malignant neoplasm 246	Heart disease 687	Heart disease 1,236	Malignant neoplasm 7,531	Malignant neoplasm 10,936
3	Unintentional injuries 38	Congenital anomalies 15	Malignant neoplasm 46	Malignant neoplasm 84	Heart disease 234	Unintentional injuries 366	CVD* 310	CVD* 2,589	CVD* 3,111
4	Unintentional injuries 27	Homicide 8	Heart disease 27	Heart disease 68	Suicide 138	Suicide 161	Unintentional injuries 250	Chronic lower resp. diseases 1,276	Unintentional injuries 2,159
5	Other resp. diseases 10	Suicide 5	Injuries of unk. intent 18	Injuries of unk. intent 33	CVD* 53	CVD* 137	Diabetes mellitus 229	Influenza and pneumonia 1,183	Chronic lower resp. diseases 1,483
6	Influenza and pneumonia 8	Influenza and pneumonia 5	Homicide 12	Homicide 22	Injuries of unk. intent 46	Liver disease and cirrhosis 135	Liver disease and cirrhosis 178	Alzheimer's disease 1,081	Diabetes mellitus 1,402
7	Septicemia 8	Septicemia 5	Congenital anomalies 6	CVD* 14	Liver disease and cirrhosis 32	Injuries of unk. intent 107	Chronic lower resp. diseases 138	Diabetes mellitus 1,040	Influenza and pneumonia 1,349
8	Other acute lower resp. 4	Other resp. diseases 5	Influenza and pneumonia 4	Influenza and pneumonia 9	Homicide 25	Diabetes mellitus 100	Suicide 130	Nephritis, nephrotic synd. 833	Alzheimer's disease 1,085
9	Injuries of unk. intent 3	Heart disease 4	Pneumonitis 3	Chronic lower resp. diseases 7	Diabetes mellitus 25	Viral hepatitis 55	Nephritis, nephrotic synd. 95	Unintentional injuries 800	Nephritis, nephrotic synd. 990
10	Heart disease 3	Perinatal conditions 3	Septicemia 3	Congenital anomalies 7	Other circ. diseases 25	Chronic lower resp. diseases 47	Viral hepatitis 81	Septicemia 466	Suicide 795

*CVD – cerebrovascular diseases, including stroke

Deaths grouped as recommended by National Center for Health Statistics http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_15.pdf.

Note: 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" (e.g., falls, drownings, poisonings, and motor vehicle-related injuries). Intentional injuries are purposefully inflicted on others (assaults) or oneself (suicide attempts).

Injury Prevention is a Public Health Priority in Hawai'i

Leading Causes of Injury Mortality and Morbidity among Hawai'i residents¹

Death Certificates (fatal)			Hospital Admission Records (non-fatal)			Emergency Department Records (non-fatal)			
Cause	# ²	%	Cause	# ³	%	Cause	# ⁴	%	
1	Suicide	159	24%	Falls	2,705	45%	Falls	20,920	26%
2	Falls	108	16%	Car occupant	414	7%	Striking ⁵	11,572	15%
3	Poisoning	98	15%	Suicide attempt/ self inflicted	361	6%	Cut/pierce	7,563	10%
4	Car occupant	58	9%	Assault	307	5%	Overexertion ⁶	6,618	8%
5	Drowning	35	5%	Motorcyclist	276	5%	Car occupant	4,204	5%
6	Suffocation	30	4%	Poisoning	207	3%	Assault	3,936	5%
7	Motorcyclist	29	4%	Striking ⁵	191	3%	Natural/ environmental ⁷	3,549	4%
8	Pedestrian	26	4%	Pedestrian	137	2%	Bicyclist	1,133	1%
9	Assault	22	3%	Overexertion ⁶	106	2%	Motorcyclist	1,044	1%
10	Fire/burn	4	1%	Bicyclist	105	2%	Fire/burn	988	1%
	<i>all other</i>	102	15%	<i>all other</i>	603	10%	<i>all other</i>	10,892	14%
	Annual total	671		Annual total	5,980		Annual total	79,576	

¹ Non-residents comprised 9% 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 2007-2011 death certificates. For underlying cause of death in the ICD-10 code series: V01-Y36, Y85-Y87, Y89, and U01-U03.

³ Annual number of injury-related hospitalizations, from 2004-2008 records. For principle diagnosis in ICD-9CM code series: 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85.

⁴ Annual number of injury-related hospitalizations, from 2004-2008 records. For principle diagnosis in ICD-9CM code series: 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85.

⁵ Most (92%) of these patients were "struck accidentally by objects or persons"; the rest (9%) were "struck accidentally by falling object". Of the former, the most commonly specified causes were "striking...in sports" (20%), and "striking against...furniture" (4%). For the 30% of 2010 and 2011 records with specific coding, most (79%) of these injuries were sports-related, most commonly "surfing, windsurfing and boogie boarding" (16%), "american tackle football" (15%), basketball (10%), baseball (9%), and soccer (7%).

⁶ Most (95%) of these injuries were related to "Overexertion and strenuous movements", with no further specificity. Subcategories include overexertion from sudden strenuous movements (39%), and trauma from repetitive motion, loads or impacts (17%). For the 30% of 2010 and 2011 records with specific coding, about half (44%) of these injuries were sports-related, including basketball (14%), and baseball, soccer and volleyball (5% each). Another 13% were due to "walking, marching and hiking", and 6% to running.

⁷ Most (98%) of these visits were related to the bites or venom of animals, most specifically dog bites (36%), bee and wasp stings (11%), centipedes (11%) and venomous marine animals (6%).

The Hawai'i State Department of Health, Injury Prevention and Control Section (IPCS), with strong support from the Injury Prevention Advisory Committee (IPAC), completed the *Hawai'i Injury Prevention Plan* (HIPP) with funding from a Public Health Injury Surveillance and Prevention Program capacity building grant and a Core Violence and Injury Prevention Program grant, both from the Centers for Disease Control and Prevention (CDC).

The *Hawai'i Injury Prevention Plan 2012-2017*, is a plan for injury prevention activities during the next five years. Developed in collaboration with partners from across the state, the plan provides:

- ▶ Overall direction and focus of IPCS and IPAC-led efforts
- ▶ Stimulus for organizations, agencies and community groups to collaborate on reducing or preventing injuries in Hawai'i

This report builds on the earlier, *Hawai'i Injury Prevention Plan 2005-2010* (available online: www.nogethurt.hawaii.gov). Details about the state's progress toward meeting the objectives outlined in the 2005-2010 report can be found in the Appendix A.

HIPP is a collaborative effort that reflects the current thinking of public health professionals and community partners in the following areas:

- ▶ Core capacity to sustain injury prevention policy and program activities
- ▶ Drowning
- ▶ Falls among older adults
- ▶ Poisoning
- ▶ Traffic-related injuries
- ▶ Suicide
- ▶ Violence and abuse

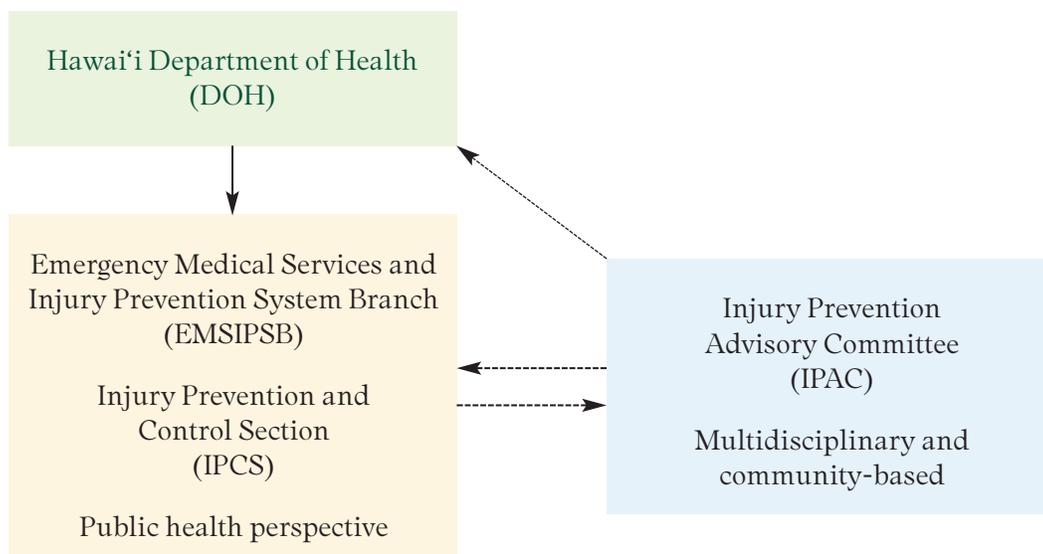
IPCS worked closely with experts and stakeholders in each area to review accomplishments, conduct needs assessments, and develop recommendations for the next five years. Additional information about the processes used to generate these recommendations are included in the individual chapters.

Injury Prevention and Control Section

The Injury Prevention and Control Section is part of the Emergency Medical Services and Injury Prevention System Branch at the Hawai'i State Department of Health. IPCS is the focal point in the Department of Health for injury prevention throughout the state for all age groups.

IPCS is responsible for coordinating, planning, conducting, and evaluating injury prevention programs; developing policy and coordinating advocacy; collecting, analyzing and disseminating injury data; and providing technical support and training. Much of their work is achieved through community coalitions and partnerships in order to increase and focus community resources, minimize duplication of effort, and support the injury prevention activities of local agencies and community organizations. The Spectrum of Prevention is used as a guiding model for IPCS's work to prevent injuries in Hawai'i (see Appendix E). IPCS also provides staff support to IPAC.

Relationship between Department of Health, IPAC, EMSIPSB and IPCS



Mission: A safe Hawai'i from the mountains to the sea.

The Injury Prevention Advisory Committee is a volunteer network of professionals and community members committed to working together to prevent injuries in Hawai'i.

IPAC Members:

- ▶ Advise the Injury Prevention and Control Section
- ▶ Educate the public about injury prevention
- ▶ Advocate for injury prevention policies and legislation
- ▶ Serve as a liaison between IPAC and individual organizations
- ▶ Help identify and secure resources to support injury prevention

How the *Hawai'i Injury Prevention Plan* Can Be Used

The Hawai'i Injury Prevention Plan (HIPP) can be used in a variety of ways by local agencies, businesses, community organizations, advocacy groups, planners, decision-makers, researchers, and others interested in preventing injuries. Examples include:

▶ ***Collaboration***

Groups and individuals interested in addressing a particular injury area can use HIPP to assess the current thinking, get an understanding of the key players involved, and build consensus for implementing priority activities.

▶ ***Policy making***

Advocacy groups working in injury prevention can use HIPP to support and act on prioritized areas of concern and identify key partners to collaborate with.

▶ ***Program planning***

Organizations and individuals interested in addressing a particular injury area can use HIPP for priority setting and action planning.

▶ ***Research***

Researchers, including graduate and medical students, can use HIPP to develop studies to adapt and evaluate evidence-based practices for Hawai'i.

Policy and Program Activities

Background and Accomplishments

Since the *Hawai'i Injury Prevention Plan 2005-2010* was released, the Hawai'i State Department of Health, Injury Prevention and Control Section (IPCS) has worked closely with partners in the community to build and strengthen the infrastructure to support injury prevention policy, research, surveillance and programs in Hawai'i.

- ▶ With the support of IPAC, IPCS added a suicide prevention coordinator to their staff and now has three permanent state-funded positions.
- ▶ Complete and accurate data are critical to assessing and understanding the injury problem, and also to developing and evaluating prevention programs. E-codes capture how an injury happened (cause), the intent (unintentional or intentional, such as suicide or assault), and the place where the event occurred. IPCS led efforts to establish new standards for external cause of injury coding (e-coding) for hospitals to achieve and maintain. Currently, 90% of all emergency department and hospital admission records meet the new standards, up from 51% in 2003.
- ▶ In collaboration with Kapiolani Community College, Emergency Services Department, IPCS helped to develop, implement and evaluate injury prevention training modules for the emergency medical technician (EMT) program and mobile intensive care technician (MICT) program, and a continuing education module for emergency medical services personnel.
- ▶ Aiming to develop a cadre of individuals and organizations who are injury literate, articulate, and active, IPCS conducted public health competency building workshops and worked with affiliated injury prevention groups to coordinate conferences specific to certain injuries.
- ▶ In 2008, IPCS produced the *Injuries in Hawai'i 2001-2006*, and disseminated the data report to state legislators. In partnership with IPAC, IPCS has worked to increase awareness among policy makers and residents of Hawai'i about injuries as a major public health problem.
- ▶ In 2008, IPCS released a series of "No Get Hurt" radio, television, and print ads with prevention messages focused on different types of injuries that IPAC members helped to disseminate.
- ▶ Recognizing the significant percentage of Hawai'i residents that are affiliated with the armed forces, IPCS has fostered partnerships with all five branches. There are military representatives on the Injury Prevention Advisory Committee (IPAC) and the Prevent Suicide Hawai'i Steering Committee, and the military actively participates in the annual "Click It or Ticket" traffic safety campaign.

Recommendations

Building on work completed for the *Hawai'i Injury Prevention Plan 2005-2010*, IPCS and the IPAC steering committee developed the following recommendations. They are based on the core components of a state injury prevention program as identified by the Safe States Alliance (2003):

- ▶ Build a solid infrastructure for injury and violence prevention
- ▶ Collect and analyze injury and violence data
- ▶ Design, implement, and evaluate programs
- ▶ Provide technical support and training
- ▶ Affect public policy

Recommendation 1: Build and sustain infrastructure to provide leadership, data, technical assistance, and to support policy and evaluation for advancing injury prevention

Hawai'i needs a strong, stable, and comprehensive program to systematically address the many causes of injury in coordination with multiple partners. "CDC recommends that states adopt a comprehensive injury prevention program to provide consistent, reliable and comprehensive data for policymakers; ensure high-risk populations are identified and helped; lead state efforts among programs with various injury prevention goals; and provide continuity amid changing administrations and budget priorities" (Foreman, 2009).

The enactment of the Trauma System Special Fund by the Hawai'i State Legislature in 2007 provided for the development of a comprehensive statewide trauma system by the Department of Health. A comprehensive trauma system addresses the problem of injury along the full continuum from primary prevention through acute care and rehabilitation.

As a core component of this system, injury prevention will be more closely integrated with other strategies that can reduce the severity and outcomes of injuries and IPCS will have access to resources to support positions and injury prevention initiatives. The new hospital trauma centers that are also part of the trauma system can play a critical role in injury prevention activities by coordinating and supporting injury prevention interventions in their communities.

Some hospitals have already instituted injury prevention interventions (e.g., policies that require staff to follow safe sleep recommendations with infants and ensure that newborns leave hospitals in appropriate safety seats). The establishment of trauma centers would allow hospitals to expand their roles in injury prevention within their organizations and the community.

Recommended Next Steps

- ▶ Secure core IPCS positions under the Trauma System Special Fund.
- ▶ Build professional capacity of Neighbor Island community partners to coordinate community-based injury prevention interventions through conference trainings and distance-based learning.
- ▶ Implement county level injury prevention interventions in coordination with trauma center staff and community stakeholders.

Recommendation 2: Serve as a clearinghouse for data, and incorporate other injury data sources to strengthen analyses and further injury prevention efforts

The Safe States Alliance recommends injury prevention programs maintain a strong data component with access to major data sources that define the injury problem (2003). Complete, accurate, and timely data are critical to informing public policies, guiding the selection, design and evaluation of interventions, and directing use of limited resources.

Hawai'i needs to build on its impressive achievements by maintaining and further enhancing the collection and distribution of injury prevention data.

Recommended Next Steps

- ▶ Maintain and increase use of standards for e-coding by emergency departments and hospitals, and evaluate the completeness of collected data.
- ▶ Ensure continued access to currently used databases.
- ▶ Expand access to data sources.
 - Work with the Medical Examiner's Office to institutionalize access to autopsy records.
 - Access and use data from the statewide Trauma Registry.
- ▶ Improve accessibility of reliable and timely injury data to partners.
 - Provide partners Hawai'i Emergency Medical Services Information System (HEMSIS) data about risk factors such as seat belt use, alcohol and drug use, and helmet use.
 - Utilize internet to increase accessibility of data to partners, decision makers, and the public.
 - Improve ability to respond to data requests quickly and effectively.

Recommendation 3: Provide training and technical assistance to increase and enhance knowledge and skills among injury prevention practitioners and partners

In order to effectively address injuries in Hawai'i, it will be essential to build injury prevention core competencies among practitioners in related fields. Core competencies include the ability to (Runyan & Stephens Stidham, 2009):

- ▶ Describe injury and violence as a public health problem
- ▶ Access, interpret, use, and present injury and violence data
- ▶ Design, implement, and evaluate injury prevention activities
- ▶ Disseminate injury prevention information to the community and key policy makers
- ▶ Affect change through policy and education

Recommended Next Steps

- ▶ Conduct a needs assessment to understand the training needs of professionals and partners, including practitioners and organizations working in related fields (e.g., first responders) or specific content areas (e.g., water safety), as well as interested members of the community. At the same time, determine where and how the different groups prefer to receive training.
- ▶ Based on results from the assessment, develop trainings to strengthen injury prevention and public health core competencies.
- ▶ Explore opportunities to provide these trainings in settings that maximize available resources.
 - Use existing venues (e.g., IPAC meetings, injury specific and public health conferences).
 - Provide annual training to trauma center staff.
- ▶ Identify and prioritize professionals and organizations that can have the greatest impact in reducing injuries, and develop tailored trainings that address their needs and interests.
- ▶ Provide partners specific training in applying evidence-based practices to help integrate injury prevention into their work.
- ▶ Support and pursue resources for professional development of injury prevention staff.

Recommendation 4: Cultivate awareness among decision makers and the public to elevate injury and violence as a major public health problem in Hawai'i

Injury prevention researchers, practitioners and advocates understand that injuries are a leading cause of death and disability that can be prevented. Many decision makers and members of the public, however, continue to think of injuries as accidents that are unavoidable.

It is imperative to communicate the personal and financial costs of injury as well as the potential solutions in order to inform policies, secure resources, change behaviors, and affect injury rates in Hawai'i. Injury prevention advocates need to work with partners and the media to reach target audiences with carefully developed and tested messages.

Recommended Next Steps

- ▶ Develop, test and disseminate injury prevention messages that are tailored to specific, prioritized audiences.
 - Disseminate messages developed by IPCS and the Fall Prevention Consortium (with training and support from CDC's Injury Center Communications Initiative). Identify and use communication channels most frequently accessed and trusted by target audiences.
 - Apply this message development process to other injury areas to create, test and disseminate additional messages.
- ▶ Develop materials that educate specific audiences, such as policy makers or employers, about priority injury areas.
- ▶ Seek opportunities to communicate with the media about current issues, using relevant data and consistent prevention messages.
- ▶ Facilitate partners' ability to effectively communicate about injury by regularly providing current data and information about evidence-based prevention strategies.
 - Use existing communication channels such as IPAC meetings and newsletters.

Recommendation 5: Inform injury prevention policy at all levels

Evidence-based policies implemented at national, state, local, and agency or organizational levels can dramatically reduce the burden of injury. State legislation that requires children to ride in safety seats, local ordinances that require pool fencing, and health care provider policies that recommend fall risk assessments for all older clients are examples of policies that can help reduce injuries.

Recommended Next Steps

- ▶ With leadership from IPAC and staff support from IPCS, develop and implement a comprehensive plan (with measurable goals and objectives) to work with partners and inform injury prevention policy at multiple levels.
- ▶ Mobilize coalitions and networks to build a support base and advocate for evidence-based policy solutions.
- ▶ Continue to identify, track, and share information about annual legislative injury prevention priorities.

Recommendation 6: Increase opportunities for collaborative injury prevention efforts in all priority injury prevention areas

Working collaboratively with partners from diverse disciplines, organizations, and perspectives inside and outside of state government is critical to success. To optimize the best use of limited resources, injury prevention partners need to coordinate efforts and address critical concerns without duplicating their efforts.

Partnerships have been essential to the work of IPCS, as evidenced throughout this report. They are critical to directing priorities, communicating messages, and sustaining programs.

Recommended Next Steps

- ▶ Work with existing and new partners to implement recommendations outlined in this report.
- ▶ Invite new partners to join current injury prevention taskforces and committees:
 - Injury Prevention Advisory Committee
 - Keiki Injury Prevention Coalition
 - Prevent Suicide Hawai'i Task Force
 - Fall Prevention Consortium

Background and Accomplishments

Drowning prevention has been a priority issue for the Hawai'i State Department of Health, Injury Prevention and Control Section (IPCS) since 1991. Hawai'i has accomplished much in the area of drowning prevention with the benefits of highly engaged experts, exceptional ocean safety officers across the state, active involvement from the visitor industry, and strong collaborative partnerships in the community.

- ▶ The Hawai'i Beach Safety website (www.hawaiibeachsafety.org) was developed in 2006 and provides beach ratings based on comprehensive risk assessments that were conducted on all guarded and unguarded beaches in the state. The site also features safety information about hazards (e.g., rip currents, dangerous shore breaks), prevention tips, surf reports, special alerts (e.g., box jelly fish notices), and warnings. Information on the website is updated several times each day. Partners on this project include the Ocean Safety and Lifeguard Services Division at the City and County of Honolulu, the Hawaiian Lifeguard Association, ocean safety and lifeguard partners on neighbor islands, the University of Hawai'i School of Ocean and Earth Science and Technology, the Hawai'i Tourism Authority, and the Hawai'i State Department of Health.
- ▶ In collaboration with the Hawai'i Association of Independent Schools, IPCS co-produced the video, "Be Ocean Minded" about the Junior Lifeguard Program. Lifeguards from all islands were interviewed to talk about ocean safety, prevention tips, and the value of the Junior Lifeguard Program. The county-based Junior Lifeguard Program runs during the summer and trains teenagers (13-17 years of age) in ocean skills, beach condition assessment, and lifesaving techniques. The video serves as a recruitment tool for the program and copies have been distributed across the state.
- ▶ In 2009, IPCS surveyed over 500 beach goers on O'ahu, both residents and visitors, to assess the impact of four types of beach warning signs: strong current, high surf, dangerous shore break, and waves breaking on ledge. Results showed that about half of those surveyed saw the signs, and among those, 66% thought the signs would influence their behavior.
- ▶ IPCS worked with the Swimming Pool Association of Hawai'i in 2009 to conduct a survey of 1,300 residential pool owners on O'ahu. The impetus for this project was to inform pool owners about a federal law designed to protect children against entrapment from the suction of pool drains and pumps. This 2009 law, the Virginia Graeme-Baker Pool and Spa Safety Act, is mandatory for commercial pools but not for residential pools. The survey asked about drain covers and pumps as well as fencing, safety latches on gates, whether there were kids in their home and if so, whether the kids participated in swimming lessons. Pool owners also were provided with pool safety and entrapment prevention information. A follow-up survey determined what safety changes pool owners made. During the survey, 163 swimming pools or spas were identified as having potentially dangerous equipment; 65 pool owners voluntarily upgraded their pumps and drains.

Recommendations

In 2010, IPCS led a statewide needs assessment that included a review of best practices for drowning prevention, in-depth telephone interviews with ten key stakeholders (i.e., representatives of organizations involved in prevention efforts, and potential partners), and two strategic planning sessions with partners from the community and the visitor industry. IPCS used the information gathered through this process to develop and prioritize the following recommendations.

Recommendation 1: Establish a task force to develop a statewide approach to drowning prevention

Each week in Hawai'i, at least one person fatally drowns. As an island state, it is essential that we create a safer environment and provide residents and tourists with information they need to have a safe and enjoyable experience in and around the water. A statewide task force for drowning prevention would bring key partners together to coordinate drowning prevention efforts, and provide guidance to IPCS moving forward. Partners in the community, including the visitor industry should be broadly represented on the task force, and efforts should be made to engage educators.

Recommended Next Steps

- ▶ Work with existing groups, including the Hawai'i Department of Land and Natural Resources and the Hawaiian Lifeguard Association to create a task force, build membership and define a clear mission.

Recommendation 2: Implement a statewide educational campaign to increase ocean safety awareness among residents and visitors

The majority of drownings in Hawai'i are ocean-related, and half of those fatalities are among tourists. Clear and effective messages for residents and visitors of Hawai'i need to be developed, tested, implemented, and evaluated. Messages may be communicated through existing communication channels, including the Hawai'i Beach Safety website and the Hawai'i Tourism Authority's Travel Smart Hawai'i website. Efforts should be made to engage partners throughout the message development and dissemination process.

PARTNERS

American Red Cross -
Hawai'i State Chapter

City and County of Honolulu
Department of Parks
and Recreation

City and County of Honolulu
Ocean Safety and Lifeguard
Services Division

County of Hawai'i Department
of Research and Development

County of Hawai'i
Fire Department

County of Hawai'i Ocean Safety

County of Kaua'i Ocean Safety

County of Kaua'i Office of
Economic Development

County of Maui Office of
Economic Development

County of Maui
Aquatics Division

Hale Koa Hotel

Hawaiian Lifeguard Association

Hawai'i State Department of Land
and Natural Resources

Hawai'i Tourism Authority

Injury Prevention Advisory
Committee

Kama'aina Kids

Kaua'i Lifeguard Association

Kaua'i Visitor Bureau

O'ahu YMCA

Resorts and adventure
tourism companies

Swimming Pool
Association of Hawai'i

University of Hawai'i School
of Ocean and Earth Science
and Technology

YMCA of Honolulu

Attention also must be paid to visitors' sources of information. Hawai'i guidebooks are of particular concern as they often direct visitors who are less familiar with ocean swimming and conditions to unguarded locations without explaining the potential dangers.

Recommended Next Steps

- ▶ Solicit partner input to develop and test clear, consistent prevention messages for visitors and residents.
- ▶ Engage partners in message dissemination and evaluation.
- ▶ Educate writers and publishers of guidebooks about drownings in Hawai'i and encourage them to include accurate information in their publications about safety conditions.

Recommendation 3: Evaluate current drowning prevention efforts and disseminate information about best practices

Drowning prevention is a complex public health concern. There are numerous factors including the age and ability of the individual, the body of water (e.g., swimming pool, ocean, stream), and current conditions (Quan, et al, 2007). More information is needed about what works to prevent drowning in Hawai'i.

Currently, there aren't many evidence-based strategies or best practices to prevent drowning. There are several promising practices that have strong behavioral elements, and very few environmental or legislative interventions. More research is needed to evaluate the effectiveness of interventions and education materials currently in use (Quan, et al, 2007). Results from such research would help solicit support from partners and policy makers, and inform decisions about resource allocation.

Equally important to completing the research will be disseminating information about best and promising practices to key audiences in the state as well as the broader drowning prevention community.

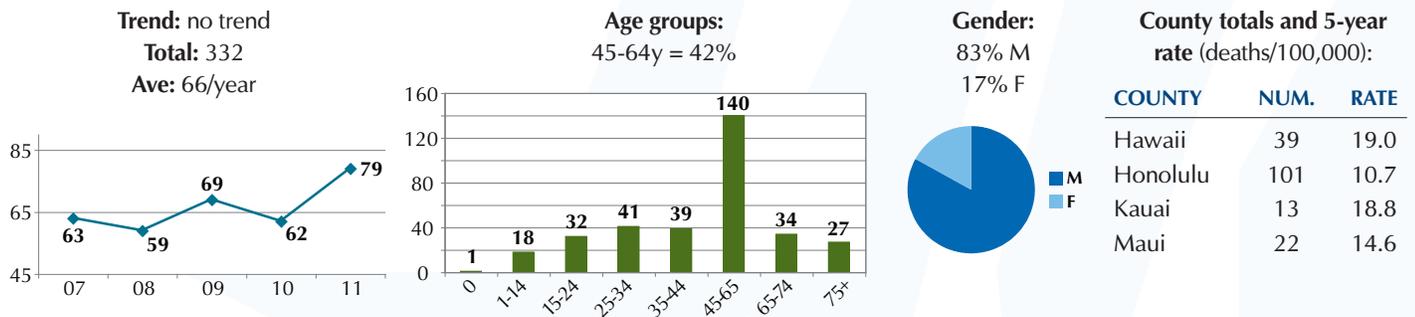
Recommended Next Steps

- ▶ Evaluate the Hawai'i Beach Safety website, www.hawaiibeachsafety.org, to determine effectiveness and use of the site.
- ▶ Provide data support and technical assistance to practitioners that need assistance evaluating their own drowning prevention programs.
- ▶ Evaluate effectiveness of safety efforts, including the provision of rescue tubes, at unguarded beaches across the state.
- ▶ Disseminate information about effective safety efforts in Hawai'i through partner organizations.

Injury Data for Drownings (residents and non-residents)

Fatal injuries

There was no clear trend in the annual number of drownings, although the 79 deaths in 2011 was the highest total since at least 1993. Most of the high total in 2011 was due to drownings on Honolulu and Maui counties. About half (53%) of the victims were Hawai'i residents, 36% from the U.S. mainland, and 12% from foreign countries. The ages of the victims were widely distributed, although only 8% were under 18 years of age. Almost all (83%) were males. About half (47%) of all the victims drowned on O'ahu. If only drownings among Hawai'i residents were considered, O'ahu residents had the lowest rates, significantly lower than rates for Neighbor Island residents as a whole. If non-residents are also included, the highest (unadjusted) rate was computed for Kaua'i, approximately twice as high as rates for Hawai'i County and more than 3 times the rates for Honolulu County (the island of O'ahu).

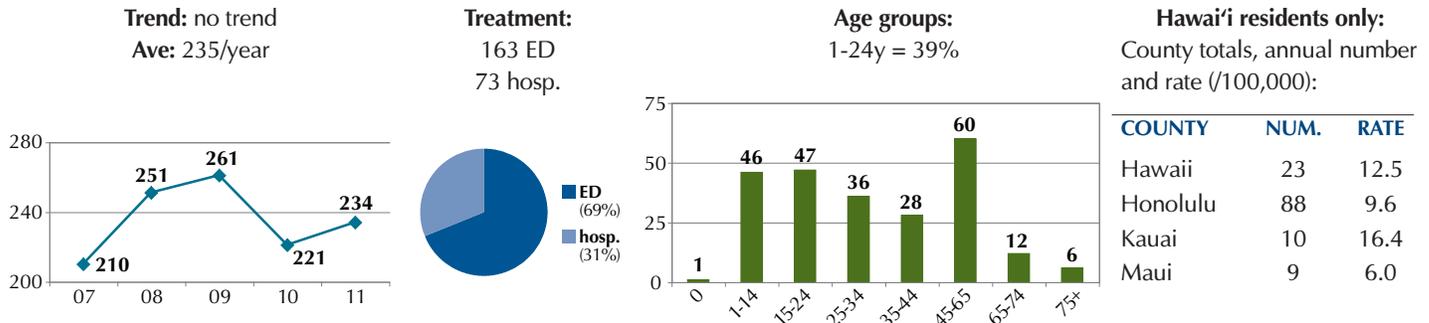


Most (78%, or 259) of the victims drowned in the ocean or saltwater environments, almost all of whom (96%) were 18 years or older. Unintentional immersions led to 13% of these drownings, including 31 victims who fell in or were swept into the ocean. Other common activities were swimming (29% of victims), snorkeling (22%), and free diving (9%). According to autopsy records, intrinsic or personal factors contributed to over half (61%) of the saltwater drownings in Honolulu County from 2007 to 2010. The most common intrinsic factor was circulatory diseases, present among 46% of the victims of all ages, and 69% of those aged 50 years and older. Only 13% of the victims tested positive for alcohol, and only 7% had BAC (blood alcohol content) levels of 0.08% or greater. Illicit drug use was considered a contribution to 12% of the drownings. Apart from ocean drownings, there were 36 drownings in swimming pools, 21 in rivers and streams, and 12 in bathtubs. Only 3 (8%) of the 36 victims who drowned in swimming pools were under 5 years of age, as victim age was widely distributed in this environment.

Drowning Prevention

Nonfatal injuries (near drownings)

There was no clear trend in the annual number of near drownings, which averaged 235 per year. Hawai'i residents comprised a slight majority (55%) of all patients treated for near drownings, but only 41% of those who were hospitalized. ED (emergency department) patients were significantly younger on average than those who were hospitalized (31 vs. 40 years of age), with more than half (56%) in the 15 to 44 year age group. Among Hawai'i residents, county-specific rate estimates were generally comparable except for Hawai'i and Maui county residents.



Hospitalizations were of a relatively short number of days (4.1, on average), but because each hospitalization incurred over \$28,000 in charges, they comprised most (91%) of the total \$2.3 million in annual medical charges related to drowning. Swimming (40%) and “surfing, windsurfing and boogie boarding” (32%) were the most common activities for the patients overall, although swimming was a more likely cause among non-residents (45%), while the latter activities were more common among residents (39%).

EMS data

Almost all (94%) of the incidents EMS responded to occurred during day time hours, including 80% between 9:31 a.m. and 5:29 p.m. More than half (59%) of the patients were Hawai'i residents. About 43% of the near drownings occurred in bodies of water, which could include both freshwater and saltwater environments. About one-third (30%) were in patient residences (10%), public buildings (12%), hotels (5%), and health care facilities (3%). Most (77%) of the patients were either transported in “serious” (46%) or “critical” (32%) condition, with no significant differences in the distribution of patient condition between residents and non-residents. Probable alcohol use was noted for only 4% of the patients. Near drownings that occurred during night time hours were significantly more likely to involve alcohol consumption than day time incidents, however (21% vs. 3%).

Hawai'i Trauma Registry (toxicology data)

Only 8% of the adult-aged (18 years and older) Hawai'i Trauma Registry near drowning patients were positive for alcohol, and only 9% tested positive for illicit drugs, although there was no toxicological testing for about two-thirds of the patients. Substance use was somewhat higher among resident patients, although this comparison is limited by the small sample sizes and the lack of testing.

Background and Accomplishments

The Hawai'i State Department of Health, Injury Prevention and Control Section (IPCS) has been working with partners in the community to prevent falls among older adults for nearly a decade.

- ▶ In 2003, IPCS supported the establishment of the Hawai'i Fall Prevention Consortium which provides a forum for information sharing, collaboration on fall prevention activities, and promotion of best practices for reducing falls among older adults. Members represent government agencies, professional associations, non-profit organizations, hospitals, care facilities, and senior organizations.
- ▶ Statewide conferences on fall prevention, held in 2005 and 2007, featured nationally recognized leaders in the field.
- ▶ In 2009, a Tai Chi for Health intervention was successfully piloted at Pohai Nani Care Facility. IPCS sponsored a similar intervention at Leahi Hospital in 2011.
- ▶ Educational materials were developed and distributed to raise awareness about fall prevention and fall prevention information, including a fall prevention directory of services and resources, was added to the state injury prevention website www.nogethurt.hawaii.gov.
- ▶ In partnership with the Fall Prevention Consortium, IPCS facilitated fall prevention screening for balance by physical and occupational therapists and medication reviews by pharmacists statewide as part of annual fall prevention awareness activities.
- ▶ The State Executive Office on Aging and county Area Agencies on Aging used data collected by IPCS to inform their 2011-2015 State and Area Plans on Aging.
- ▶ In 2011, the Executive Office on Aging and IPCS partnered to establish the Hawai'i State Fall Prevention Task Force. This short-term, volunteer Task Force comprised of key stakeholders is developing a comprehensive statewide approach to fall prevention by December 2012 that will address recommendations in this report.
- ▶ The Centers for Disease Control and Prevention (CDC) selected IPCS as one of three states to participate in an injury prevention message development and framing initiative. In 2010, IPCS, members of the Fall Prevention Consortium, and other community partners engaged in training to develop a coordinated communication strategy for fall prevention. Participants developed messages for independent older adults that IPCS tested, and the Fall Prevention Consortium is coordinating final revisions and dissemination.

Recommendations

In 2010, a statewide needs assessment was conducted that included a literature review, an online survey of more than 200 fall prevention professionals and community members, and follow-up telephone interviews with 58 key informants. IPCS, together with the Fall Prevention Consortium and other partners, used the results from this needs assessment as the basis for the following recommendations.

Recommendation 1: Raise awareness about fall prevention among older adults, caregivers, and providers

Enhance awareness among the public, older adults, caregivers, and providers that falls can be prevented and promote adoption of four key prevention behaviors:

- ▶ Beginning a regular exercise program
- ▶ Having one's health care provider review medicines
- ▶ Having one's vision checked
- ▶ Making one's home safer

The scientific literature and the June 2010 survey of key informants in Hawai'i confirmed that many older adults are unaware of their increased risk of falling or the simple steps they can take to reduce their risk (World Health Organization (WHO), 2007).

Recommended Next Steps

- ▶ Disseminate previously developed and tested messages for older adults.
- ▶ Develop and test additional clear, audience-specific messages for care givers, pharmacists, and physicians.
- ▶ Identify and use appropriate communication channels to reach key audiences.
- ▶ Distribute messages through community partners, including Fall Prevention Consortium members.
- ▶ Develop a packet of fall prevention educational materials to be distributed through partners.

PARTNERS

AARP Hawai'i
Catholic Charities of Hawai'i
Child and Family Service
Gerontology Program
City and County of Honolulu
Area Agency on Aging
Comforting Hands Hawai'i
Executive Office on Aging
Fall Prevention Consortium
Hawai'i Community
Pharmacists Association
Hawai'i County Fire Department
Hawai'i County Office on Aging
Hawai'i Optometric Association
Hilo Medical Center
HMSA Health Ways Corporation
Injury Prevention
Advisory Committee
Kaua'i Agency on Elder Affairs
Kaiser Permanente
Kapi'olani Community College
Kupuna Education Center
Kuakini Health Systems
Kupuna Caucus
Maui County Office on Aging
Ohana Pacific Rehab, Inc.
Project Dana
Rehabilitation Hospital
of the Pacific
Straub Medical Center,
Physical Therapy Division
Tai Chi for Health Institute
The Queen's Medical Center
United States Veterans
Administration
University of Hawai'i Center
on Aging
University of Hawai'i
John A. Burns School of Medicine
University of Hawai'i Office
of Public Health Studies

Recommendation 2: Increase availability and accessibility of fall prevention programs statewide

Fall prevention programs can help older adults:

- ▶ Assess balance and strength
- ▶ Exercise to increase their strength and balance
- ▶ Get their medications reviewed and adjusted at least annually
- ▶ Assess and modify their homes to reduce fall hazards
- ▶ Check for and correct vision impairments

The scientific literature has shown these activities can reduce the risk of falling, and there are various fall prevention programs available in the state (WHO, 2007). These programs are not, however, available across all islands and in all communities. In addition, these services are not always covered by insurance; for example, Medicare does not pay for eye glasses.

Recommended Next Steps

- ▶ Expand exercise programs tailored to increase balance and strength such as Enhanced Fitness, Tai Chi, and No Fear of Falling.
- ▶ Increase the availability and use of successful home safety assessment programs.
- ▶ Develop strategies to coordinate services among venues where older adults gather, such as community clinics, senior centers, meal sites, senior housing, assisted living facilities, care homes, day health centers, shopping centers, schools, and churches.
- ▶ Develop and disseminate an updated fall prevention resource guide to supplement current materials produced by the Area Agencies on Aging and the Adult Disability Resources Centers (ADRC).
- ▶ Explore resources to print translations of educational materials. Languages might include Ilocano, Tagalog, Mandarin Chinese, and Korean.

Recommendation 3: Engage professionals and community members in fall prevention activities

Develop fall prevention activities that engage:

- ▶ Public workers (e.g., paramedics, fire fighters, public health nurses, Area Agency on Aging staff)
- ▶ Health care providers, elder care providers, ADRC staff members, program trainers (e.g., physicians, nurses, social workers, physical and occupational therapists, pharmacists)
- ▶ Coalitions (e.g., Fall Prevention Consortium, the Hawai'i Healthy Aging Program)
- ▶ Non-profit organizations (e.g., AARP, YMCA)
- ▶ Interested individuals (e.g., retired workers, volunteers)

Many individuals and organizations must join together to prevent falls in Hawai'i. Already, paramedics and some pharmacists provide medication reviews, and many hospitals and rehabilitation programs assist with home assessments and modifications. But more individuals and organizations can, and should be enlisted in the cause.

Preventing Falls Among Older Adults

Recommended Next Steps

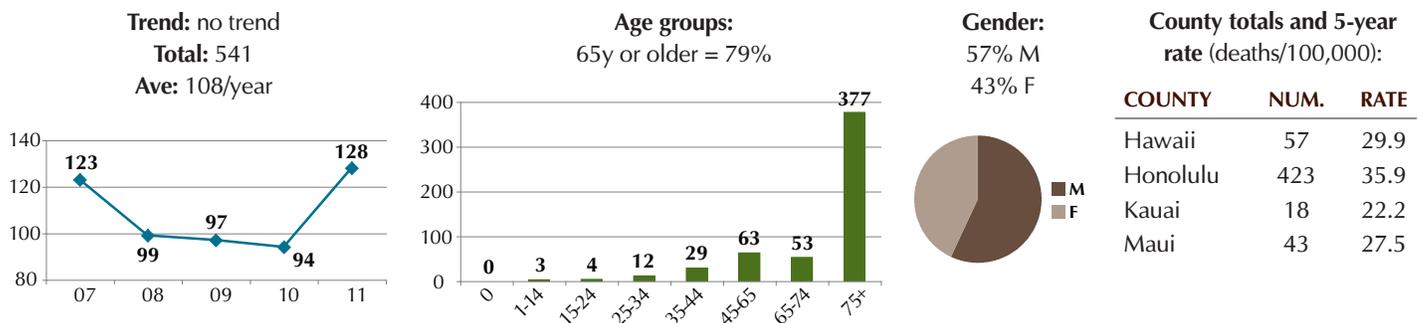
Develop mutually beneficial partnerships with groups to facilitate fall prevention activities, for example:

- ▶ Encourage community partners, such as fire departments and EMS providers to assist with home assessments.
- ▶ Enable more pharmacists and other qualified professionals to provide free annual medication reviews.
- ▶ Encourage medical professionals to provide fall risk assessments.
- ▶ Train care home providers to lead exercise programs for their residents.
- ▶ Engage and support students in professional schools by:
 - Training occupational and physical therapy assistants to certify eldercare providers in senior-friendly exercise programs.
 - Enlisting medical and pharmacy students to assist with medication reviews.
 - Training nurses, certified nurse aid students, and certified medical assistants in home assessment.
- ▶ Work with partners to develop and implement a training program and tool kit to educate all health care providers about the special needs of older adults and fall prevention strategies.
- ▶ Engage new and current members of the Fall Prevention Consortium, including representatives from the Aging Network, to achieve identified priorities.

Injury Data for Falls

Fatal injuries

Falls were the most common type of fatal unintentional injury in the state, with the 541 deaths accounting for 25% of the total. More than three-quarters (79%) of the victims were aged 65 years or older, and the risk of fatal falls increased dramatically across the senior age range. Males comprised the majority (78%) of victims under 65 years of age, while gender was more equally distributed for the senior-aged victims. Honolulu County residents comprised most of the victims of all ages (77%) and those who were 65 years or older (81%). The fall fatality rate estimate for senior-aged residents of Honolulu County was significantly higher than the rates for residents of Kaua'i or Maui counties, and 45% higher than for Neighbor Island residents considered as a whole.

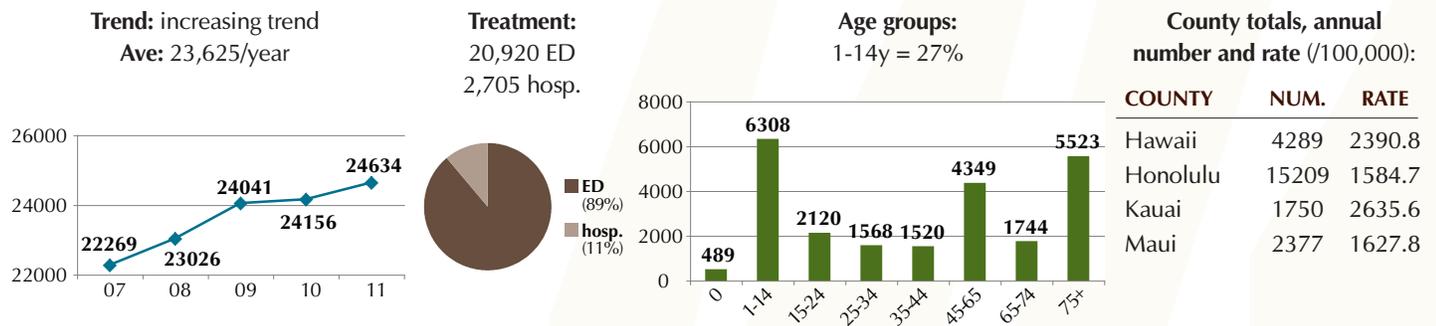


Preventing Falls Among Older Adults

Death certificates provided little information on the causes of falls, as most were coded as “falls on the same level” with no further description (48%), or “unspecified” causes (32%). Falls from stairs or steps were the most specifically coded cause, but comprised only 4% of the total. More than half (61%) of the falls occurred at the residence of the victim, including 68% of the senior-aged victims.

Nonfatal injuries

Falls were the leading cause of nonfatal injuries among Hawai'i residents, with nearly 21,000 ED (emergency department) visits and over 2,700 hospitalizations each year. The annual number of injuries generally increased. Children aged 1 to 14 years comprised 27% of all patients, but about two-thirds (68%) of those who were hospitalized were 65 years or older. Gender was equally distributed among patients treated in EDs, but females comprised 59% of the patients that were hospitalized.



Residents of Hawai'i and Kaua'i counties had significantly higher rates of nonfatal injuries from falls than residents of Honolulu and Maui counties. The residents of Honolulu County had the lowest rates of hospitalizations. Among the more specifically coded injuries, the most common causes were falls from stairs, steps and escalators (5.3% of the total), beds (3.7%), skateboards (3.5%), and chairs, playground equipment, and ladders (about 2% for each). At least half (53%) of the falls that caused hospitalizations in seniors occurred in home environments. This proportion increases to 84% if only records with specific information on location are considered. The most common activity related to the falls was “walking, marching and hiking”, accounting for 30% of the total. Skateboarding, running, tackle football, and bathing and showering were also prominent activities. Hospitalizations averaged nearly 1 week in duration, resulted in over \$31,000 in medical charges, and accounted for 72% (\$84 million) of the total annual charges of \$116.6 million related to falls. Fractures were present in nearly three-fourths (74%) of the hospitalized patients, including 29% with hip fractures.

Preventing Falls Among Older Adults

EMS data

More than half (57%) of the EMS-attended falls occurred in the home or residence of the patient, and this proportion was significantly higher among the seniors (71%) compared to younger aged patients (41%). More than half (54%) of the patients were 65 years or older, including 22% who were 85 years or older. Senior-aged patients had worse dispositions, as they were more likely to be transported in serious condition (49%, compared to 40% of younger age patients) and less likely to be released at the scene (12% vs 19%, respectively). Probable alcohol use was noted 8% of the patients, and male patients were more than twice as likely to have used alcohol compared to females (12% vs. 5%).

Hawai'i Trauma Registry (toxicology data)

Only 11% of the adult-aged (18 years and older) Hawai'i Trauma Registry resident patients who were injured by falls were positive for alcohol, with 4 times higher use among patients in the 18 to 64 year age group (19%), compared to senior-aged patients (5%). Fifteen percent of the patients tested positive for illicit drugs, most commonly narcotics (11%). Considered together, about one-quarter (24%, or 587) of the patients tested positive for either alcohol or drugs, although that proportion was much lower among the senior-aged patients (13%), compared to younger patients (36%).

Background and Accomplishments

The Hawai'i State Department of Health, Injury Prevention and Control Section (IPCS) has collaborated with partners to address different types of poisonings among different populations.

- ▶ IPCS strongly supports the Keiki Injury Prevention Coalition (KIPC) in their ongoing efforts to prevent poisoning.
 - In 2009, KIPC received a grant from the Hawai'i Department of Agriculture related to the recognition and management of pesticide-related injuries. KIPC has conducted poisoning prevention education and outreach activities for the public to increase awareness of household pesticide exposures and reduce exposures in and around households.
 - KIPC works to raise public awareness about, and increase use of, the 24 hour Hawai'i poison control hotline for information about potential poisonings and medications.
- ▶ In 2010, IPCS began serving as a clearinghouse to disseminate poisoning prevention materials to community partners. Materials disseminated to pediatricians, preschools, hospitals, and health care clinics on all islands include magnets and stickers to promote the Hawai'i poison control hotline, poisoning prevention information fact sheets, "No Get Hurt" poisoning prevention posters, and information on the correct use of pesticides from the Department of Agriculture.
 - As part of the "No Get Hurt" campaign, IPCS printed poisoning prevention posters in 2010 for use by the Department of Health Women Infant and Children (WIC) Services Branch and other community partners.
- ▶ IPCS collaborated with a community partner to analyze data about poisonings from opioids in Honolulu County between 2004-2008. The results of this analysis showed the most common way to access opiates was through a personal prescription (46% of the victims). Only a minority of victims accessed opiates through prescriptions written for other people (4%), or purchased drugs illicitly (4%). However, access to opiates was not known for a large proportion (41%) of the victims, limiting the reliability of this data source.
- ▶ In 1992, the Department of Public Safety (DPS) established Hawai'i's Prescription Drug Monitoring System (PDM) - one of the best practices for determining misuse and abuse of controlled substances. In 2012, improvements were made to the program to ensure the PDM database is effectively used and maintained. In addition to maintaining the PDM system, DPS is required to "carry out educational programs designed to prevent and determine misuse and abuse of controlled substances" (HRS 329-58).
- ▶ In 2011, IPCS began collaborating with state and community organizations working on STD/AIDS and substance abuse prevention in an effort to understand and address the increase in prescription drug overdoses.

Recommendations

While poisoning among children has decreased with interventions such as childproof caps, the past few years have revealed dramatic increases in prescription drug overdoses (CDC, 2011b). IPCS analyzed trend data for poisoning fatalities and injuries, including prescription drug overdoses, and conducted a comprehensive review of current best practices. Results from this analysis formed the basis for the recommendations below.

IPCS first presented results of the analysis to the Department of Health, STD/AIDS Prevention Branch and the CHOW Project (The Community Health Outreach Work to Prevent AIDS Project), which were subsequently shared with the Hawai'i Advisory Commission on Drug Abuse and Controlled Substances (HACDACS). As set forth by the Legislature, HACDACS is the primary advisory body to the Departments of Public Safety and Health and to the Legislature, and an appropriate partner to support in developing policy changes for the prevention of prescription drug overdoses.

Partners from public and private sectors (e.g., public safety, insurance, medicine, pharmacology, substance abuse treatment, law enforcement) can all help reduce poisonings, especially prescription drug overdoses, in Hawai'i.

Recommendation 1: Enhance use of data resources to understand the problem of prescription drug overdoses in Hawai'i and facilitate prevention efforts

To better address the issue of prescription drug overdoses, more data and analyses are necessary. Death certificates describe an overall increasing trend but provide limited data on the type of drugs causing deaths. Autopsy data provides more information about deaths due to prescription drugs, including the specific substances involved and whether victims accessed drugs through legal or illegal means, although information about access is missing from a significant proportion of autopsy records. Therefore, linking autopsy data with the PDM database would help describe access to the specific substances involved in overdoses and provide a clearer picture of drug overdose fatalities in Hawai'i.

Additional data sources such as survey-based data and fatality reviews that go beyond information gathered for autopsy reviews, would add to the body of knowledge about prescription drug use and practices, and help identify risk factors and effective prevention measures.

Recommended Next Steps

- ▶ Determine ability to gain access to the Department of Public Safety's PDM database and other state agencies' data related to drug poisoning (Medicaid, workers' compensation data).
- ▶ Link death certificate and autopsy records with the PDM database to learn more about decedents' access to drugs.
- ▶ Use additional data sources to describe general drug use and poisoning in the population and indicate areas for further research (i.e., Hawai'i Health Information Center, Trauma Registry, Poison Center Data, Behavioral Risk Factor System Survey, Youth Risk Behavior Survey).

- ▶ Provide comprehensive data and injury prevention expertise to support partnerships and strategies for addressing prescription drug overdoses. Key partners include:
 - The Hawai'i Advisory Commission on Drug Abuse and Controlled Substances
 - Hawai'i State Department of Health Alcohol and Drug Abuse Division
 - Hawai'i State Department of Health STD/AIDs Branch
 - The CHOW Project (The Community Health Outreach Work to Prevent AIDS Project)
 - Hawai'i Substance Abuse Coalition
 - Hawai'i State Department of Public Safety
 - Hospitals and trauma centers
 - First responders
 - County police departments
 - Physicians and pharmacists
 - Insurance companies
 - Community organizations

Recommendation 2: Identify and support enactment of policies and practices that reduce both inappropriate and illegal prescribing, and evaluate their effectiveness

Promising policies and practices target the prescribing practices of health care providers to help prevent prescription drug abuses and overdoses while allowing safe and effective pain management. These include prescription drug monitoring programs, patient review and restriction programs, health care provider accountability, laws and education to prevent prescription drug abuse and diversion, and better access to substance abuse treatment, including risk reduction strategies and education. Increasing capacity of pharmacists and other prescribers to educate patients about overdose can also leverage prevention efforts. These interventions need to be evaluated locally to determine their effectiveness in reducing prescription drug overdose deaths (CDC, 2011b).

States play key roles in regulating the use of prescription drugs and the practices of prescribers and pharmacists, and in financing and regulating health care for people with Medicaid - a group at greater risk for overdose (CDC, 2011a).

State agencies need to work in partnership with organizations in the private sector from health care and related fields to bring about changes in organizational practices. Implementing screening and brief intervention and referral and treatment protocols in state-funded trauma centers, and adding screening for potential misuse and abuse of prescription drugs can serve as a model practice for other hospitals and health care systems to adopt. As important potential users of the PDM database, emergency physicians are one of the key partners in prescription drug overdose prevention efforts.

Recommended Next Steps

- ▶ Collaborate with the Department of Public Safety to support and evaluate use of the Hawai'i Prescription Drug Monitoring System.
- ▶ Work with organizations such as the American College of Emergency Physicians, the Hawai'i Medical Association, Hawai'i pharmacy associations, health care systems, and legislators to develop and enact policies that support prescribing practices to reduce prescription drug misuse and abuse.
- ▶ Collaborate with state-funded trauma centers across the state to adapt screening and brief intervention practices that identify potential prescription misuse and abuse problems. Develop policies to support the intervention and share them with other health care settings as a model for implementing similar interventions (Ohio Injury Prevention Partnership, 2010).
- ▶ Collaborate with the Hawai'i Board of Pharmacy, the Hawai'i Pharmacists Association, and the Hawai'i Community Pharmacists Association to identify and promote educational strategies for pharmacists to help regulate the use of prescription drugs.
- ▶ Partner with insurance companies, and physician and pharmacy associations to educate the public on the potential misuse of drugs received from friends and family.
- ▶ Support risk reduction training for first responders, health care providers, and other service providers to reduce the risk of death from opioid overdoses.

Recommendation 3: Support primary poisoning prevention education and maintenance of the poison information hotline

Poisoning prevention education and the poison information hotline encourage appropriate actions that can reduce poisoning injuries, fatalities, and their associated hospital and health care costs. In addition to responding to calls for diagnostic or treatment recommendations on poison exposure for which callers would otherwise go to the emergency department, health care providers rely on the hotline for toxicology expertise in handling severe overdoses. The poison hotline also identifies and alerts the public to poisoning trends, and provides a drug identification service to callers that reduces drug errors from improper use of medications.

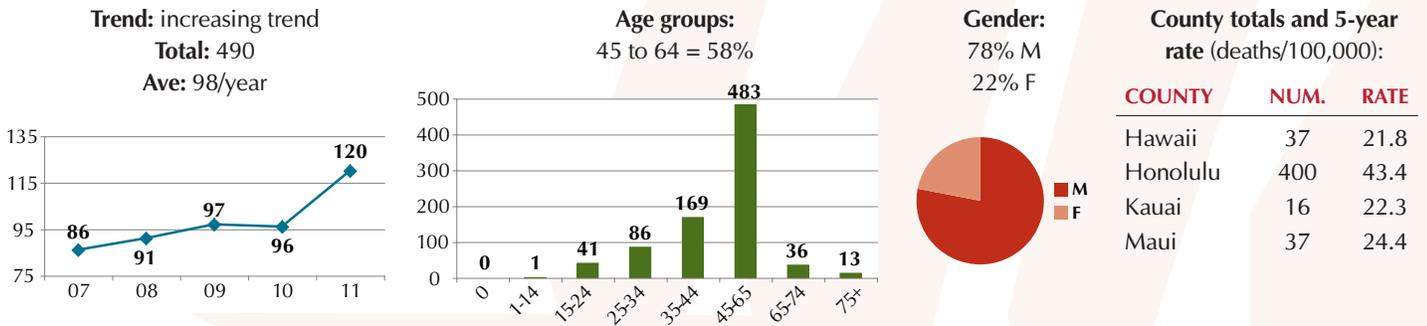
Recommended Next Steps

- ▶ Continue collaborating with KIPC to provide educational materials and promote the poison information hotline.
- ▶ Use data collected from the poison information hotline to identify trends and problem areas and inform prevention strategies.
- ▶ Help secure continued funding for the poison information hotline.

Injury Data for Poisonings

Fatal injuries

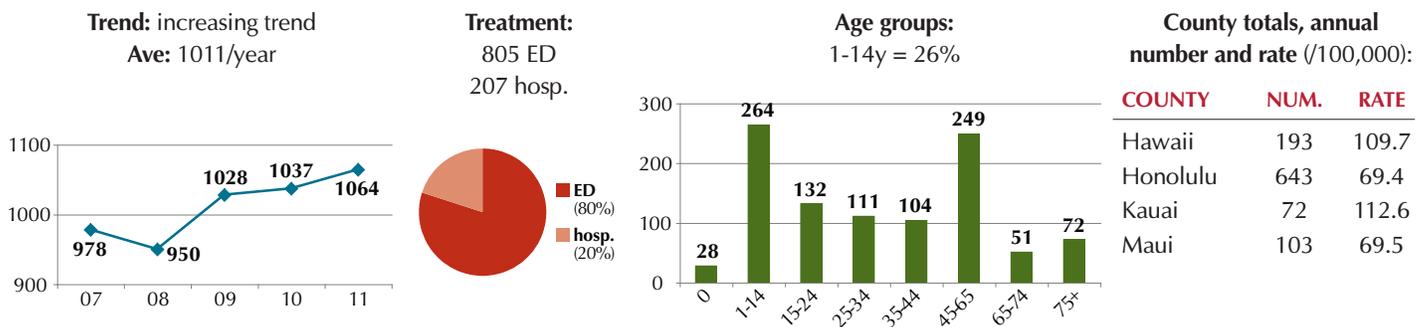
There was an increasing trend in the annual number of unintentional poisonings. (There was no consistent trend in the number of poisonings of undetermined intent over this period.) Victim age was narrowly distributed, as 58% were in the 45 to 64 year age range. Males comprised 78% of the victims. Most (82%) of the victims were poisoned on O’ahu, and the highest fatality rates were computed for Honolulu County residents. Inclusion of poisonings of undetermined intent resulted in significantly lower rates among O’ahu residents compared to Hawai’i or Maui county residents, so these comparisons are unreliable. Drugs caused almost all (93%) of the poisonings, including 32% from “narcotics and hallucinogens” and 34% from “sedative-hypnotic and psychotropic drugs”.



Poisoning Prevention

Nonfatal injuries

There was an increasing trend in the number of nonfatal poisonings, but this was evident only for ED (emergency department) visits among Honolulu and Maui county residents. Gender was nearly equally distributed with 53% male patients. Patient age was broadly distributed, although one-quarter (26%) were 1 to 14 years of age. Seniors comprised only 13% of all patients, but (23%) of those who were hospitalized. Rates of ED visits were highest by far for residents under 5 years of age, nearly 5 times higher than the rate for all other age groups. Residents of Honolulu and Maui counties had comparable injury rates, significantly lower than the rates for residents of Hawai'i and Kaua'i counties.



Patients were hospitalized for slightly over 3 days on average, with nearly \$18,000 in medical charges related to poisoning. Most (76%) of the poisonings were caused by drugs or medicinal substances, including 92% of those that required hospitalization. Narcotics caused 21% of the hospitalizations, tranquilizers 13%, aromatic analgesics (which include acetaminophen, or Tylenol) 8%, and cardiovascular agents 8%.

Background and Accomplishments

The Injury Prevention and Control Section (IPCS) has led suicide prevention activities within the Hawai'i State Department of Health since 2005 with support from the Child and Adolescent Mental Health Division, the Adult Mental Health Division, and the Alcohol and Drug Abuse Division.

- ▶ The Prevent Suicide Hawai'i Task Force (PSHTF) has chapters in each county and includes more than 100 members representing a broad network of agencies and stakeholders. PSHTF provides guidance to IPCS related to suicide prevention programming and activities. PSHTF grew out of the Suicide Prevention Task Force that was initiated in 2000 by the Department of Health, Maternal and Child Health Branch.
- ▶ In 2006, IPCS secured funds for a permanent suicide prevention coordinator to lead and implement initiatives based on the National Strategy for Suicide Prevention and the Hawai'i State Plan for Suicide Prevention.
- ▶ With an established PSHTF and suicide prevention coordinator, suicide prevention gatekeeper trainings began to be offered statewide to representatives from health and human services, education, emergency services, faith-based organizations and the general public. Trainings included:
 - ASIST (Applied Suicide Intervention Skills Training) – a two-day intensive training program to help participants identify and assess the risk of individuals in crisis and provide early intervention and referral to reduce the risk.
 - safeTALK – a three hour suicide intervention training that prepares participants to identify persons with thoughts of suicide and connect them to suicide prevention first aid resources.
- ▶ In 2007, legislation was passed to support a youth prevention program with \$100,000 annually. IPCS used these funds, in collaboration with PSHTF, to build a statewide network of public and community partnerships with task forces on each island, to build public awareness and to increase professional and community capacity for responding to individuals at risk for suicide through gatekeeper training.
- ▶ In 2008, the Substance Abuse and Mental Health Services Administration awarded IPCS funding through the Garrett Lee Smith grant. The 3-year federal award provided \$500,000 annually to support continued implementation and evaluation of ASIST and safeTALK trainings and a pilot of the Signs of Suicide training for teachers and students. These gatekeeper trainings focused on youth, partnering with three agencies: Honolulu Police Department; Department of Education; Department of Health, Alcohol and Drug Abuse Division.
- ▶ In 2011, the *Sustainability Plan for Suicide Prevention Training in Hawai'i* was developed to address gatekeeper training needs for the future. The plan was built on previous efforts and community partnerships.

Recommendations

The following recommendations were informed by a needs assessment of 500 key stakeholders, including PSHTF members, ASIST trainers and other partners, and additional input was provided by PSHTF sub-committee chairs. IPCS, together with the PSHTF and other partners, agreed to continue expanding efforts highlighted in the *Hawai'i Injury Prevention Plan 2005-2010*. The national Suicide Prevention Resource Center supports these recommendations.

Recommendation 1: Enhance ongoing suicide prevention trainings for gatekeepers

A “gatekeeper” can be any individual who interacts with others at work, in schools, at play, at home, or in community settings (i.e., other than clinical settings). Gatekeepers trained in suicide prevention and intervention learn to:

- ▶ Recognize early signs of suicidal behavior
- ▶ Implement timely and effective intervention strategies
- ▶ Identify opportunities to reinforce protective factors
- ▶ Intervene in crisis situations
- ▶ Refer people to appropriate professionals, or “open the gate” to mental health services

Training gatekeepers is considered a best practice among suicide prevention professionals. Evaluation of ASIST trainings has described positive gains in trainees’ self-rated capacity to identify, assess, and refer potentially suicidal people, both immediately after the ASIST training, and approximately one year after.

Recommended Next Steps

- ▶ Continue evaluation of gatekeeper training programs to determine which approaches are most effective across different settings.
- ▶ Continue providing culturally competent trainings to increase the number of gatekeepers in the community.
 - Specific attention should be paid to training gatekeepers that reach underserved populations, including youth, seniors, the homeless, those who are incarcerated, adults with mental health challenges, and individuals who are lesbian, gay, bisexual or transgendered.

PARTNERS

Chaminade University	Hawai‘i State Department of Health	Life’s Bridges Hawai‘i
CHOW Project	Child and Adolescent Mental Health Division	Maui Police Department
Coalition for a Drug-Free Hawai‘i	Hawai‘i Veterans’ Administration	Mental Health America of Hawai‘i
Equality Hawai‘i	Hawai‘i Youth Services Network	Prevent Suicide Hawai‘i Task Force
Harm Reduction Hawai‘i	Honolulu Community College	Queen Liliuokalani Children’s Center
Hawai‘i National Guard	Honolulu Police Department	Queen’s Medical Center
Hawai‘i Pacific University	Hawai‘i SPEAR (Suicide Prevention Education Awareness Research)	Tripler Army Medical Center
Hawai‘i Police Department	Injury Prevention Advisory Committee	United States Armed Services
Hawai‘i State Department of Education	Kapi‘olani Community College	University of Hawai‘i, John A. Burns School of Medicine, Department of Psychiatry
Hawai‘i State Department of Health Adult Mental Health Division	Kapi‘olani Medical Center	University of Hawai‘i, Social Science Research Institute
Hawai‘i State Department of Health Alcohol and Drug Abuse Division	Kaua‘i Police Department	
	Life Foundation	

- Recommended participants include law enforcement officers, school personnel, medical first responders, clinicians, community members with access to persons at-risk for suicide, and health education students.
- ▶ Use the Sustainability Plan for Suicide Prevention Training in Hawai'i to continue to build community access to trained gatekeepers.

Recommendation 2: Develop and implement a public awareness campaign

The stigma associated with suicide has been recognized as a barrier to treatment for many people who are having suicidal thoughts or who have made previous suicide attempts. Lives can be saved through public understanding that suicides are preventable and that individuals and groups can play a significant role in suicide prevention.

A statewide public awareness campaign would aim to increase awareness about suicide as a serious public health problem, dispel myths, and decrease stigma related to suicide. Messages and materials would support a shift in beliefs, promote help-seeking behavior, and publicize available prevention, intervention, and aftercare services in the community.

Recommended Next Steps

- ▶ Solicit input from community partners to develop and test clear, audience-specific messages to promote help-seeking behaviors.
- ▶ Work with partners to develop a dissemination plan and get messages out to the community.

Recommendation 3: Develop and promote effective clinical and professional practices and policies

Barriers to effective and appropriate services for individuals at risk for suicide include a shortage of culturally sensitive preventive services and treatment options for mental illness and substance abuse that promote help-seeking behaviors.

The health services system should be strengthened to:

- ▶ Raise awareness of services available.
- ▶ Ensure statewide access to screening and appropriate care.
- ▶ Provide culturally sensitive services that target underserved populations, including youth, seniors, the homeless, those who are incarcerated, adults with mental health challenges, individuals who are lesbian, gay, bisexual or transgendered, and others.
- ▶ Offer flexibility in health insurance reimbursements for mental health services.

Suicide Prevention

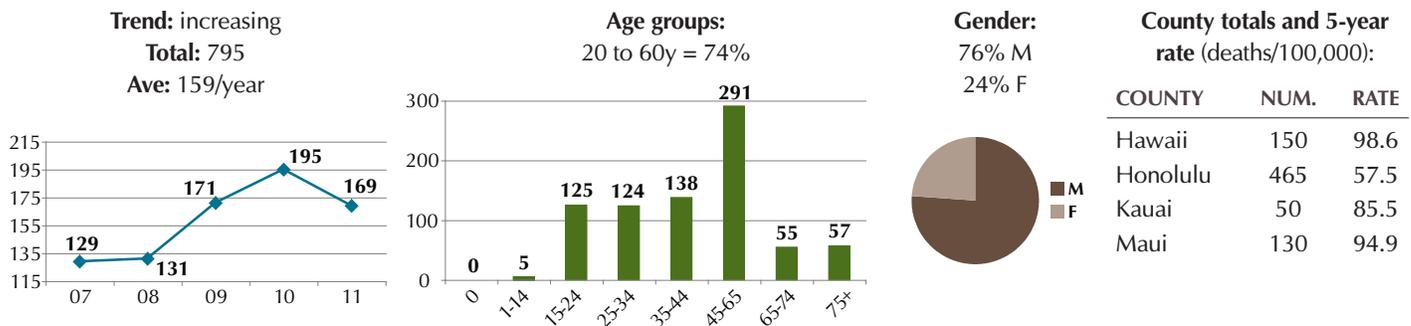
Recommended Next Steps

- ▶ PSHTF should provide leadership and coordination to:
 - Enhance collaboration with allied health areas to address the need for culturally sensitive prevention services.
 - Increase communication among health providers to improve the responsiveness of the system.
- ▶ Make trainings accessible to clinicians and provide continuing education credits as incentives.
- ▶ Continue providing culturally competent gatekeeper trainings to increase the number of gatekeepers in the community.

Injury Data for Suicides and suicide attempts

Fatal injuries

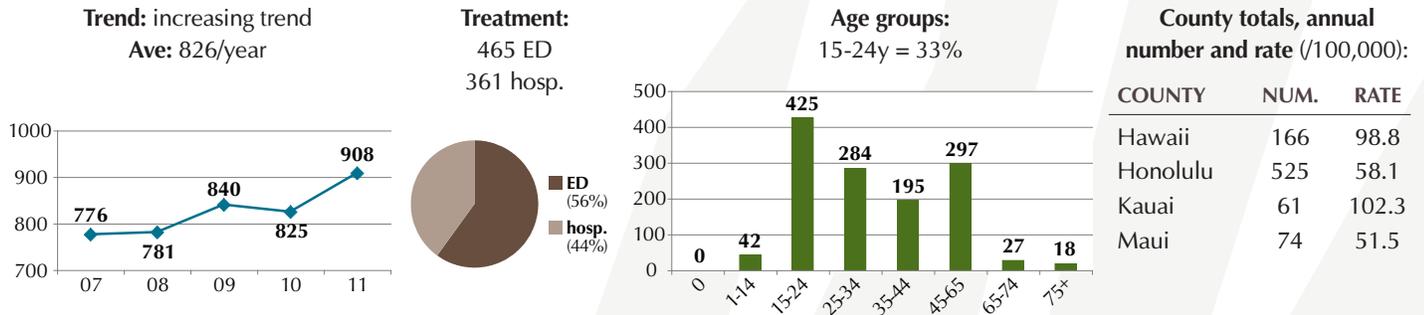
There was a generally increasing trend in the number of suicides in the state, and the 195 deaths in 2010 was by far the highest total in the 21-year period (1991-2011) for which data was available. Victim age was widely distributed, although almost all (95%) were 19 years or older. The highest fatality rates were computed for residents aged 45 to 54 years and those 85 years and older. Male victims outnumbered females by approximately 3-to-1. More than half (58%) of the victims were residents of O’ahu, but the fatality rate for O’ahu (58/100,000 residents) was significantly lower than the rate for the combined Neighbor Islands (94/100,000).



The most common mechanism was by hanging or suffocation (49% of the suicides), followed by firearm use (20%). Most (65%) of the O’ahu victims had a documented history of mental illness (as variously defined), according to autopsy records from 2007 to 2010. The most common negative life events for the victims were related to intimate relationship problems (34%), usually a break-up or divorce (12%), or serious illness or medical issues (26%). The latter was documented for 60% of the senior-aged victims. Over one-third (37%) had a history of substance abuse, 19% had a BAC (blood alcohol content) level over 0.08%, and 34% tested positive for illicit drugs. Nearly one-third (32%) of the victims had a previous suicide attempt documented in the record, and more than half (56%) had verbally threatened suicide.

Nonfatal injuries

There was an increasing trend in the number of nonfatal suicide attempts, which was only evident in the annual number of injuries that were treated in EDs (emergency departments). Slightly more than half (56%) of the injuries were treated in EDs, unlike most types of injuries. Most (58%) of the patients were under 35 years of age, and residents aged 15 to 19 years had the highest rates of hospitalizations and especially ED visits. The gender distribution of patients was similar for both settings, with females comprising 57% of the total.



Residents of Kaua'i and Hawai'i counties had significantly higher rates of nonfatal self-inflicted injuries compared to residents of Honolulu and Maui counties. Over half (58%) of the ED visits and most (85%) of the hospitalizations were caused by poisonings from drugs or medicinal substances, most commonly from the "analgesics, antipyretics, and antirheumatics" class (22% of ED visits, 33% of hospitalizations), which includes both narcotics (heroin, and other opiates), as well as aspirin and acetaminophen. Female patients were more likely to attempt by drug or medicinal poisonings (76%, vs. 62% for male patients).

Background and Accomplishments

The Hawai'i State Department of Health, Injury Prevention and Control Section (IPCS) has worked in traffic safety for more than twenty years. Since 2005, IPCS has strengthened relationships with state, county and community traffic safety partners through its commitment to the development, implementation and evaluation of the Department of Transportation's *Hawai'i Strategic Highway Safety Plan*.

- ▶ IPCS supported and evaluated the Graduated Driver's Licensing (GDL) legislation that was enacted in 2006. In 2010, data from the evaluation led to removal of the sunset clause, making GDL permanent in Hawai'i .
- ▶ With support and testimony provided by IPCS and traffic safety partners, Hawai'i passed an ignition interlock law in 2008 that took effect January 2010. The use of ignition interlocks, an evidence-based strategy to prevent alcohol-impaired driving, has been proven to reduce re-arrest rates.
- ▶ In partnership with the Department of Transportation (DOT), IPCS annually supports the nationwide "Click It or Ticket" Campaign – an enhanced enforcement program shown to increase safety belt use.
- ▶ IPCS assists with quality assurance of the traffic safety data collected in real time from Emergency Medical Services (EMS) personnel across the state in the Hawai'i Emergency Medical Services Information System (HEMSIS). HEMSIS is an integral part of the statewide trauma system that the Department of Health EMS Branch established.
- ▶ With the support of the DOT, the Keiki Injury Prevention Coalition (KIPC) has established regular safety check up sites and a network of trained technicians, including child passenger services for children with special health needs.
- ▶ IPCS provides data and technical support to numerous traffic safety partners across the state.

Recommendations

The following recommendations were prioritized based on results from a statewide survey of 45 state, county and community traffic safety partners. This survey included a list of evidence-based program and policy recommendations, many of which are in the *Hawai'i Strategic Highway Safety Plan*.

Motorcycle and Moped Safety

Recommendation 1: Increase helmet use among motorcycle and moped riders by supporting a universal moped and motorcycle helmet law

Properly worn helmets prevent deaths and brain injuries. In the event of a crash, helmets reduce the risk of death by 42% and the risk of a head injury by 69% (Liu, et al. 2008). States that have enacted universal helmet laws have seen significant reductions in fatality rates, head injuries and overall medical expenses related to motorcycle injuries (NHTSA 2011).

In 1968, Hawai'i enacted a universal helmet law under a federal mandate; it was repealed in 1977. Between 1968-1976, motorcycle fatalities in Hawai'i decreased by 57% (6 per 10,000 registered motorcycles between 1968-1976 vs. 14 per 10,000 registered motorcycles prior to 1968 and after the repeal in 1977; NHTSA, 2012).

Hawai'i currently has a partial helmet statute that requires riders under the age of 18 to wear a helmet. States with universal helmet laws have motorcycle rider fatality rates that were 20-40% lower than states with partial helmet laws (Ulmer & Preusser, 2003).

In Hawai'i from 2005-2009, more than two thirds (67%) of fatally injured motorcycle riders and almost all (96%) of fatally injured moped riders were not wearing a helmet at the time of the crash; and nearly half (47%) of motorcycle riders and 86% of moped riders were not wearing a helmet in non-fatal crashes (NHTSA 2012). Medical costs of helmeted riders average 67% lower than that of un-helmeted riders (Queen's Hospital Financial System data, 2005-2007). Currently Medicaid, Medicare, and Quest pay 22.5% of the medical costs for head injuries associated with motorcycle or moped crashes (Hawai'i Health Information Corporation, 2008).

Recommended Next Steps

- ▶ Establish a working group comprised of traffic safety advocates to work on helmet legislation.
- ▶ Enhance awareness among decision makers and the public about the benefits of motorcycle and moped helmet laws.
 - Develop and disseminate messages to key decision makers and the public that emphasize the effects of helmet laws on health care costs.
 - Partner with trauma centers to publicize how helmets can prevent traumatic brain injuries and reduce health care costs.
- ▶ Continue to provide data to traffic safety partners to highlight the effectiveness of helmets and their cost saving benefits.

Impaired Driving

Recommendation 1: Reduce impaired driving by increasing the use of screening and brief interventions in hospitals and primary health centers across the state

Driving under the influence (DUI) of alcohol or drugs is common in fatal crashes nationally, and especially in Hawai'i. Compared to other states, Hawai'i has a higher proportion of fatal crashes that involve impaired driving (NHTSA, 2012).

Impairment from alcohol or drugs is represented in all types of traffic related injuries as well as non-traffic related injuries. It is important to address penalties and sanctions to deter impaired

PARTNERS

AARP Hawai'i
 City and County of Honolulu,
 Department of Transportation
 Services
 Hawai'i Bicycling League
 Hawai'i Traffic Commanders
 Hawai'i State Department of
 Health, Healthy Hawai'i Initiative
 Hawai'i State Department
 of Transportation
 Injury Prevention
 Advisory Committee
 Kaua'i Path
 Keiki Injury Prevention Coalition
 Mothers Against Drunk Driving
 North Hawai'i Motor Vehicle
 Crash Reduction Group
 O'ahu Metropolitan
 Planning Organization
 One Voice for Livable Islands
 Peoples Advocacy for
 Trails Hawai'i
 State Highway Safety Council
 (formerly Governor's Highway
 Safety Council)
 Strategic Highway Safety
 Planning Committee

driving and also create opportunities within the medical system to direct high-risk substance users to methods of reducing substance misuse or treatment. Consistent and swift penalties serve as a deterrent, and access to treatment helps reduce future incidents.

Research has shown that screening and brief interventions can reduce recidivism of alcohol-related trauma by up to 50%, which can help reduce DUI arrests and health care costs (Dill, et al., 2004). Screening and brief interventions are practices that help to identify a real or potential alcohol problem and motivate an individual to do something about it. According to NHTSA's 2011 report, *Countermeasures that Work: A Highway Safety Countermeasure Guide for State Highway Safety Offices*, the use of screening and brief interventions is a best practice strategy for reducing and preventing impaired driving.

Recommended Next Steps

- ▶ Use data about impaired driving injuries and fatalities to raise awareness about the problem among key decision makers.
- ▶ Raise awareness among key decision makers about the effectiveness of screening and brief interventions to prevent impaired driving.
- ▶ Provide technical assistance to hospitals and primary health centers interested in implementing a screening and brief intervention program.

Occupant Protection

Recommendation 1: Increase restraint use by supporting a universal safety belt law for all vehicle passengers

The safety belt law in Hawai'i does not require a seat belt to be worn by passengers over the age of 17 who are riding in the back seat. A comprehensive safety belt law would cover all seating positions equipped with a seat belt, in all passenger vehicles. Between 2006-2009, nearly 75% of unrestrained passengers involved in fatal crashes were unbelted in the back seat of a motor vehicle (NHTSA, 2012).

Recommended Next Steps

- ▶ Raise public awareness about injuries and fatalities among unbelted passengers in the back seats of vehicles.
- ▶ Educate key decision makers about the benefits of a universal safety belt law.
- ▶ Continue to provide data and technical assistance to traffic safety partners about seat belt usage.

Recommendation 2: Increase promotion of “high visibility enforcement efforts” for all traffic safety laws

Effective, high-visibility communications and outreach are essential components of successful safety belt law enforcement programs (Solomon, et al., 2003). According to NHTSA, strong advertising around the “Click It or Ticket” campaign has been shown to increase safety belt use by 8.6% (Solomon, et al., 2002).

IPCS maintains a database of traffic safety partners, including programs within the Department of Health, county fire departments, county police departments, and local hospitals. During the annual “Click It or Ticket” campaign, IPCS disseminates materials provided by the Hawai‘i Department of Transportation to partners who have expressed an interest and willingness to participate. The same dissemination methods could be used to promote other national traffic campaigns aimed at reducing impaired or distracted driving.

Recommended Next Steps

- ▶ Maintain and continuously update IPCS’s partnership database.
- ▶ Seek new partners to help promote national traffic safety campaigns.

Pedestrian and Bicycle Safety

Recommendation 1: Decrease pedestrian and bicycle-related injuries and fatalities by supporting “complete streets” policies in each county

“Instituting a complete *streets policy* ensures that transportation planners and engineers consistently design and operate the entire roadway with *all users* in mind - including bicyclists, public transportation vehicles and riders, and pedestrians of all ages and abilities.” (National Complete Streets Coalition)

Since 2005, there has been an increased effort among traffic safety partners and advocates to reduce bicycle-related injuries and fatalities. In conjunction with engineering improvements, improved planning and design policies, targeted enforcement and public education efforts, and reductions in the average number of vehicle miles traveled, bicycle-related deaths in 2009 were nearly half of what they were in 2005 (NHTSA, 2012).

In 2009, the Hawai‘i State Legislature passed Act 54 to support complete streets. Act 54 requires the Department of Transportation and county transportation departments to adopt a complete streets policy when planning future transportation projects.

Currently, Hawai‘i still has the highest pedestrian fatality rate in the nation for older adults, and 16 out of 17 bicycle fatalities over the past 5 years involved a motor vehicle. Implementing complete streets design policies and Safe Routes to School programs will encourage infrastructural, behavioral, and educational changes to improve the safety and transportation equity for all road users.

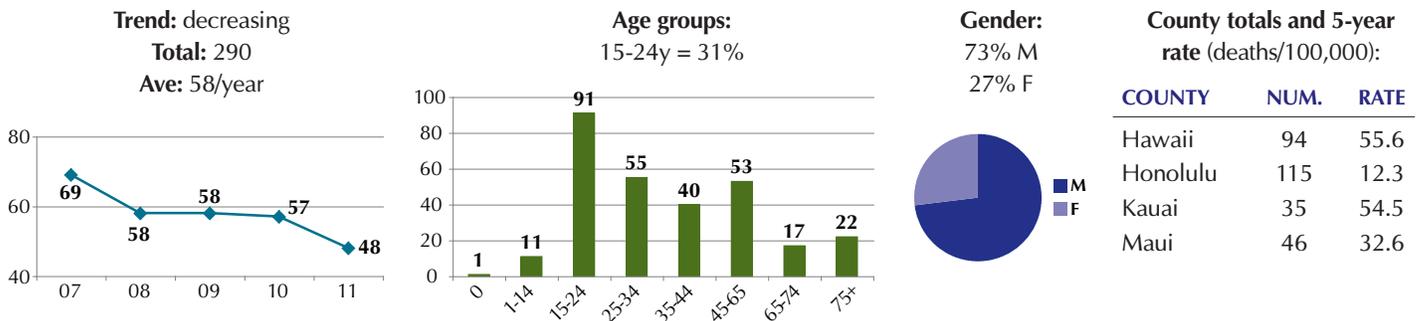
Recommended Next Steps

- ▶ Provide pedestrian and bicycle injury data to traffic safety partners to support implementation of complete streets policies and Safe Routes to School programs in each county.
- ▶ Support complete streets training and continuing education opportunities for engineers, planners, transportation agency heads and elected officials.

Injury Data for Motor vehicle crashes, occupants (excluding motorcyclists)

Fatal injuries

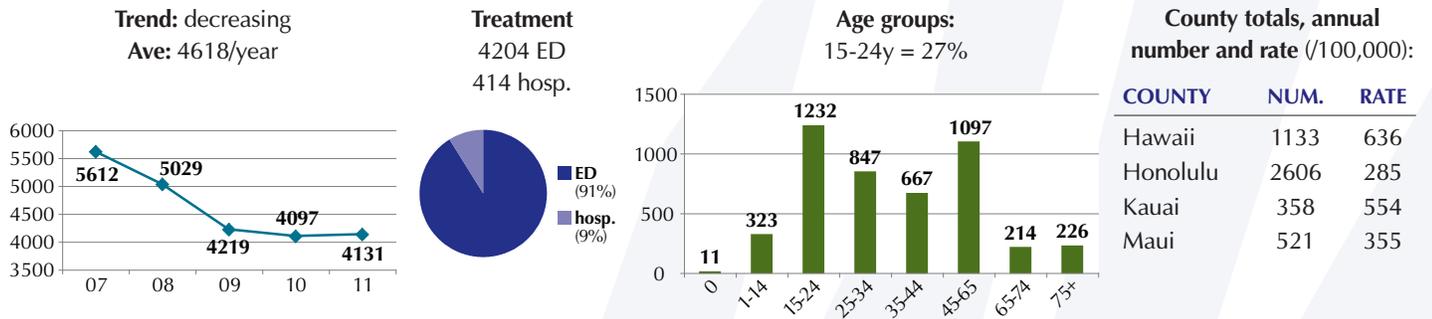
This category was the 4th leading cause of fatal injuries to Hawai'i residents, averaging 58 deaths per year. About one-third (32%) of the victims were 15 to 24 years of age. Most (73%) of the victims were males. Fatality rates were significantly higher among Neighbor Island residents, compared to O'ahu residents. The rates for residents of Hawai'i and Kaua'i counties were particularly high, more than 4 times higher than that computed for Honolulu County.



More than half (57%) of the fatal crashes occurred during nighttime hours (7:29 p.m. to 5:31 a.m.), and 61% involved only a single vehicle. Lack of restraint use was a major risk factor for occupant fatalities, as less than half of the victims (47%) were wearing seat belts at the time of the crash. Restraint use was especially low among back seat passengers (25%). Speeding was the most common contributing factor, noted for 41% of the drivers. Substance use was also an important contributing factor, as 40% of the drivers involved in fatal car crashes tested positive for alcohol, almost one-quarter (23%) tested positive for drugs, and nearly half (49%) tested positive for either alcohol or drugs. The peak age of alcohol use among drivers was 21 to 24 years of age, as 56% tested positive for alcohol. More than half (56%) of the fatalities from car crashes were related to alcohol consumption by at least one driver involved in the crash.

Nonfatal injuries

There were more than 4000 nonfatal injuries among car occupants each year in Hawai'i, with a decreasing annual trend. Most (91%) of the injuries were treated in EDs (emergency departments). Patient age was widely distributed, although 27% were 15 to 24 years of age, and this age group also had by far the highest rate of injury. There were nearly equal numbers of female (52%) and male (48%) patients.



The nonfatal injury rate for residents of Hawai'i County was significantly higher than the rate for residents of any other county, while the rate for Honolulu County residents was significantly lower than that for residents of any other county. Almost all (95%) of the injuries were coded as "traffic", or occurring on public roads. Patients were hospitalized for an average of nearly 1 week, with nearly \$46,000 in average medical charges per patient.

EMS data and 2007 linked data (EMS, DOT, HHIC, FARS, death certificates)

Most (86%) of the injured occupants treated by EMS were wearing seatbelts. Restraint use was strongly associated with EMS patient disposition, including a 7-fold increase in mortality rate among unrestrained occupants (4.5%) compared to those who wore seatbelts (0.6%). Probable alcohol use was noted for about 10% of the patients, and drinkers were significantly less likely to use seatbelts (71%, vs. 88% for other occupants). Linked data from 2007 showed unrestrained EMS patients had more than twice (2.3) the odds of an injury that required hospitalization or resulted in death, compared to restrained occupants, and more than triple (3.2) the odds of a fatal injury. These excess risks were statistically independent of patient age, gender, or the county of the crash.

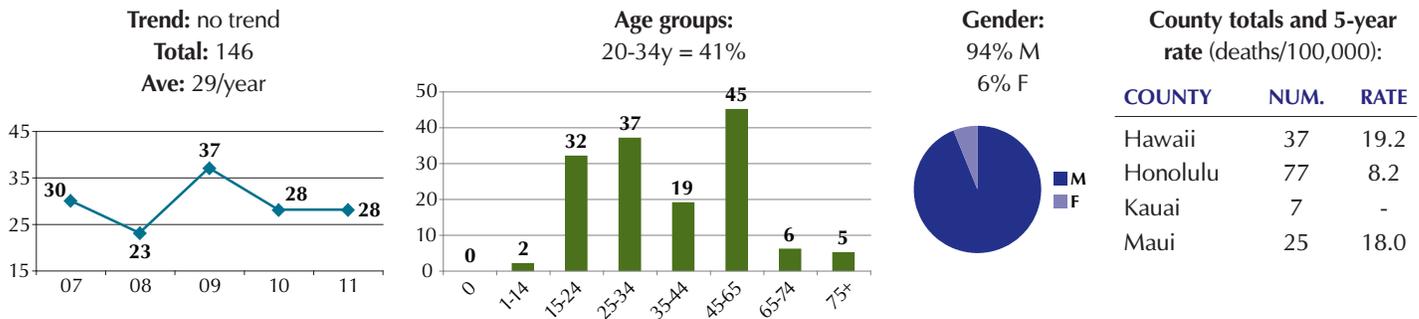
Hawai'i Trauma Registry (toxicology data)

About one-third of the injured resident occupants in the Hawai'i Trauma Registry tested positive for alcohol (32%) or illicit drugs (35%). Considered together, more than half (52%, or 626) of the occupants tested positive for either alcohol or drugs. Occupants who were drinking were significantly younger than those who tested negative for alcohol (32 vs. 41 years, on average), more likely to be male (75% vs. 56%), and less likely to have used seat belts (46% vs. 63%).

Injury Data for Motor vehicle crashes, motorcyclists

Fatal injuries

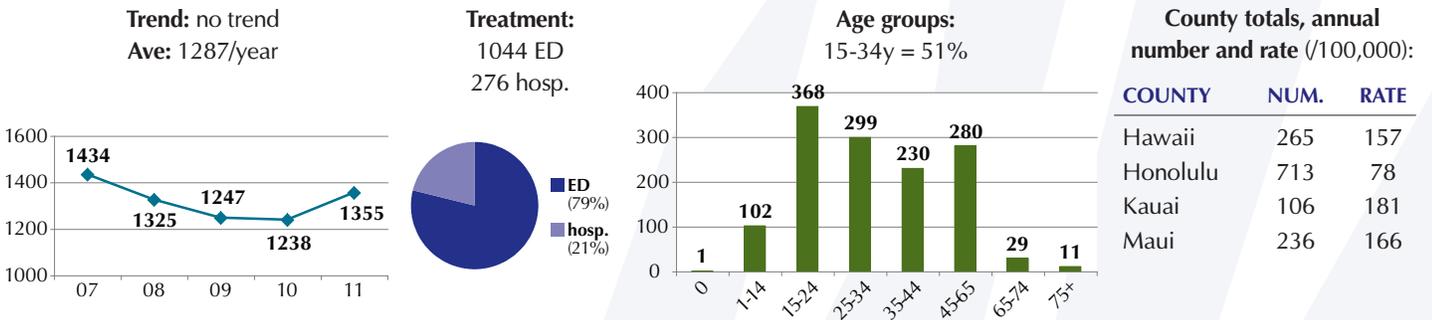
Deaths among motorcyclists were the 6th leading cause of fatal unintentional injuries in the state, accounting for 146 total deaths from 2007 to 2011. Nearly half (45%) of the victims were adult males 20 to 40 years of age. Most (73%) of the decedents were riding motorcycles; there were also 27 moped riders who were killed, including 16 over the 2010 to 2011 period. The 5-year fatality rates were significantly higher for residents of Hawai'i and Maui counties compared to Honolulu County.



Almost half (46%) of the fatal crashes did not involve another vehicle, although that proportion was lower (26%) among the fatally injured moped riders. Only about one-fourth (27%) of all riders were wearing a helmet at the time of the crash, including only 7% of the moped riders. Nearly half (47%) of the decedents tested positive for alcohol, and 29% for illicit drugs. Alcohol use was most common among drivers who crashed during nighttime (66%) and among those in crashes without another motor vehicle (69%). About half (51%) of the fatally injured drivers did not have a valid motorcyclist license, and that proportion was significantly higher among those who had consumed alcohol (58%, vs. 44% among other drivers). More than one-half (58%) of the riders were noted to have been speeding at the time of the crash, a proportion that was higher among motorcyclists (62%) and those who crashed on O'ahu (66%).

Nonfatal injuries

There was a decreasing trend in the annual number of nonfatal injuries among motorcyclists over the 2007 to 2010 period, but an increase in 2011. More than 1000 were treated in EDs each year and another 276 were hospitalized. Patient age was narrowly distributed, with 51% between 15 and 34 years of age. The peak age for rates of both ED visits and hospitalizations was among 20 to 24 year olds. Most (83%) of the patients were males.



Although about half (54%) of the patients were residents of Honolulu County, residents there had significantly lower rates of nonfatal injuries than residents of any other county. Injury rates were approximately twice as high among residents of Neighbor Islands. Forty-four percent of the crashes did not involve a collision, but were due to loss of control by the rider. Three-fourths (75%) of the nonfatal injuries were coded as “traffic” related, or occurring on a public roadway, while 25% were in “non-traffic” environments, including off-road crashes. Nearly one-fifth (19%) of the patients who were injured in non-traffic crashes were 5 to 14 years of age. The average hospitalization was nearly 1 week in duration and resulted in over \$51,000 in medical charges. About two-thirds (64%) of the hospitalized patients and one-quarter (23%) of those treated in EDs had fractures.

EMS data and 2007 linked data (EMS, DOT, HHIC, FARS, death certificates)

About 55% of the EMS Patients were riding motorcycles (55%), and 40% were riding mopeds (status unknown for 5%). About two-thirds (65%) of all riders were wearing a helmet. The proportion not wearing helmets was significantly higher, nearly doubled, among the moped riders (68%), compared to motorcycle riders (38%). Patient condition differed by helmet usage, as helmeted riders were significantly more likely to be transported with minor or moderate injuries (23%, compared to 19% for unhelmeted riders), and significantly less likely to be transported in critical condition (1.9% vs. 3.7%). The mortality rate among helmeted riders (2.5%, or 31 of 1249) was also significantly less than that among unhelmeted riders (4.6%, or 86 of 1879). Probable alcohol use was noted for about 12% of the patients, and alcohol users were significantly less likely to have worn helmets (14%, vs 41% among those with no alcohol use).

Linked data from 2007 showed the odds of sustaining an injury that required hospitalization or resulted in death were 40% higher among unhelmeted rides compared to helmeted riders, and the former also had more than twice the odds (2.2) of a fatal injury. The protective effects of helmet use were magnified if only motorcycle riders were considered. Unhelmeted motorcycle riders had twice the odds of an injury that required hospitalization or resulted in death, more than 3 times the odds of a fatal injury, and 3 times the odds of a TBI (traumatic brain injury).

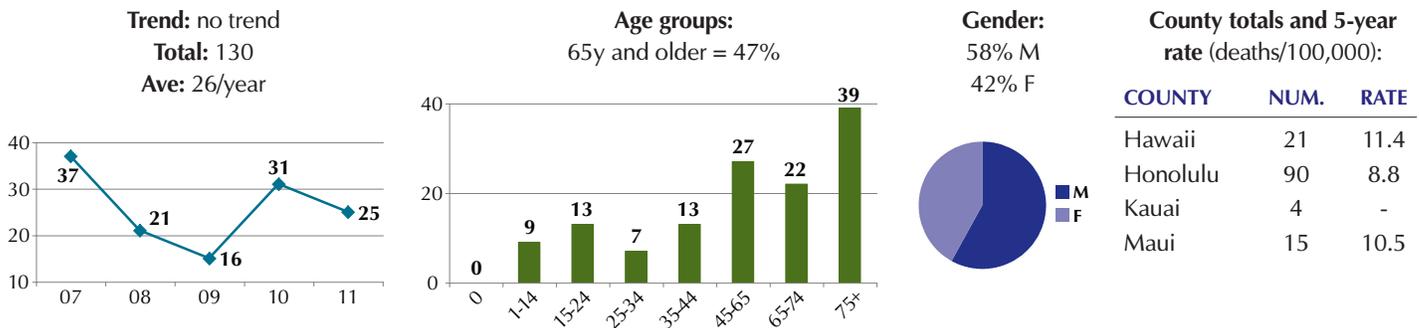
Hawai'i Trauma Registry (toxicology data)

About one-fourth (26%) of the injured resident motorcycle/moped riders in the Hawai'i Trauma Registry tested positive for alcohol, including 21% (178) with BAC (blood alcohol content) levels of 0.08 or greater, and 14% (117) with BAC levels of 0.16% or greater. Moped riders were significantly more likely than motorcyclists to have been drinking (31% vs 24%, respectively). More than half (54%, or 464) of the riders tested positive for either alcohol or drugs, including most (78%) of the 285 moped riders. Alcohol usage was 4 times more common among those who crashed during night time (54%) compared to those who crashed between 6:30 a.m. and 7:29 p.m. (14%).

Motor vehicle crashes, pedestrians

Fatal injuries

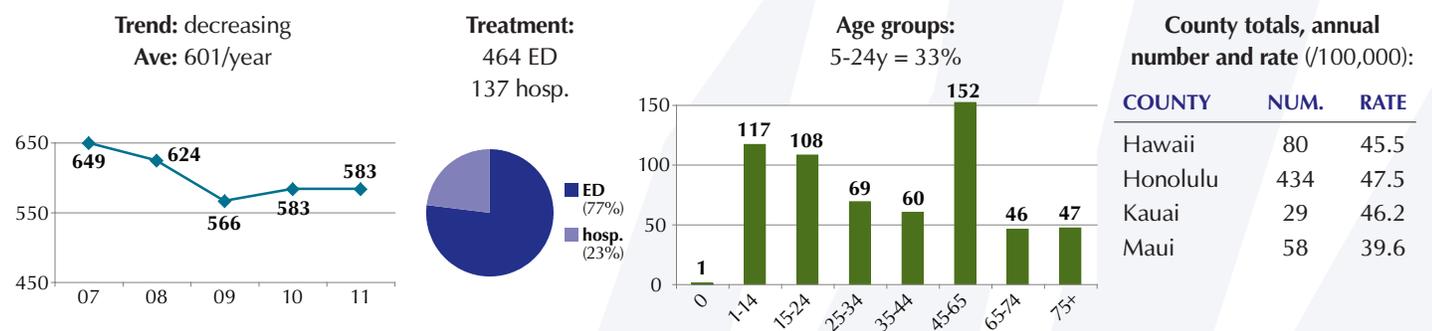
There was no statistically significant trend in the annual number of pedestrian fatalities, although the highest total occurred in 2007 (37 deaths). Senior-aged residents comprised 47% of the victims, and the fatality rates increased dramatically across the oldest age groups. Most (69%) of the victims were hit on O'ahu, but there were no significant differences in county-specific fatality rates. Almost all (80%) of the victims who were 65 years or older were hit on O'ahu, and the fatality rate for O'ahu seniors was statistically comparable to that for seniors living on Neighbor Islands (36 vs. 22 deaths /100,000, respectively).



There were 2 peak times for pedestrian fatalities: 27 crashes (21% of the total) occurred between 5:31 a.m. and 9:29 a.m., and 40 (31%) took place between 5:31 p.m. and 11:29 p.m. Only 34% of the victims were in a crosswalk at the time of the crash; a nearly equal proportion (35%) were hit on open stretches of roadway. The most common speed zone was 25 miles per hour (45% of crashes). Almost two-thirds than half (63%) of the senior-aged victims were hit in 25 mph or slower zones, compared to 33% of pedestrians under the age of 65 years. According to FARS data from 2007 to 2010, more than one-quarter (26%) of the 84 fatally injured pedestrians tested positive for alcohol, and 25% had BAC levels of 0.08% or higher. Alcohol use was significantly higher among male victims (42%) compared to females (6%). The highest prevalence of alcohol use was seen among victims in the 21 to 34 year age group (70%, or 7 of 10), and the 35 to 54 year age group (52%, or 11 of 21). According to FARS data, 39% (33) of the pedestrian victims were in the roadway erroneously, most commonly by “improper crossing of roadway or intersection”, including jaywalking (21%, or 18 victims). Including the victims who tested positive for alcohol or drugs, 54% (or 45) of the pedestrians made an error that contributed to the crash. More than half (59%, or 52) of the 88 drivers made an error which contributed to the crash. Most commonly, they were described as “inattentive” (38%), failed to yield the right of way (25%), or were speeding (18%).

Nonfatal injuries

The annual number of nonfatal injuries to pedestrians generally decreased from 649 in 2007 to 583 in 2011. About one-quarter (23%) of the patients with nonfatal injuries were admitted to hospitals, the highest such proportion for any unintentional injury category. Patient age was widely distributed, but one-third (33%) were in the 5 to 24 year age group. This group also had the highest rate of nonfatal injuries that were treated in EDs, while senior aged residents had the highest rates of hospitalizations.



The rates of both ED visits and all injuries (ED visits combined with hospitalizations) were lowest for Maui County residents, although all county-specific rates were statistically comparable. Most (88%) of the nonfatal injuries were coded as “traffic” related, or occurring on a public roadway, while 12% were in “non-traffic” environments, including private roads, driveways and parking lots. Thirty percent of the patients injured in non-traffic crashes were in the 1 to 14 year age group. Patients were hospitalized for an average of 9 days, with nearly \$60,000 in medical charges. Hospitalizations accounted for most (73%) of total patient days and 87% of the \$9.4 million in total medical charges.

EMS data and 2007 linked data (EMS, DOT, HHIC, FARS, death certificates)

There were 2 peak periods for the time of the EMS-attended crashes, from 6:31 a.m. to 8:29 a.m. (13%, or 287 crashes), and from 2:29 p.m. to 7:29 p.m. (35%, or 788 crashes). The time distribution differed by patient age, as crashes with senior-aged pedestrians were more likely to occur during daytime hours (86%), compared to crashes involving pedestrians under 65 years of age (73%). Patient condition differed by age, as senior-aged pedestrians were significantly more likely to be transported to a hospital, compared to pedestrians under 65 years of age (85% vs. 79%, respectively), and had a significantly higher mortality rate (10.3%, or 47 of 456, vs. 3.6%, or 67 of 1855). The mortality rate was also significantly elevated among pedestrians who were hit during night time hours (7.4%, or 42 of 566), compared to those hit between 5:31 a.m. and 7:29 p.m. (4.1%, or 72 of 1747), despite the younger age distribution among the former. Probable alcohol use was noted for about 9% of the patients. Patients who had used alcohol had generally worse dispositions, and were more than three times as likely to require transport in critical condition, and nearly twice as likely to have died, compared to those who did not use alcohol.

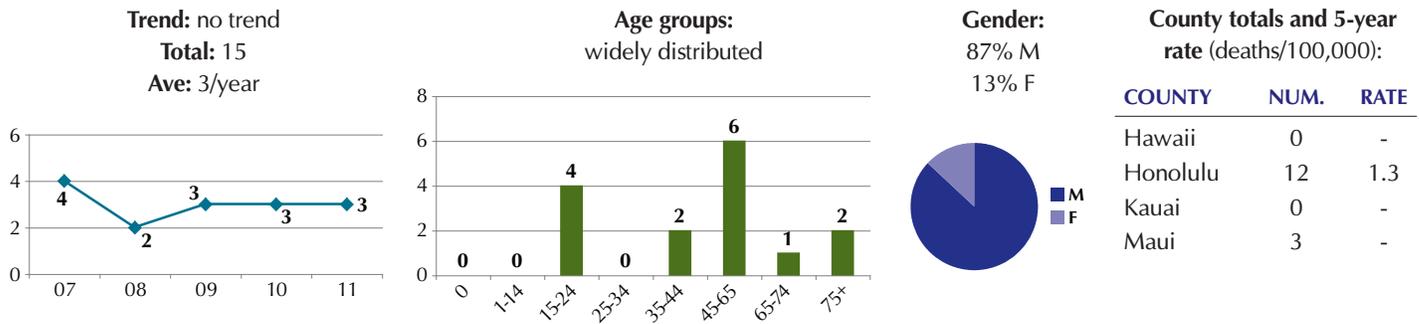
Hawai'i Trauma Registry (toxicology data)

Only 16% of the injured pedestrians in the Hawai'i Trauma Registry had been drinking at the time they were hit. This percentage was significantly higher among those under 65 years of age (22%), as only 2% (3) of the 138 senior-aged pedestrians tested positive for alcohol. Illicit drug usage was documented for 25% of the patients, including 30% of those who were under 65 years of age. Alcohol use was nearly 8 times likely among pedestrians hit during night time hours (41%) than among those hit between 6:30 a.m. and 7:29 p.m. (5%).

Injury Data for Motor Vehicle Crashes, Bicyclists

Fatal injuries

There were between 2 and 4 bicyclists killed in Hawai'i each year, and 80% (12) of the 15 deaths occurred on O'ahu. There was no apparent high-risk age group. Almost all (87%, or 13) of the bicyclists killed over the 5-year period were males. Most (87%, or 13) of the victims were hit by a car; 2 others died after falling off their bicycles. Only 2 of the victims were wearing helmets at the time of the crash (status unknown for 2 others). There was no notable peak time of the day for the crashes; most (64%, or 9) occurred between during daylight hours between 7:31 a.m. and 7:00 p.m.

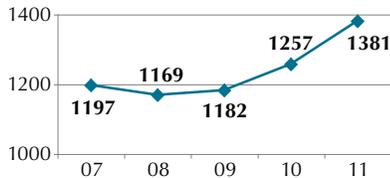


Almost all (91%, or 10) of the 11 traffic-related crashes (from 2007 to 2010) involved cars traveling straight on the road; only 1 crash was due to a car making a turn. Two (18%) of the 11 bicyclists tested positive for alcohol, and 4 (36%) tested positive for drugs. Overall, about half (54%, or 6) of the victims tested positive for either alcohol or drugs. Besides substance use 2 bicyclists were traveling against traffic at the time of the crash and another failed to yield the right-of-way. Four (36%) of the 11 drivers made an error which contributed to the crash, most commonly substance use and speeding (2 instances each).

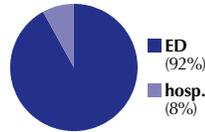
Nonfatal injuries

There were more than 1200 nonfatal injuries to bicyclists each year, with a generally increasing trend. Most (92%) of the injuries were treated in EDs (emergency departments). Males comprised 75% of the patients, including 80% of those who were hospitalized. Nearly one-third (31%) of the patients were 5 to 14 years of age, and the injury rate for 5 to 14 year-olds (244 injuries/100,000 residents) were more than 3 times higher than the rate for residents of other ages (74/100,000).

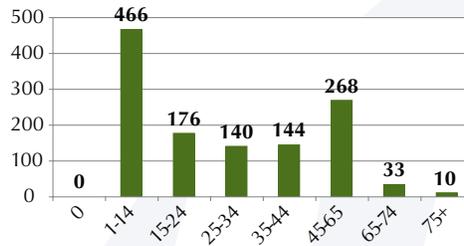
Trend: increasing trend
Ave: 1237/year



Treatment:
1133 ED
105 hosp.



Age groups:
1-14y = 38%



County totals, annual number and rate (/100,000):

COUNTY	NUM.	RATE
Hawaii	201	120.4
Honolulu	779	90.7
Kauai	109	182.8
Maui	148	102.9

The injury rate for Kaua'i County residents was significantly higher than the rates for any other county, and approximately double the rate estimates for residents of Honolulu or Maui counties. Almost all (85%) of the injuries were coded as “non-traffic”, or occurring on private roads, driveways, or off-road environments. Most of the injuries treated in EDs (88%) and requiring hospitalization (71%) were coded to indicate crashes that did not involve a collision with another vehicle or object, but were probably due to the patient falling off of the bicycle. Although 92% of the patients were treated in EDs, hospitalizations comprised 32% of the treatment days and 66% of the total medical charges of \$5.8 million/year. Most (63%) of the hospitalized patients had fractures, including 15% with skull fractures and 20% with leg fractures. More than one-third (38%) of these patients had a traumatic brain injury.

EMS data and 2007 linked data (EMS, DOT, HHIC, FARS, death certificates)

Most (73%) of the EMS-attended bicyclist crashes were distributed over the 11-hour period of 7:31 a.m. to 6:29 p.m., with a peak from 4:31 p.m. to 6:29 p.m. (17%). About half (53%) of the injuries involved motor vehicles and 47% did not. Only 27% of the injured bicyclists wore helmets. Unhelmeted riders had a significantly higher proportion of “critical” or fatal injuries (2.1%, or 22 of 1031), compared to helmeted riders (0.7%, or 3 of 458). These differences were accentuated among crashes that involved motor vehicles, as the proportion of unhelmeted bicyclists with critical or fatal injuries was 3.1% (17 of 540), compared to 0.9% (2 of 214) among helmeted riders. Probable alcohol use was noted for about 9% of the patients. If only the bicyclists with known alcohol and helmet status were considered, helmet use was 5 times higher among those who did not consume alcohol (35%), compared to the drinkers (5%).

Linked data from 2007 showed odds of sustaining an injury that required hospitalization or resulted in death were 80% higher among unhelmeted rides compared to helmeted riders, although this estimate was only of “borderline” statistical significance (p=0.11).

Hawai'i Trauma Registry (toxicology data)

Only 11% of the injured bicyclists in the Hawai'i Trauma Registry had been drinking at the time they were injured. This percentage was nearly three times higher among those hurt in crashes that did not involve a motor vehicle compared to those who were hit by motor vehicles (15% vs. 6%, respectively). About one-quarter of the bicyclists tested positive for illicit drugs, most commonly narcotics (17%), and this proportion did not differ by the type of crash. Overall, one-third (33%, or 89) of the 271 patients tested positive for either alcohol or drugs. None of the 28 bicyclists who had been drinking were wearing a helmet at the time of the crash, compared to 27% usage among those who tested negative for alcohol, and 31% among those who were not tested.

Background and Accomplishments

The Hawai'i State Department of Health, Maternal and Child Health Branch (MCHB) leads activities in the state to prevent intimate partner violence, sexual assault, and child maltreatment, with support from the Injury Prevention and Control Section (IPCS) and other partners in the community. IPCS has been specifically involved with bullying prevention and also leads activities in the state to prevent suicide prevention.

- ▶ Beginning in 2009, IPCS and community partners worked with MCHB to identify Title V bullying prevention and child abuse and neglect prevention performance measures. With technical support from the national Children's Safety Network, MCHB and IPCS collaborated to conduct the first statewide cross-program integration training in November 2009 for bullying and child abuse and neglect prevention. The training strengthened collaborative efforts between IPCS, MCHB, and community partners on program and policy initiatives related to violence prevention.
- ▶ The Safe Schools Community Advisory Committee developed 33 recommendations for policies and strategies to address bullying and harassment in public schools. Members are currently working to get these recommendations adopted by the Board of Education and Department of Education.
- ▶ The Maui County Ho'ōikaika Partnership is a group of agencies working together since 2008 to implement best practices and policies as they strengthen violence prevention services for children and their caregivers. This collaborative initiative serves as a model for similar partnerships across the state.
- ▶ The Asian/Pacific Islander Youth Violence Prevention Center was established in 2000 as one of ten National Academic Centers of Excellence on Youth Violence Prevention funded by CDC. Since then, the Center has partnered with IPCS and other organizations to conduct research on youth violence and develop, implement and evaluate violence prevention programs.
- ▶ IPCS helped establish a non-profit coalition to promote primary prevention of violence, Prevent Violence Hawai'i. IPCS funded the University of Hawai'i Social Science Research Institute to produce, *Ending Violence: A 2004 Status Report on Violence Prevention in Hawai'i*. The report's recommendations were based on the World Health Organization's approach to addressing risk factors and solutions common to all areas of violence. Concerns about sustaining efforts in individual areas of violence hampered the organization's ability to take a unified approach to violence prevention, and the non-profit dissolved in 2010.

Recommendations

In 2010, a statewide needs assessment was conducted that included an online survey of 149 people representing government agencies, law enforcement, schools and universities, medical centers, non-profit organizations, private businesses, and grassroots organizations; and qualitative interviews with 21 key informants from state agencies and universities. A cross-disciplinary stakeholder group was convened to review the results and recommendations, and assess whether they reflected the potential for measurable progress and impact over the next five years.

The resulting recommendations outlined here build on *Ending Violence: A 2004 Status Report on Violence Prevention in Hawai'i* and the *Hawai'i Injury Prevention Plan 2005-2010*. They reflect stakeholders' renewed readiness to collaborate. Effectively preventing violence will take the concerted efforts of individuals and organizations from all sectors working together across all areas of violence.

Recommendation 1: Establish and promote forums for collaboration and information sharing to help integrate violence and abuse prevention efforts statewide

While different types of violence share common risk factors and prevention strategies, prevention efforts are often independent. Forums that encourage organizations that serve different populations and address different types of violence to share information about effective strategies would facilitate collaboration and coordination of efforts (Saul, et al, 2008).

Efforts should be comprehensive and address the different types of violence, encourage the use of evidence-based program and policy practices, and account for primary, secondary, and tertiary prevention as appropriate.

Recommended Next Steps

- ▶ Facilitate opportunities for inter-agency collaboration and coordination among organizations serving different populations and addressing various sub-forms of violence.
- ▶ Expand the use of new and existing channels of communication such as newsletters, listservs, websites, clearinghouses, and other means of technology to facilitate the exchange of information and resources among partners at all levels and in all areas of violence.

Recommendation 2: Collaborate with professionals and community workers to develop a public awareness campaign about violence and abuse prevention.

Current partners represent all levels of prevention and include community and non-profit social service organizations, primary health care centers, law enforcement, and selected policymakers. But there are additional partners who may not be aware of their potential role in violence prevention or understand the value of their programs to violence prevention efforts.

Engaging partners in the development, implementation and evaluation of a communications campaign to raise public awareness will increase likelihood of success at all levels (e.g., developing messages, producing materials, identifying appropriate channels for dissemination).

PARTNERS

Child Death Review Council	Hawai'i State Department of Human Services
Domestic Violence Fatality Review	Hawai'i State Department of the Attorney General
Hawai'i Children's Trust Fund Advisory Council	Hawai'i State Judiciary, Children's Justice Center and First Circuit Court
Hawai'i Coalition Against Sexual Assault	Hóoikaika Partnership
Hawai'i Community Foundation	Injury Prevention Advisory Committee
Hawai'i Youth Services Network	Maui County Domestic Violence Task Force
Hawai'i State Department of Education, School Based Behavioral Health	University of Hawai'i, John A. Burns School of Medicine, Department of Psychiatry
Hawai'i State Department of Health, Family Health Services Division, Maternal and Child Health Branch	University of Hawai'i, Social Science Research Institute

Recommended Next Steps

- ▶ Identify and reach out to potential partners that may not perceive their work as being related to violence prevention.
- ▶ Work with existing and new partners to develop and implement a public education campaign using clear, consistent, tested messages.
- ▶ Partner with representatives from the media to enhance efforts and increase reach for messaging.

Recommendation 3: Promote training that enhances knowledge and skills of community workers and professionals working in violence prevention and related fields

There should be continued training among providers and organizations, and audiences should extend beyond those working directly in the violence and abuse prevention fields. For example, teachers and counselors could receive related information as part of their academic training. Organizations could adopt violence prevention modules as part of their new employee orientation protocols.

Recommended Next Steps

- ▶ Identify training opportunities and resources available to community workers in the violence and abuse prevention fields to enhance their knowledge and skills in primary prevention.
- ▶ Identify training opportunities and resources for other professionals and community members to enhance their knowledge and skills in primary prevention.

Recommendation 4: Enhance the use of data to understand common risk and protective factors for violence prevention

Data are crucial to understanding the complex issue of violence. Data help programs develop priorities, guide interventions and policies, and mobilize support (World Health Organization, 2002). Barriers to collecting and sharing information across agencies need to be removed so that data are accessible to everyone. There also are additional data sources (i.e., on different types of violence) that would help illustrate trends and better guide research and intervention efforts.

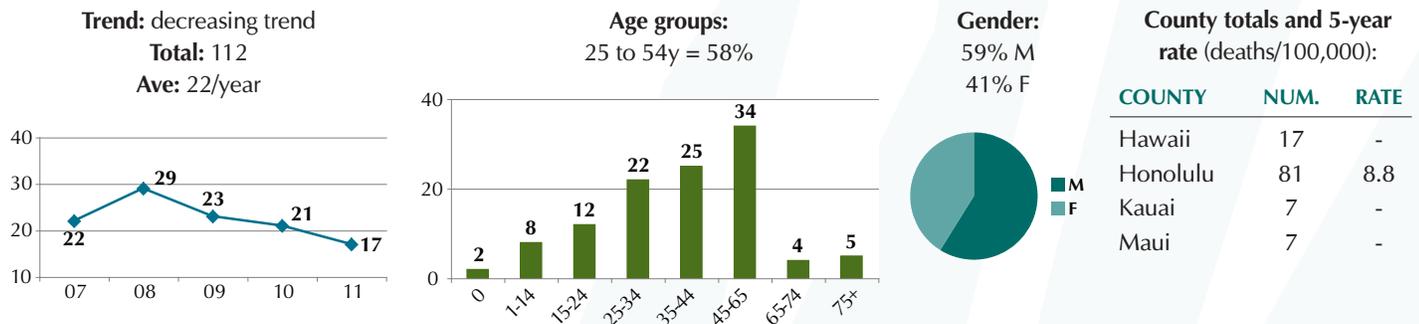
Recommended Next Steps

- ▶ Facilitate data and information sharing across state agencies.
- ▶ Identify and acquire new data sources to develop an annual report on child maltreatment that will enhance understanding of violence and abuse.

Injury Data for Homicides and Assaults

Fatal injuries

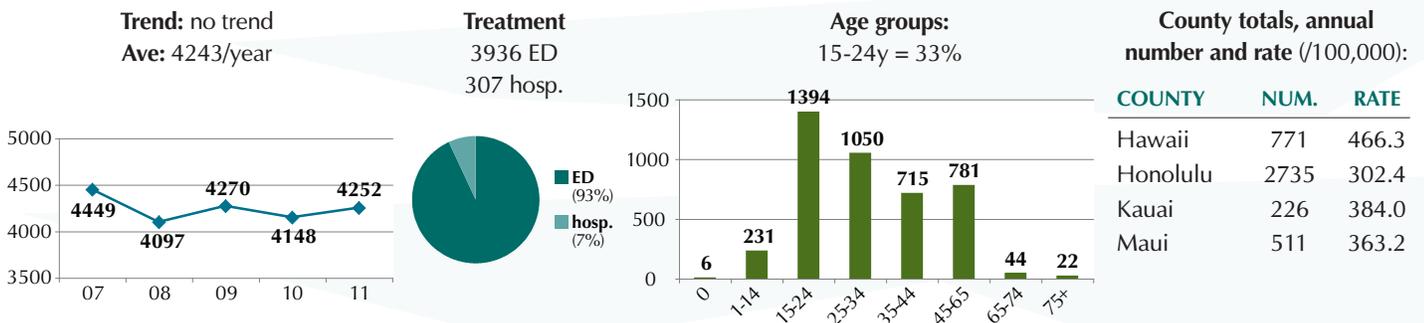
There were 112 victims of homicide over the 5-year period, with a decreasing trend from 29 in 2008 to 17 in 2011. More than half (58%) of the victims were in the 25 to 54 year age range, but there were also 6 victims (5%) who were under 5 years of age. Males comprised 59% of the victims. The fatality rate for residents of O'ahu (8.8 deaths/100,000 residents) was statistically comparable to the rate for all Neighbor Island residents (8.4/100,000).



The most common method was the use of firearms (35%), followed by stabbings (28%), and physical force or unarmed beatings (25%). According to Uniform Crime Reports from 2007 to 2009, most (73%) of the homicide victims knew their assailant, and only a minority (19%) were killed by strangers. Female victims were most likely to be killed by their intimate partner (37%, vs. 5% of male victims), while males were most likely to be killed by extra-familial acquaintances (40%) or strangers (25%).

Nonfatal injuries

There were over 4200 nonfatal injuries from assaults among Hawai'i residents each year, with no clear trend over time. Males comprised two-thirds (67%) of the patients treated in EDs (emergency departments) and an even greater proportion (89%) of those who were hospitalized. More than half (58%) of the patients were 15 to 34 years of age; few (5%) were under 15 years of age, or over 65 years of age (1%). The peak age for rates of both ED visits and hospitalizations was the 15 to 29 year age group, particularly 20 to 24 year-olds.



Violence and Abuse Prevention

The injury rate for residents of Hawai'i County was significantly higher than for any other county, while the rate for residents of Honolulu County was significantly lower than any other county. Patients were hospitalized for nearly 5 days on average, with over \$31,000 in charges for each admission. Unarmed beatings caused 70% of all injuries, and 61% of those that required hospitalization. Fractures were the most common type of injury (53%) that required hospitalization, including 44% of patients admitted with a skull fracture.

EMS data

The number of EMS-attended incidents generally increased over the course of the day (starting at 6 a.m.), reaching a broad peak during the 7:31 p.m. to 2:29 a.m. period (48% of the total). The home or residence of the patient was the most common location for the assault (40%), followed by other indoor location or buildings (17%), most commonly "public buildings" (7%), and bars and restaurants (6%). One-fifth (20%) of the patients were transported in serious or critical condition. That proportion was highest among the senior-aged victims (29%). Probable alcohol use was noted for 29% of the patients. Patients who had consumed alcohol were significantly less likely to be released at the scene (34%, vs. 52% for other patients), and twice as likely to be transported in serious condition (31% vs. 15%, respectively).

Hawai'i Trauma Registry (toxicology data)

Nearly half (46%) of the adult-aged (18 years and older) Hawai'i Trauma Registry resident patients who were injured by assaults were positive for alcohol, and more than one-third (38%) tested positive for illicit drugs. About three-fourths (76%, or 286) of the 375 drinkers had BAC (blood alcohol content) levels of 0.08% or greater. THC (marijuana) was the most commonly documented drug (19% of the patients), followed by amphetamines (15%) and narcotics (15%). Considered together, about two-thirds (67%) of the patients tested positive for either alcohol or drugs. Alcohol use was significantly more likely among the male patients (49%) compared to females (27%), among those injured on weekends (54% vs. 41% for those assaulted on weekdays), and among those assaulted during night time hours (54%, vs. 30% for those injured between 6:31 a.m. and 7:29 p.m.).

Appendix A: Hawai'i Injury Prevention Plan 2005-2010 Status Report

INFRASTRUCTURE			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
<p>Stabilize IPCS funding and support expansion of injury prevention services to all counties throughout the state.</p> <ul style="list-style-type: none"> ▶ Stabilize funding for Core IPCS positions ▶ Establish suicide prevention coordinator position ▶ Establish Neighbor Island positions 	<p>Progress Made</p> <p>Objective Met</p> <p>Progress Made</p>	<p>✓</p> <p>✓</p>	<p>IPCS has 3 permanent state funded positions – Program Manager, Planner, and Suicide Prevention Coordinator. In 2012, the Hawai'i State Legislature approved potential funding for injury prevention positions with Trauma Special Funds. Trauma coordinator program manager positions at trauma centers across the state are funded through DOH Emergency Medical Services Injury Prevention System Branch and are required to incorporate injury prevention into their work.</p>
<p>Establish standards for completeness and accuracy of external cause of injury coding (e-coding) for hospitals to achieve and maintain.</p>	<p>Objective Met</p>		<p>E-coding is at 90% for emergency department and hospital admission records.</p>
<p>Produce and disseminate annual and specialized injury reports.</p>	<p>Objective Met</p>		<p><i>Injuries in Hawai'i 2001-2006</i> was published in 2008. IPCS developed an injury data overview for the IPAC orientation packet. Injury specific data overviews are updated each year and shared with IPAC and other partners.</p>
<p>Incorporate injury prevention into Hawai'i's Health Education Standards for grades K through 12.</p>	<p>Progress Made</p>		<p>The Hawai'i Health standards-based playground safety curriculum and unintentional injury curriculum were developed for public elementary schools.</p>
<p>Develop a cadre of individuals and organizations who are injury literate, articulate, and active.</p>	<p>Progress Made</p>	<p>✓</p>	<p>An injury prevention module was developed for emergency medical and mobile intensive care technician classes at Kapi'olani Community College, and the course was taught across the state. IPCS coordinated injury prevention integration training with Department of Health Family Health Services Division, Maternal and Child Health Branch as well as several injury specific conferences and public health core competency workshops.</p>
<p>Cultivate awareness and advocacy among policy makers and the public in recognizing and addressing injuries as a major public health problem in Hawai'i.</p>	<p>Progress Made</p>	<p>✓</p>	<p>IPCS distributed <i>Injuries in Hawai'i to 2008</i> Legislators; provided testimony for injury-related legislation; developed and disseminated materials for the injury prevention "No Get Hurt Hawai'i" campaign with prevention tips; and developed IPAC packet.</p>
<p>Foster partnerships with the military to address injury prevention issues in which the military can have impact.</p>	<p>Progress Made</p>	<p>✓</p>	<p>IPAC and Prevent Suicide Hawai'i Steering Committees include representatives from the military. Members of the military are involved in the Department of Transportation's "Click It or Ticket" campaign as well as Prevent Suicide Hawai'i Task Force suicide prevention efforts.</p>

Appendix A: Hawai'i Injury Prevention Plan 2005-2010 Status Report

DROWNING			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Develop a beach rating system that includes comprehensive risk assessments for all beaches in the state.	Objective Met		The rating system and beach safety website were developed (www.hawaiibeachsafety.org).
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.	Progress Made	✓	Conducted an evaluation of beach warning signs in 2009.
Support mandatory 4-sided isolation fencing for residential pools.	On Hold		IPCS not currently involved.
Conduct a coordinated educational campaign targeting residential pool owners and pool service providers to promote pool safety and the adoption of safety devices.	Objective Met		Worked with Swimming Pool Association of Hawai'i to develop a pool safety awareness campaign; conducted a pool safety survey of pool owners.
FALLS			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Enhance public awareness that falls are preventable and promote actions that reduce the risk of injury.	Progress Made	✓	IPCS participated with partners, including Fall Prevention Consortium members, in annual campaign for fall prevention awareness. Fall prevention questions were added to statewide health survey in 2008.
Increase availability and accessibility of fall prevention programs statewide for caregivers and older adults on how to prevent falls and effectively use community resources.	Progress Made	✓	Fall Prevention Resource Guide developed and posted online, will be revised in 2012. Needs assessment conducted in 2010. Piloted two <i>Tai Chi for Health</i> projects.
Expand the role of medical and health care professionals in screening, educating, and referring older adults to fall prevention programs.	Progress Made	✓	IPCS participated with partners in annual campaign for fall prevention awareness working with physical therapists and pharmacists.
MOTORCYCLE			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Advocate for a mandatory universal helmet use law.	Progress Made	✓	IPCS continues to work on this through Strategic Highway Safety Plan committee.
Enhance and expand training of county police officers to recognize impaired motorcyclists.	On Hold		IPCS not currently involved.

Appendix A: Hawai'i Injury Prevention Plan 2005-2010 Status Report

MOTOR VEHICLE OCCUPANT			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Increase “high visibility enforcement efforts” of traffic safety laws and publicity of those efforts as a combined strategy.	Progress Made	✓	IPCS works with DOT Safe Communities Offices to distribute “Click It or Ticket” annual campaign materials to traffic safety partners.
Develop a statewide task force for traffic safety advocacy.	Objective Met		The Strategic Highway Safety Plan (SHSP) was developed. See partner list in Traffic Safety chapter.
***Support a statewide task force for traffic safety advocacy.	Progress Made	✓	IPCS involved in on-going SHSP implementation of efforts.
Advocate for a Graduated Driver’s License System for Hawai'i.	Objective Met		Act 72 (2005) established a 3-stage graduated driver licensing program for persons under the age of 18. Department of Health and Department of Transportation were required to conduct yearly evaluations.
***Evaluate the Graduate Driver’s License System for Hawai'i.	Objective Met		IPCS completed evaluations from 2007-2010, when the law became permanent
***Reduce impaired driving.	Progress Made	✓	Ignition interlock bill was passed in 2008 and became effective in 2010. IPCS continues to be involved, specifically in evaluating of the law.
PEDESTRIAN			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Maintain and upgrade existing crosswalks and walkways; develop new crosswalks and walkways based on pedestrian safety factors such as location and condition.	Progress Made	✓	IPCS has on-going involvement with pedestrian and bicycle safety efforts. Since 2005, Complete Streets state legislation and an O’ahu Complete Streets ordinance have passed.
Conduct a media awareness campaign aimed at changing attitudes and behaviors of drivers and pedestrians to improve road sharing.	Progress Made		“No Get Hurt” TV PSA includes pedestrian safety.
Incorporate pedestrian safety in the health education standards of the Department of Education’s K-12 curriculum.	Progress Made		The Hawai'i Health standards-based unintentional injury curriculum, which includes pedestrian safety, was developed for public elementary schools.

Appendix A: Hawai'i Injury Prevention Plan 2005-2010 Status Report

UNINTENTIONAL POISONING

RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Through legislation, improve labeling on prescription drugs to include: <ul style="list-style-type: none"> ▶ Diagnosis and instructions to patients ▶ Physical description 	On Hold		IPCS worked with community partner on analyses of unintentional poisoning of prescription narcotics which may have implications on future legislation.
Expand age-appropriate education efforts in poison prevention.	Progress Made		Keiki Injury Prevention Coalition (KIPC) distributed poisoning prevention materials across the state. "No Get Hurt" poisoning prevention poster distributed through DOH.
Maximize use of the 24-hour Hawai'i Poison Hotline for poison AND medication/drug information.	Progress Made	✓	Distribution of poisoning prevention materials included information on the Hawaii Poison Hotline.

SUICIDE

RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Develop and implement suicide prevention training for "gatekeepers."	Objective Met		Gatekeepers were trained from all counties. IPCS coordinated workshops statewide. As of 2012, there are 37 ASIST (Applied Suicide Intervention Skills Training) trainers and more than 2,500 gatekeepers trained.
***Maintain and evaluate suicide prevention training for "gatekeepers."	Progress Made	✓	IPCS evaluated gatekeeper trainings and worked with partners to develop a sustainability plan for suicide prevention training efforts.
Launch a public awareness campaign.	Progress Made	✓	IPCS worked with Visionary Related Entertainment (VRE) Hawai'i to develop a radio spot in 2009. The "No Get Hurt" TV PSA aired on Olelo in 2009, and the "No Get Hurt" suicide prevention posters were distributed statewide. IPCS coordinated two statewide suicide prevention conferences and co-sponsored "Survivors of Suicide" conferences with Hawai'i SPEAR (Suicide Prevention Education Awareness Research).
Promote and support research on suicide and suicide prevention.	Progress Made		IPCS evaluated gatekeeper training.
Develop and promote effective clinical and professional practices and policies.	Progress Made	✓	The Prevent Suicide Hawai'i Task Force (PSHTF) and IPCS coordinated conferences for clinicians and professionals.

Appendix A: Hawai'i Injury Prevention Plan 2005-2010 Status Report

VIOLENCE AND ABUSE			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Promote and support the development of “full-service” schools.	On Hold		IPCS not currently involved.
Identify approaches used in local and national programs that effectively reduce community violence.	Progress Made		The Asian/Pacific Islander Youth Violence Prevention Center worked on this recommendation. This Center is represented on IPAC.
Conduct research to better understand violence in Hawai'i.	Progress Made		The Asian/Pacific Islander Youth Violence Prevention Center worked on this recommendation. This Center is represented on IPAC.

HIPP 2005-2010 was revised in 2009 to include additional recommendations in traffic and suicide that reflect on-going efforts. These are noted with ***

*Objective met – IPCS and partners completed the recommendation

Progress made – IPCS and partners accomplished a portion of the recommendation

On-Hold – IPCS was unable to make progress on recommendation due to a lack of resources (time, personnel, etc) or other reasons

** Current Efforts – a check mark in this column reflects on-going efforts.

Appendix B: Data Sources and Methods

With the exception of the chapter on drowning, the data presented in this plan refers only to injury among residents of Hawai'i. This is consistent with national reporting conventions of injury mortality and allows for the comparison of fatal injury rates in Hawai'i 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 9%, hospitalizations by 9%, and emergency department visits by 9%. (Non-residents comprised 47% of the drowning victims in Hawai'i, so they are included in some of the data in the drowning section.)

The calculation of injury mortality rates necessitates the definition of "at risk" populations for the denominator. This data was obtained from the web site for the U.S. Census Bureau (2012). Rate estimates used the average annual population estimate over the 2007 to 2010, since 2011 estimates were not available when preparation of this report began.

The primary source of injury mortality data in Hawai'i is the death certificate database of the Hawai'i Department of Health. The ICD-10 underlying cause of death codes were grouped as recommended by the Centers for Disease Control and Prevention, with some exceptions (CDC, 2002). For some types of injuries, the open text information on how the injury occurred was reviewed to extract information not captured by the cause of death code. Supplemental data was also used for certain injury categories. Data from the Fatal Analysis Reporting System (FARS) of the National Highway Traffic Safety Administration (NHTSA) was linked to death certificate data for deaths from traffic crashes (NHTSA, n.d.). Supplemental data on homicides was abstracted from the Uniform Crime Reports (UCR), maintained by the National Archive of Criminal Justice data (2010). The autopsy records of O'ahu suicide and drowning victims were also reviewed for the 2007 to 2010 period.

The main source of data on nonfatal injuries was the Hawai'i Health Information Corporation (HHIC), which receives abstracted data from the medical records of patients treated in all hospital-based emergency departments (EDs) and hospitals in the state, with the exception of ED records from Tripler Army Medical Center. A record was defined as injury-related if the principle diagnosis was within the ICD-9CM series 800-995.85, with the following exclusions: 909.3, 909.5, 995.0-995.4, 995.6-995.7 (Injury Surveillance Workgroup, 2003). Patients who died in the hospitals or who were discharged to hospice facilities were excluded from these analyses. To prevent double-counting of injuries, patients who were transferred to another hospital at discharge were excluded. Injuries resulting from "adverse effects", as indicated by external cause of injury codes (E-codes) were also excluded (CDC, 2007). E-codes were used to group nonfatal injuries into mechanisms that corresponded to the groupings for fatal injuries (CDC, 2007). In this report, all nonfatal self-inflicted injuries are described as "suicide attempts", although this is not actually discernible through E-codes. This may have resulted in an overestimation of suicide attempts, but it is also possible that self-inflicted injuries in general are underreported.

It is important to note that the extent of E-coding varied across the counties patients reside in, and over time within those counties. The records for residents of Neighbor Islands were significantly more likely to have E-codes than records for residents of Honolulu County (on average 97.4% vs. 87.5%, respectively). There were also decreasing trends in the proportion of inpatient records with E-codes for all counties except Maui, although these were most meaningful for O'ahu hospitals. These variations in E-coding need to be considered when interpreting comparisons between counties and examining trends within a county

over time. Most statistics in this report are based only on E-coded records, and therefore underestimate the real magnitude of injuries by about 9% for both those treated at EDs and for those injuries requiring hospitalizations. There was some inconsistency in the contribution to the HHIC database from certain individual hospitals. One O'ahu hospital began contributing ED records in November, 2008, although this hospital accounted for only 1.4% of ED records. Two other O'ahu hospitals closed operations in mid-December of 2011.

EMS data is included in certain chapters (motor vehicle crashes, falls and assaults) for which there were discreet injury codes in the EMS data collection system. EMS personnel document the use of protective equipment (seat belts and helmets) and the approximate time and location of the injury, elements which are lacking from the more population-based HHIC data. Patient use of alcohol and drugs is also noted in EMS data, either by patient admission, the smell of alcohol on the breath, or physical evidence (e.g. bottles, drug paraphernalia, etc.) at the scene. However, since use of "drugs" is not specific, only the EMS characterization of patient alcohol use is examined. To avoid double-counting of individual patients, those who were transferred to another EMS unit were excluded from analyses. Patients who refused transport to hospitals (or released at the scene) and those who were dead upon EMS arrival or who died while in EMS care were included, however, to provide a full description of the effects of protective factors or alcohol use.

A grant from the Hawai'i Department of Transportation (DOT) enabled the linkage of 2007 EMS records related to motor vehicle crashes to DOT, HHIC, and FARS, and death certificate records. EMS records were linked to DOT, FARS and death certificate records probabilistically, on the basis of time, date, and location of the crash, and patient age, gender and seating position. This product was then linked to HHIC records by deterministic methods using patient identifiers, including name and date of birth. This linked dataset provided examination of the effect of protective devices (as described by EMS, DOT and FARS) with the ultimate medical disposition of the patients (as described by HHIC records and death certificates).

More complete and test-based results of toxicology were available from the Hawai'i Trauma Registry (HTR). The HTR includes data from the 7 main trauma centers in the state. Data was available for the 2008 to 2011 period, but 6 of the trauma centers did not begin contributing data until 2009. HTR data was included to provide a description of substance use among patients who had nonfatal (although serious) injuries from a variety of mechanisms. To avoid double-counting, the results of HTR patients who were transferred at discharge were excluded. Patients who died, either in the ED or after hospitalization, were included, to examine associations between substance use and mortality for injuries where these relationships are not better described through other data systems (e.g. motor vehicle deaths and FARS).

Most of the injury rates have been standardized for age distribution, by the direct method, using the U.S. 2000 standard population (Anderson & Rosenberg, 1998). Sixteen age groups were used for standardization across all ages, although certain calculations were restricted to more narrow age ranges. Statistical tests were conducted with t-tests for continuously distributed variables (e.g. patient age) and chi-squared tests for categorical variables (e.g. patient gender). Some trends (described as "significant" or "non-significant") were formally assessed using Poisson regression (Clayton & Hills, 1993). Rate differences were tested using different techniques, depending on sample size and use of age standardization (Dever, 1984). All statistical significance testing was conducted at the 95% confidence level.

Appendix C: Acronyms

ADRC – Adult Disability Resources Centers

ASIST – Applied Suicide Intervention Skills Training

BRFSS – Behavioral Risk Factor Surveillance System

CDC – Centers for Disease Control and Prevention

CHOW Project – Community Health Outreach Work to Prevent AIDS project

DOH – Hawai‘i State Department of Health

DPS – Department of Public Safety

DOT – Hawai‘i State Department of Transportation

DUI – Driving under the influence (alcohol or drugs)

E-code – External cause of injury codes within the ICD-9 system

ED – Emergency Department

EMS – Emergency Medical Services

EMSIPSB – Emergency Medical Services and Injury Prevention Systems Branch, within DOH

FARS – Fatal Analysis Reporting System

GDL – Graduated Driver’s Licensing

HACDAC –Hawai‘i Advisory Commission on Drug Abuse and Controlled Substances

HEMSIS – Hawai‘i Emergency Medical Services Information System

HHIC – Hawai‘i Health Information Corporation

HIPP – Hawai‘i Injury Prevention Plan

HMSA – Hawai‘i Medical Service Association (Hawai‘i’s Blue Cross Blue Shield)

ICD-9-CM – International Classification of Diseases, 9th Revision, Clinical Modifications

ICD-10 – International Classification of Diseases, 10th Revision

IOM – Institute of Medicine

IPAC – Injury Prevention Advisory Committee

IPCS – Injury Prevention and Control Section, within DOH EMSIPS Branch

KIPC – Keiki (childhood) Injury Prevention Coalition

LGBT – Lesbian, Gay, Bisexual and Transgendered

MCHB – Maternal and Child Health Branch, within DOH

NHTSA – National Highway Traffic Safety Administration

PDMP – Prescription Drug Monitoring Program

PSHTF – Prevent Suicide Hawai‘i Task Force

SAMHSA – Substance Abuse and Mental Health Services Administration

STD/AIDS – STD/AIDS Prevention Branch, within DOH

WIC – Women, Infant and Children Services Branch, within DOH

YRBSS – Youth Risk Behavior Surveillance System

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The New Spectrum of Prevention: Guiding Injury Prevention in Hawai'i

The Spectrum of Prevention is a broad framework that outlines seven levels of intervention, or strategies, intended to address complex public health problems. These strategies account for the various factors that contribute to community health and safety and can be used to develop a comprehensive approach to address public health concerns.

Influencing Policy and Legislation

Legislation and policy initiatives affect large numbers of people by improving their environments, encouraging healthy lifestyles, and providing for consumer protections.

Mobilizing Neighborhoods and Communities

Engaging neighborhoods and communities in the process of identifying, prioritizing and addressing public health concerns leads to more accepted and successful community interventions.

Changing Organizational Practices

Modifying internal policies and practices of agencies and organizations can lead to improved health and safety for staff and clients and contribute to a healthier community. Changing practices in some agencies (e.g., law enforcement, schools) may also affect community health.

Fostering Coalitions and Networks

Coalitions and networks that represent local government, public health, private and nonprofit organizations, health care, and the community provide an opportunity for collaborative planning, coordinated use of resources, and strong support of legislation and organizational change.

Educating Providers

Educated providers, in and out of the health field, play an important role by identifying injury prevention issues and intervening as needed. Providers may encourage adoption of injury prevention behaviors, offer education, and advocate for legislation and organizational change.

Promoting Community Education

Community education uses different communication channels to reach as many people as possible with health education messages. These messages aim to change behaviors and build a critical mass of people who will become engaged in the issue.

Strengthening Individual Knowledge and Skills

Health educators and trained community members work directly with individuals to promote health and safety. Attention may be given to building individuals' capacity to use new approaches, educate others, or become more engaged in advocacy.

Source:

The original Spectrum of Prevention was developed by Larry Cohen based on the work of Dr. Marshall Swift. The Contra Costa Health Services Public Health Division, Community Wellness & Prevention Program later added the strategy Mobilizing Neighborhoods and Communities and renamed the framework The New Spectrum of Prevention: A Model for Public Health Practice.

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IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans 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;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

IV. Narrative Plan

T. Use of Technology

Adult Mental Health Division

The Adult Mental Health Division expanded 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 included 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 expanded 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 plans to 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.

Child and Adolescent Mental Health Division

CAMHD will begin to import and translate providers' data into CAMHD'S Electronic Health Records (EHR). CAMHD's EHR has achieved meaningful use. CAMHD's system has begun to tie client care documentation to billing and payment services. On Kauai, through a Memorandum Agreement, the Department of Education is able to maximize reimbursement by partnering with CAMHD's billing system. To facilitate the use of technology, CAMHD is providing Information Technology technical assistance to its providers to assist them in moving toward meaningful use certification. CAMHD is working with the Governor's Office in expanding the bandwidth for high-speed connectivity. CAMHD seeks TA on addressing confidentiality issues as information goes from one agency to another.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. 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.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

IV. Narrative Plan

U. Technical Assistance

Adult Mental Health Division

AMHD will request technical assistance from SAMHSA in the following areas:

- Developing Health Homes for SMI/SPMI consumers.
- Assistance in training AMHD staff to improve in the development of key performance indicators for adoption as dashboard measures.
- Additional Face-to-face training on Client Level Data.

IV: Narrative Plan

V. Support of State Partners

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, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. 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, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and 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.⁴⁵ 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 justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in 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, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal 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 and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

IV. Narrative Plan

V. Support of State Partners

Adult Mental Health Division

AMHD will solicit letters of support from the following partners:

- Acting Hawaii State Hospital Administrator. The intent of this letter is for supporting consumers in successful transitions to community settings, where consumers do not have the financial resources before their entitlements are received.
- The Institute of Human Services. The intent of this letter of support will be in collaboration with the Homeless Pilot project.
- The Honolulu Police Department (HPD). The intent of this letter of support in regard to HPD's collaboration with AMHD's Jail Diversion Program activities and the Central Receiving Desk.
- The Office of Health Status Monitoring. The letter of intent will be in regard to collaboration on collecting suicide data.
- The Maui Police Department. The letter of intent will be in regard to providing training to police officers in Maui County's (Maui, Molokai, and Lanai) crisis intervention project.

Child and Adolescent Mental Health Division

The Child and Adolescent Mental Health Division (CAMHD) has strong strategic partnerships with the state agencies in charge of social services, education, health, the juvenile correctional authority, and the judiciary.

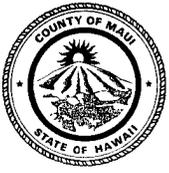
The Statewide Interagency Quality Assurance Committee continues to be very active with implementation of the joint treatment planning and coordination of services for very difficult cases that cross agency responsibilities. Multi-agency treatment teams meet to develop plans that can be collaboratively agreed to. These discussions of particularly problematic cases have resulted in new joint programming with possible joint governance and fiscal support. The heightened level of cooperation and collaboration among the various agencies is to be acknowledged.

CAMHD has an excellent working relationship with the MedQuest Division of the Department of Human Services. CAMHD provides carve-out services for children and youth with high levels of behavioral health problems. In discussions, MedQuest is favorable to adding further services for Medicaid reimbursement and dispensing with oversight of CAMHD in the future. MedQuest is highly supportive of CAMHD's initiatives to provide services through telehealth. Recently, a

new work group was formed with MedQuest Division and Child Welfare Division to assess and develop policies concerning the use of psychotropic medication in the foster care population.

CAMHD has been cooperatively working with the University of Hawaii as they develop a pilot project for wrap-around services for youth in the juvenile justice system. This pilot will help CAMHD coordinate and communicate with Family Court judges, so that the therapeutic goals of CAMHD are represented when judges decide cases. CAMHD is a member of the Children in Family Court Committee of the Supreme Court.

CAMHD applied for and was awarded a SAMHSA children's services grant. The grant, Project Laulima, is targeted at developing interagency coordination of services for a gap group of youth with the combined problems of behavioral issues and developmental delay. A strategic plan was developed for this population of interest and three "system spanners" were hired to be liaisons between the Developmental Disabilities Division and Child & Adolescent Mental Health Division of the Department of Health, the School-Based Behavioral Health and Special Education programs of the Department of Education and Child Welfare Services and Medicaid Division of the Department of Human Services. CAMHD has been implementing the goals and objectives of the integration plan. Copies of the letters of support for that grant application from the Department of Education, Department of Human Services, Office of Youth Services (juvenile corrections authority), Department of Health, and a mental health provider are attached.



ALAN M. ARAKAWA
MAYOR

OUR REFERENCE
YOUR REFERENCE

POLICE DEPARTMENT

COUNTY OF MAUI

55 MAHALANI STREET
WAILUKU, HAWAII 96793
(808) 244-6400
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GARY A. YABUTA
CHIEF OF POLICE

CLAYTON N.Y.W. TOM
DEPUTY CHIEF OF POLICE

August 28, 2013

Ms. Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health
Department of Health
P.O. Box 3378
Honolulu, HI 96801-3378

To Whom It May Concern:

Re: Letter of Support – Adult Mental Health’s Mental Health Block Grant (MHBG) Application

The Maui Police Department receives outstanding collaborative support from the Maui Community Health Center and the Department of Health. They are providing mental health services to consumers living with severe and persistent mental illness, and they work closely with us to handle incidents involving the mentally ill and those in crisis.

We are writing in support of the Adult Mental Health Block Grant 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 our community. The Maui Community Health Center and its Forensic Coordinator, Dr. Dara Rampersad, provides team training in crisis intervention to our police officers, and we look forward to continuing our relationship with the assistance of the Adult Mental Health Block Grant.

Sincerely,

GARY YABUTA
Chief of Police

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

IV. Narrative Plan

W. State Behavioral Health Advisory Council

The State Council on Mental Health, also known as, the Planning Council is a diverse group of individuals comprised of consumers of mental health services, family members, representatives from each of the four county Service Area Boards, representatives of state agencies, and other community stakeholders. The Council maintains a membership of twenty-one members, who are appointed by the Governor and confirmed by the Senate during Hawaii's Legislative Sessions. One member is in a dual role by participating in the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS). HACDACS minutes and legislative involvement are shared monthly with Council members.

The vision of the Council is for a Hawaii where people of all ages with mental health challenges can enjoy recovery in the community of their choice. The mission statement of the Council is to advocate for a Hawaii where all persons affected by mental illness can access treatment and support necessary to live a full life in the community of their choice.

The Council serves as an advisory body to the Department and shall not include clinical, administrative or supervisory functions of the Department of Health (DOH). They:

- Advise the DOH on allocation of funds and resources, statewide needs, and programs affecting two or more service areas.
- Review and comment on plans and submitting to the State any modification that they deem necessary.
- Serve as an advocate for adults with severe mental illness, children requiring support for serious emotional disturbance, other individuals with combined mental illness and substance abuse disorders.
- Monitor, review, and evaluate, not less than once per year, the allocation and adequacy of mental health services in the State.

The Council is divided into four committees, namely: Social Services and Health; Public Education; Homelessness and Housing, and Judiciary.

- The Social Services Group ensures that consumers of all ages have the needed social and health supports that promote recovery.
- The Public Education Group ensures that educational opportunities are available to consumers of all ages.
- The Homelessness and Housing Group ensures that consumers of all ages have affordable housing with needed supports.
- The Judiciary Group ensures that consumers of all ages who encounter the judicial system receive needed and timely mental health services.

This past legislative session, the Council was actively involved in reviewing and tracking state legislation relating to mental health services. Through presentations and research, their work turned into the support and testimony at legislative hearings, advocating for the populations

the Council is appointed to serve. In collaboration with other advocates, the assertive community treatment bill became law.

The Council is kept abreast of current issues, programs, upcoming grants, and other topics in behavioral health field through presentations from AMHD, CAMHD and community partners.

Members of the Council participated in the development of the FY2014/2015 Mental Health Block Grant Application by their involvement with the AMHD Needs Assessment process. Several members participated in County Focus Groups. Members facilitated groups and wrote the results from each Focus Group. Other members developed narratives for the Narrative Plan section of the MHBG Application which are included in the application. An Ad Hoc committee of the Council is in the process of reviewing the MHBG Application to provide feedback and make recommendations for improvement.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Katrina Lorenzo	Others (Not State employees or providers)		P.O. Box 424 Papaikou, HI 96781 PH: 808-989-7120	katrinalorenzo@aol.com
Louise Crum	State Employees		Mental Health Court, 777 Punchbowl Street Honolulu, HI 96813 PH: 808-593-4573	louise.k.crum@courts.hawaii.gov
Susan Foard	State Employees		Vocational Rehabilitation Office, 1901 Bachelot Street Honolulu, HI 96817 PH: 808-586-9746	sfoard@dhs.hawaii.gov
Theresa Minami	State Employees		810 Richard Street, Ste. 400 Honolulu, HI 96813 PH: 808-429-5602	timinami@dhs.hawaii.gov
Steve Shiraki, Ph.D.	State Employees		260 D North School Street Honolulu, HI 96817 PH: 808-753-3110	steve_shiraki@notes.k12.hi.us
Marie Vorsino, Psy.D.	State Employees		FCLB, 42-477 Kalaniana'ole Highway Kailua, HI 96734 PH: 808-266-9922	marie.vorsino@doh.hawaii.gov
Chad Koyanagi, M.D.	Providers		John A. Buirns School of Medicine, 1356 Lusitana Street, 4th Floor Honolulu, HI 96813 PH: 808-479-3200	koyanagic@dop.hawaii.edu
Christopher Holschuh	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1644 Kilauea Avenue, Apt. 106 Hilo, HI 96720 PH: 808-936-2553	christopherholschuh@yahoo.com
Susan King	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1889 Loke Street, Apt. 316 Wailuku, HI 96793 PH: 808-276-7523	susanking421@gmail.com
Patrick Brown	Family Members of Individuals in Recovery (to include family members of adults with SMI)		443 Paumakua Place Kailua, HI 96734 PH: 808-263-9818	plr7brown@yahoo.com
Sheila Calcagno	Family Members of Individuals in Recovery (to include family members of adults with SMI)		P.O. Box 370 Kilauea, HI 96754 PH: 808-821-8167	sheilainhi@yahoo.com
Charlene Daraban	Family Members of Individuals in Recovery (to include family members of adults with SMI)		275 Olive Avenue Wahiawa, HI 96786 PH: 808-487-8785	charlie.daraban@hfaa.net
G. Mike Durant	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2311 Ferdinand Avenue Honolulu, HI 96822 PH: 808-295-2611	gmdurant@earthlink.net
Haaheo Mansfield	Family Members of Individuals in Recovery (to include family members of adults with SMI)		P.O. Box 601 Kaaawa, HI 96730 PH: 808-223-8818	hm@haheomansfield.com

Sandra Simms, (Rtd. Judge)	Family Members of Individuals in Recovery (to include family members of adults with SMI)	94-415 Kealakaa Street Mililani, HI 96789 PH: 808-222-5501	sandra.simms48@gmail.com
Noelani Wilcox	Family Members of Individuals in Recovery (to include family members of adults with SMI)	1968 Paula Drive Honolulu, HI 96816 PH: 808-382-4213	noelaniwilcox@yahoo.com

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	7	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="3"/>	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	13	61.9%
State Employees	5	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="2"/>	
Total State Employees & Providers	8	38.1%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="2"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="1"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Planning Council members chose three areas in Part IV (I - Justice; E - Parity Education; O - Children and Adolescents) of the MHBG Plan Application to research and write on.

Planning Council members chose an Ad Hoc committee to review and make recommendations to the MHBG Plan.

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

IV. Narrative Plan

X. Enrollment and Provider Practices Including Billing Systems

Adult Mental Health Division

\$64,000 of the MHBG funds has been slated for Hawaii's providers. The AMHD plans to solicit the use of the funds in the following manner:

For Goods and Services:

- Invite providers to submit bids, or
- Submit sealed proposals

If the provider plans to use the funds for direct services then the service will be procured through:

- A request for information (RFI), and then
- By a request for proposal (RFP)

Child and Adolescent Mental Health Division

CAMHD is using the Resource and Patient Management System (RPMS) electronic health record system throughout its state system. The Resource and Patient Management System (RPMS) has achieved meaningful use compliance in other states. "Meaningful use" is an emerging set of federal standards to improve the safety, quality, and efficiency of health care. By upgrading to RPMS, CAMHD's system will be more compatible with other systems and will be able to engage in data sharing initiatives at the local level. The RPMS electronic health record provides immediate hands-on access to client data such as client progress notes across multiple disciplines, clinical measures and outcomes, provider treatment and progress summary data, and historical service utilization. The electronic health record system sends out automatic notifications on a regular basis. This allows for more informed decision-making, and ultimately increases the quality of care that youth receive. The RPMS system was recently updated to include a medication module. CAMHD has integrated Oracle Business Intelligence (OBI) in its computer system. These technological upgrades and improvements of the electronic health record allow CAMHD the ability to better monitor measurable objectives as defined by CAMHD's Workflow Procedures and Business Guidelines. Automated clinical notifications along with supporting Financial Cost Analysis provide a check and balance support structure to validate the effectiveness of the quality measures. Information that was previously unattainable can now be tracked and reported in a logical and timely fashion. This allows CAMHD to respond to client needs in a much more uniform and timely manner. The Family Guidance Center Branches can now tailor reports to meet their needs.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

IV. Narrative Plan

Y. Comments on State Plan

The AMHD will distribute the draft application to the Ad Hoc Committee of the Planning Council for review, comment, and provide recommendations to the AMHD and CAMHD Planners.

The draft application will be placed on each program's website with information on how community stakeholders can provide comments to the application.

The final application will be placed on each program's website with a newspaper ad soliciting comments. Comments received after the application is submitted will be uploaded into WebBGAS.