Hawaii

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/31/2015 10.39.58 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State DUNS Number

Number	809935679
Expiration Date	12/9/2015

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

Agency Name	Department of Health
Organizational Unit	Behavioral Health Administration
Mailing Address	P.O. Box 3378
City	Honolulu
Zip Code	96801

II. Contact Person for the Grantee of the Block Grant

First Name	Lynn
Last Name	Fallin
Agency Name	Department of Health, Behavioral Health Administrator
Mailing Address	P.O. Box 3378
City	Honolulu
Zip Code	96801-3378
Telephone	808-586-4416
Fax	808-586-4368
Email Address	lynn.fallin@doh.hawaii.gov

III. Expenditure Period

State Expenditure Period	
From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Judith
Last Name	Clarke
Telephone	808-453-6946
Fax	808-453-6997
Email Address	judith.clarke@doh.hawaii.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

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 II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II 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**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 OPMâ€™s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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 childrenâ€™s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to childrenâ€™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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II 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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Virginia Pressler, M.D.

Signature of CEO or Designee[1]: _____

Title: Director of Health

Date Signed: _____

mm/dd/yyyy

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

EXECUTIVE CHAMBERS

HONOLULU

DAVID Y. IGE
GOVERNOR

May 11, 2015

TO: Virginia Pressler, M.D.
Director of Health

SUBJECT: Designation of Signature Authority to the Director of Health for the Annual Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) Community Mental Health Block Grant Application

As the Director of the Department of Health, I hereby designate you as the State of Hawaii's signature authority for the Community Mental Health Block Grant Application that is submitted annually to the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. You are hereby authorized to sign all Funding Agreements, Certifications and Assurances that must be signed and submitted for the annual Community Mental Health Block Grant Application and related documents. This designation will remain in effect until such time as it may be rescinded.

DAVID Y. IGE
Governor, State of Hawaii

Signature of CEO or Designee[1]: Virginia Pressler

Title: Director of Health

Date Signed: AUG 28 2015

mm/dd/yyyy

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

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Footnotes:

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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

Title

Organization

Signature: _____ Date: _____

Footnotes:

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, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Step I. 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 Statutes[1], 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.

The publically funded system is only one part of the overall behavioral healthcare system in Hawaii. The Department of Human Services (DHS) also provides behavioral health services to individuals living with mental illness, in addition to other insurance companies and private funding.

Single Mental Health Authority (SMHA)

The Hawaii Department of Health, Adult Mental Health Division, is considered the single mental health authority. The authority is within the Behavioral Health Administration (BHA). Four

[1] Hawaii Revised Statutes §334-3

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 Purchase of Service providers through state procurement contracts. CAMHD and DDD provide direct and contracted services.

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, 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 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 includes clinical and administrative lines of authority and oversight responsibility under the leadership of the AMHD Administrator. The AMHD Chief of Psychiatry 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 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) Long Term Care. In this organizational context, Utilization Management and Performance Improvement are also considered part of the clinical lines.

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.

Opportunities for the clinician to gain an understanding of the person and for the person served to access the most appropriate mental health services; an assessment of the person's physical, psychological and social functioning status is conducted for admission to the AMHD. For individuals ages 18 and older who are seeking mental health services, the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 is used in assessing disability. 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. Services provided by county are:

CASE MANAGEMENT/SUPPORT SERVICES

1. **Community-Based Case Management (CBCM)**
   - Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

2. **Bi-Lingual Interpreter Services**
   - Island served: Oahu

3. **Representative Payee**
   - Islands served: Oahu, Hawaii, Maui

4. **Homeless Outreach**
   - Islands served: Oahu, Hawaii, Maui, and Kauai

5. **Peer Coach**
   - Islands served: Oahu, Hawaii, Maui, and Kauai

TREATMENT SERVICES

6. **Hospitals (Inpatient, General, Non-Forensic)**
   - Islands served: Oahu, Hawaii, Maui, and Kauai

7. **Specialty/State, Forensic**
   - Island served: Oahu (Hawaii State Hospital)

8. **Intensive Outpatient (IOP) Hospital**
   - Island served: Oahu

9. **Specialized Residential Treatment - Mental Health**
   - Islands served: Oahu, Maui

10. **Day Treatment:**
    - Islands served: Oahu, Maui

11. **Outpatient Treatment:**
    - Islands served: Oahu, Hawaii, Maui, Molokai, Lanai and Kauai

CRISIS SERVICES

12. **Crisis Line of Hawaii**
    - Islands served: Statewide

13. **Crisis Mobile Outreach (CMO)**
    - Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

14. **Crisis Support Management (CSM)**
    - Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

15. **Licensed Crisis Residential Services (LCRS)**
    - Islands served: Oahu, Maui, Hawaii

16. **Pre-Booking Jail Diversion**
    - Island served: Oahu

17. **Central Receiving Division Project**
    - Island served: Oahu

COMMUNITY HOUSING

18. **24 Hour Group Home**
    - Islands served: Oahu, Hawaii, Maui, and Kauai

19. **8-16 Hour Group Home**
    - Islands served: Oahu, Hawaii, Maui, and Kauai

20. **Semi-Independent Housing**
    - Islands served: Oahu, Hawaii, Maui, and Kauai

21. **Supported Housing/Bridge Subsidy**
    - Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

22. **Shelter Plus Care (S+C) for the Homeless**

- Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

23. **Transitional Housing, Safe Haven**
    - Islands served: Oahu, Hawaii, Maui

PSYCHOSOCIAL REHABILITATION SERVICES

24. **Clubhouse**
    - Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

25. **Transitional Employment (TE)**
    - Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

26. **Supported Education (SE)**
    - Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

27. **Supported Employment (SE)**
    - Islands served: Oahu, Hawaii, Maui, and Kauai

FORENSIC SERVICES

28. **Post-Booking Jail Diversion**
    - Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

29. **Hale Imua**
    - Island served: Oahu

30. **Community-Based Fitness Restoration**
    - Island served: Oahu

31. **Conditional Release Exit Support and Transition Program (CREST)**
    - Islands served: Statewide

OTHER SERVICES

32. **Expanded Adult Residential Care Home (E-ARCH)**
    - Island served: Oahu

Community Mental Health Centers

Effective with the state operated Community Mental Health Centers (CMHC) reorganization on July 1, 2015, each County CMHC is under the direction of a Public Health Program Manager. The managers ensure that the standards, service definitions, reporting requirements, and policies and procedures are implemented and followed by each CMHC. The 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 Public Health Program Managers, but are clinically supervised by the AMHD Chief of Psychiatry. Each CMHC also has 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. According to the 2014 State of Hawaii Data Book, Table 02.35, as of December 31, 2013, 3,000 individuals received mental health services from the CMHCs. There were 2,151 admissions, 1,797 were discharged for a total of 3,744 individuals served for the entire year.

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 210 filled beds as of August 25, 2015. 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. During 2013 Admission to HSH were 333[2] and 315 individuals were discharged with an overall number of 465 individuals served for the year.

AMHD's Contractual Relationships

In addition to contracts with fifty-two 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). Additionally, a Provider Manual and Provider Bulletin keep providers abreast of changes within the AMHD system. All providers are required to provide services that are culturally and linguistically appropriate for all recipients of behavioral health services.

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

[2] 2014 State of Hawaii Data Book, Table 02.34.

Roundtable for consumers provides an opportunity for consumers and family members to make their concerns and needs known to the AMHD Administrator.

Consumers continue to play an integral role in AMHD's Trauma Informed Care Initiative (TIC-IT) and 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 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 have been revised to include a fee schedule 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 2014, Hawaii held its first Forensic Peer Specialist Certification training. There were twenty-four participants, who had undergone the regular Peer Specialist training. 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 CMHCs statewide with the goal of being more accessible for consumers and families.

Services in Rural Areas

Services are provided in rural areas through the CMHCs, CMHC, satellite clinics, and the contracted purchase of service provider network. Counties consistently experience shortages of dentists, psychiatrists, psychologists, and social workers. 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.

Services for Special Populations

Mental Health Treatment in Jails and Prisons

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. Administrators from several organizations form the Interagency Council on Intermediate Sanctions Committee (ICIS). Members of the Committee include the DPS, the Judiciary, the Department of Health, the Department of Attorney General, the 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 reviewed 14 indicators which were derived from records on offenders who were sentenced to probation, released on probation and released from prison during the period of FY2009-2013. Of the 14 indicators, six were seen to show desirable trends based on the evidence-based practices used in Hawaii's criminal justice system. Results also indicated that there were significant declines in rearrests for new violators across offender risk levels.

Older Adults

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 2013 U.S. Census, approximately 63.2 percent are between the ages of 18 and 64. Census data show a projection that by 2030 one out of every five individuals in Hawaii will be age 65 or older.

Over the past 15 years, the reported incidents of fatal drug overdoses among Hawaii residents 60 or older have nearly quadrupled (Star-Advertiser, Addictions Leads to tragic ends, December 7, 2014). Through the Hawaii Needs Assessment Report[3], seniors were reported as having the most hospitalizations due to short-term complications of diabetes, mental health hospitalizations, and drug abuse. Specific needs of older residents due to misuse and abuse of powerful painkillers, anti-anxiety medications, and other pharmaceuticals are increasing sometime with deadly results. The AMHD in collaboration with the Office of Aging, and the

[3] HAH Healthcare Association of Hawaii, July 3, 2014.

Suicide Prevention Task Force will be collaborating in 2015 to address the needs of the aging population in the area of suicide prevention.

LGBTQ Community

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 not 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 2013 U.S. Census, approximately 77 percent of Hawaii's population belong 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 (COFA) 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 Report[4], 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 AMHD served approximately 10,408 for FY2014 of which 20 percent are Native Hawaiians and Pacific Islanders. 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.

Services to the Homeless

The number of homeless in Hawaii increased to its highest level in five years, which resulted in an increase of unsheltered homeless individuals, who now outnumber the sheltered. The Honolulu City Council approved a plethora of measures which they hope will lead to a decrease in the numbers of homeless individuals and families in areas that are popular with tourists. On Sept 16, 2014, a Sit Lie Bill was signed by the Mayor Kirk Caldwell. The bill prohibits individuals from sitting or lying down along public sidewalks in specified boundaries. If citations are given, the fine is up to $1,000 or 30-days jail time. The City and County have not only committed

[4] HAH Healthcare Association of Hawaii, Ethnic & Minority Data.

monies to create new affordable housing development and creative housing solutions for the homeless population statewide, but they have partnered with non-profit organizations such as non-profit developers and service providers to develop a niche in the provision of affordable housing and housing for special needs groups. The City and County is currently participating in the 25 cities initiative and Housing first joint efforts by the Veterans Administration (VA), The U.S. Department of Housing and Urban Development (HUD), the U. S. Interagency on Homelessness and local community partners.

Housing first is a nationally recognized best practice that is proven to be the most effective and efficient approach to getting chronically homeless people off of the streets. City, state, federal and service providers are aligning their funding and programmatic goals to efficiently and effectively bring homeless individuals and families into housing. Service providers visit clients in their homes and offer assistance with mental illness, substance abuse, job training, and other life skills until the person chooses to accept help. This is a radically different approach. They work through an effort called Hale 'O Malama, in conjunction with the Federal effort known as the 25 Cities Initiative.

The 25 cities initiative campaign has recognized 25 cities across the country with the highest rates of homelessness and engages community stakeholders to develop a plan to address the issue and work towards ending homelessness. The original focus was around homeless veterans but the campaign has broadened to recognize the chronically homeless population as well. Sponsored by HUD and VA, the group includes representation from HUD, VA, City and County of Honolulu, DHS, the state Public Housing Authority, the Department of Health's Alcohol and Drug Abuse Division (ADAD) (homeless services grant), AMHD, Protecting Hawaii's Ohana, Children, Under-served, Elderly and Disabled (PHOCUSED), Catholic Charities and the broad network of homeless services and housing providers on Oahu. All community partners are working together for the common goal of ending all homelessness by the year 2020.

According to the 2015 annual Point in Time Count (PIT) for Honolulu, Oahu's homeless population not only grew, but a higher percentage are living on the streets rather than in shelters. The latest PIT, conducted over a five-day period of January 25-30, 2015, shows that statewide 7,620 individuals were homeless, 60 percent were homeless individuals and 88 percent of homeless families were sheltered in an emergency or transitional facilities. Among the counties, only Kauai showed a decrease (56 percent) of homeless individuals living in emergency or transitional facilities. Maui had the highest percent of homeless family individuals (74 percent), and Hawaii Island had 62 percent homeless individuals. Overall, there were significant increases in each unsheltered category across the State. Table 2 below shows the number of unsheltered and sheltered homeless individuals by county from 2010-2015.

As the homeless population encampments rapidly increases in Honolulu, government officials have formed the Governor's Leadership Team on Homelessness[5] to work with social service agencies to find alternate housing for homeless individuals. The team is billed as high-level

[5] Honolulu Star-Advertiser, "Taking the Team Approach." July 28, 2015.

decision makers committed to tackling Hawaii's complex homelessness problems together at the city, state and federal level. The leadership team includes Hawaii Governor David Ige; Honolulu Mayor Kirk Caldwell; Honolulu City Council Chairman Ernie Martin; State Senator Jill Tokuda, State Representative Sylvia Luke (who lead the legislative money committees in their respective chambers); Rachel Wong, Director of the Department of Human Services, and representatives from the offices of the U.S. Senator Mazie Hirono and U.S. Senator Brian Schatz.

Table 2: Number of Homeless People in Hawaii[6]

County	Category	2010	2011	2012	2013	2014	2015
Oahu	Sheltered Homeless	2,797	2,912	3,035	3,091	3,079	2,964
	Unsheltered Homeless	1,374	1,322	1,318	1,465	1,633	1,939
	TOTAL	**4,171**	**4,234**	**4,353**	**4,556**	**4,712**	**4,903**
Maui	Sheltered Homeless	392	394	420	421	445	505
	Unsheltered Homeless	399	658	454	455	514	632
	TOTAL	**791**	**1,052**	**874**	**876**	**959**	**1,137**
Kauai	Sheltered Homeless	60	97	101	73	78	88
	Unsheltered Homeless	213	239	301	273	300	251
	TOTAL	**273**	**336**	**402**	**346**	**378**	**339**
Hawaii	Sheltered Homeless	286	229	170	160	211	220
	Unsheltered Homeless	313	337	447	397	658	1,021
	TOTAL	**599**	**566**	**617**	**557**	**869**	**1,241**
State	Sheltered Homeless	3,535	3,632	3,726	3,745	3,813	3,777
	Unsheltered Homeless	2,299	2,556	2,520	2,590	3,105	3,843
	TOTAL	**5,834**	**6,188**	**6,246**	**6,335**	**6,918**	**7,620**

[6] Homeless Point-in-Time Count, 2015, City and County of Honolulu.

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"[7] 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. In 2014, 840 consumers were served through the PATH Program, of which, 352 individuals were enrolled in AMHD to receive mental health services.

Veteran's Administration

The AMHD collaborates with the Federal Department of Veterans Administration (VA) quarterly to exchange ideas and information on assisting veterans who may be eligible for AMHD services. As the number of men and women returning home from Afghanistan and Iraq increases, mental health services availability for veterans continues to be a high profile issue. The AMHD provides returning veterans services free of charge. The State of Hawaii does not seek reimbursement from the federal government as state funds are expended for services free of charge.

The PATH program is a valuable resource in Hawaii for the VA veterans in Hawaii who receive benefits and pensions and utilize the VA primarily for dental care, hospitalization and physical

[7] 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."

health care. In many cases, due to the stigma of living with mental illness, veterans receive their mental health services through traditional community services rather than the VA.
The AMHD has a Memorandum of Agreement with the City and County of Honolulu, the VA and Kalihi-Palama Health Center to collaborate to provide services to homeless veterans and housing veterans with severe mental illness with co-occurring disorder or severe mental illness. Case managers have the experience and training to identify veterans with a history of PTSD or trauma. Linking veterans to a variety of supports and services such as Community Based Case Management are outreach case managers top priority.

The City and County continues to commit funds to create new housing solutions and affordable housing developments for the homeless veteran populations statewide. Honolulu is currently participating in the 25 cities initiative, a joint effort by VA, HUD and the U. S. Interagency on Homelessness and local community partners. Every 100-days, the 25 cities initiative campaign calls for at least 69 homeless individuals from placed into permanent supported housing. Continued participation with efforts such as 25 cities campaign and the 100-day plan helps to rebuild connections with other housing authorities where consumers could be housed given the appropriate levels of support. Subsequently, the 100-day efforts will continue to refine and set goals as each community partner collaborates and they will work together towards ending veteran homelessness by 2015.

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.

Medicaid[8]

The majority of Hawaii's 102,000 uninsured residents are eligible for Medicaid as part of an expansion of the program under the Affordable Care Act. Hawaii has expanded Medicaid coverage to residents earning up to 138 percent of the poverty level, or about $32,500 for a family of hour. With this change, 57 percent of the uninsured in Hawaii will qualify for the government insurance program. The State's 1974 Prepaid Health Care Act, which required employers to provide medical coverage for full-time workers, is credited with driving down the uninsured population in the islands.

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

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. The 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.

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.

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. 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 Services[9]:

- 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)
- 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 occurred 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.

[9] Med-QUEST Division Behavioral Health Protocol, 2013.

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, and the state's largest women's homeless shelter. 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. 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, which resulted in consumers in Hawaii reporting improvement in functioning from mental health treatment received in the public mental health system (81 percent) compared to the nation as a whole (70 percent), (2014 SAMHSA Barometer).

Trauma Informed Care

One of the strengths of AMHD is the Trauma Informed Care Initiative (TIC-IT). A trauma-informed system of care was established within the AMHD's community-based case-management agencies at the administrative, provider and consumer levels. At the administrative level, a formalized trauma-informed policy and procedure was implemented statewide; at the provider level, trauma-informed environments and infrastructures were created within eight of the community mental health centers and at twelve of the contracted providers of case management services, and at the consumer level, trauma-informed care was implemented in the care consumers received. 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 SPMI 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 has increased to 90% of 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 44 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. Education and Training continues to be provided to the care giver, their staff and the private pay RN case managers. 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 2013 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. 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.

Police Officers are trained to recognize individuals in crisis whether the person is mentally ill or emotionally disturbed. Police Psychologists work in collaboration, who are on call 24/7, provide consultation for the officers when a PIC is arrested. Additionally, Advanced Practice Registered Nurses (APRNs) are in the Central Receiving Division cellblock to assist individuals with SMI to provide physical and mental health screenings, first aid or emerging medical services and treatment when needed.

Currently 50%[10] of all the individuals who pass through the cellblock have severe mental illness, which means that of the 5,485 individuals with SMI that passed through the cellblock in 2013. Of those, 3,120 received some level of service from the APRN's. During 2013, the nurses dispensed 4,072 medications to 1,952 detainees. Of the 2,503 medications prescribed to detainees during 2013, 957 were psychotropic medications. The nurses were able to notify the case managers of all detainees that were identified as having AMHD services 67% of time, so that the case managers could assist their clients in navigating the criminal justice system and maintaining mental health services while they were in the criminal justice system. Data collected by the HEPSJDP continues to show that many individuals with mental illness are still being arrested and not receive mental health treatment. This results in an increase in severity of mental illness and leads to risk of harm to themselves, the general public and police officers.

[10] 2013 HEPSJDP Summary Report

Child & Adolescent Mental Health Division

The Hawaii State Department of Human Services, Med-QUEST Division (MQD) administers Hawaii's Medicaid and other health insurance programs. In FY2014, the Hawaii MQD expended approximately $2.1 billion (including $ 1.2 billion in federal funds) for benefits and administration of the state Medicaid program. The MQD provides health coverage through several Medicaid programs under Title XIX of the Social Security Act (SSA). The coverage includes the Hawaii QUEST Integration, Medicaid Fee-For-Service (FFS) programs and the State Children's Health Insurance Program (S-CHIP).

The State Children's Health Insurance Program (S-CHIP) was created to help states expand health coverage to more children whose parents may be working but do not earn enough to pay for private health coverage for their children. In Hawaii, SCHIP was implemented as a Medicaid expansion program.

At the close of FY 2014, the MQD was providing health care coverage to more than 325,510 eligible residents statewide. All islands, except Molokai, saw double-digit increases in the number of recipients and an overall increase of 11 percent% over the previous year. The MQD Eligibility Branch continues to actively work with community agencies and groups to ensure access to health coverage and problem resolution. The MQD accepts and processes applications throughout the year. If an applicant is not eligible for an MQD program, their application information is automatically sent to the Hawaii Health Connector (health insurance exchange). The Connector offers a variety of health plans and determines individual eligibility for tax credits and other help affording health insurance.

Community Care Services (CCS) Program. The QUEST Integration plan provides a full array of behavioral health services through the health plans for individuals over 18 years old. Adults with serious mental illness (SMI), serious and persistent mental illness (SPMI), who require support for emotional and behavioral development (SEBD), or who need additional specialized behavioral health services can access additional services through a carved out Community Care Services (CCS) program contract. Prior to the March 2013 implementation of the new CCS contract program, mental health services were fragmented between the DHS QUEST Integration plan, and the DOH Adult Mental Health Division (AMHD). With this new contract, services are provided through a single vendor making it easier for recipients and behavioral health providers to navigate the system. Medicaid recipients from AMHD and the QUEST plans that need specialized behavior health services have been transitioned to the new contractor. Upon meeting criteria for additional behavioral health services, an individual will have access to intensive case management, biopsychosocial rehabilitation, crisis management, crisis residential services, hospital-based residential services, intensive family intervention, intensive outpatient hospital services, and therapeutic living supports/foster care supports. The MQD added clubhouse, peer specialist, representative payee, supportive housing, and supportive employment services in March 2013. The assigned CCS case manager assures that patients have access to the behavioral health services they need.

For youth under 21 years old who require support for emotional and behavioral development, CAMHD is the MedQUEST carve out. CAMHD services include mental health evaluation; psychological and psychiatric assessments; intensive case management; individual, group and family therapy; intensive in-home therapy; Multisystemic Therapy; Functional Family Therapy; independent living skills; therapeutic respite home; transitional family home; community-based residential; partial hospitalization; hospital-based residential; medication management; ancillary services, and respite support. Recently CAMHD and MedQUEST began coordinating care on emerging adults with MedQUEST approving overlap of services in order to coordinate care during the transition process to CCS.

The MQD coordinates with health insurers to ensure that Medicaid QUEST Integration recipients who have other health insurance coverage exhaust those benefits and reimbursements before Medicaid pays for recipient services (Third Party Liability).

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.

The Hawaii Primary Care Association (HPCA) began the project in late 2012. Their tasks were to identify potential FQHCs and initiate two pilot integration projects. At the pilot sites, HPCA began to facilitate routine screening for children's mental health issues, coordinate the development of a consultation and referral system, provided training opportunities, and assisted 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 project was initiated at two other FQHCs. The project was successful in sharing some joint cases and providing psychiatric consultation and training in mental health issues.

CAMHD is now in the process of melding the two projects with the Hawaii Primary Care Association providing administrative and model support and UH JABSOM utilized primarily for clinical resources in a consultative model.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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 (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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 SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Step II. Needs and Gaps in the AMHD's Service System

In addition to the Uniform Reporting System (URS) data, the SAMHSA Mental Health Statistics Improvement Program (MHSIP), and the Quality of Life Assessment results to understand the needs of the adult system, the AMHD uses other reliable sources used to monitor and inform decision-making. For example, the 2014 SAMHSA-funded Behavioral Health Barometer and the prevalence rate are used to identify needs and gaps in services for the adult population to effectively measure quality and service utilization for system improvement.

The prevalence of serious mental illness and severe and persistent mental illness among adults against the numbers of individuals currently being served by AMHD is a good indicator to develop an estimate of unmet need.

Estimated Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) Prevalence among Adults by County, FY2014

Table 1: Adult Population, Prevalence and Treated Prevalence By County

County	Adult Population[1]		Estimated Adult Number of SMI[2] (5.4%)	Estimated Adult Number of SPMI[3] (2.6%)	Number SPMI Served[4]	Percent SPMI Served of SPMI Prevalence[5]
	Number	Percent	Number	Number	Number	Percent
Hawaii	151,440	13.6	8,178	3,937	2,383	60.5
Maui	126,721	11.4	6,843	3,295	1,478	44.9
Kauai	54,753	5.0	2,957	1,424	745	52.3
Oahu	778,203	70.0	42,023	20,233	5,802	28.7
Statewide	**1,111,117**	**100.0**	**60,001**	**28,889**	**10,408**	**36.0**

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%

[1] 18 years and above, Hawaii State Department of Business, Economic Development and Tourism. The State of Hawaii Data Book, Table 1.32 – Resident Population by Selected Age Groups by County: July 1, 2014.
[2] 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.
[3] 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.
[4] FY2014 Uniformed Reporting System Table 2A, Profile of Persons Served; Statewide and by County.
[5] Prevalence Rate Calculation, e.g., 10,408/28,889 = 36.0

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 1,419,561[6] persons statewide in 2014. Of these, 1,111,117 persons were 18 years of age and above. Application of the SPMI rate of 2.6% to 1,111,117 adults yields 10,408 adults. Of the 28,889 adults with SPMI, the AMHD served 10,408 adults (unduplicated) in FY2014. AMHD served 36.0 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. Between 2010 and 2014, Honolulu County has seen the greatest increase in population of 70 percent, followed by the Big Island (Hawaii County) with a 13.7 percent population increase, Maui County with 11.5 percent, and Kauai County with 5.0 percent increase. 2,382 individuals living with mental illness received services from AMHD.

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 194,190 based on the 2014 Hawaii Data Book. The total number of consumers served by AMHD in FY2014 is 2,383 with a prevalence rate of 60.5 percent.

Kauai County: In FY2014, 745 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 FY2014, 1,478 persons received AMHD services.

The preponderance of residency on O`ahu necessitates a larger proportion of services to be delivered within the City and County of Honolulu which must be balanced against provision of a comprehensive integrated system of care in all counties. Also of note, the AMHD system of care is only one part of the treatment system for adults with SPMI. Significant numbers of persons are also served through the private sector, Hawai`i's Pre-paid Health Insurance Act, and

[6] 18 years and above, Hawaii State Department of Business, Economic Development and Tourism. The State of Hawaii Data Book, Table 1.06 - Resident Population by Selected Age Groups by County: July 1, 2014.

government insurance programs including Medicaid, Medicare, and Med-QUEST. Due to the transition of many individuals to the Health Plans, only 9.6% of Hawai`i residents lack health insurance, and of this percentage, AMHD is responsible for providing mental health services to individuals with SMI. Based on the prevalence results, more behavioral health services is needed across the state and identifying resources and service deployments is critical for understanding and addressing behavioral health services.

Housing

As stated in Step 1, Hawaii's homeless population not only grew in 2015, but a higher percentage of individuals are living on the streets rather than in shelters. 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 need. For the AMHD population many consumers do not respond well in shelters. Based on outreach efforts, during FY2014, 840 individuals were served through this homeless outreach, of which 352 (42 percent) were enrolled in AMHD to receive mental health services. Many AMHD consumers have medical comorbidity, such as, diabetes and many 24-hour group homes will not accept these individuals who are insulin dependent. The AMHD is in the process of developing more Therapeutic Living Programs through contracts that have the nursing services component, and which will accommodate these individuals.

Staff are also monitoring the utilization of all group homes to move consumers through the housing continuum of care by implementing the Office of Health Care Assurances rigorous standards. This will avail more vacancies for the critically homeless individuals. For some AMHD consumers with personality disorders, living in group homes do not meet their needs and they do not do well in semi-independent type housing. As a result, AMHD staff are collaborating with the local Partners-in-Care to develop versatility in housing options to meet varied needs of the homeless populations.

Shortage of Psychiatrists

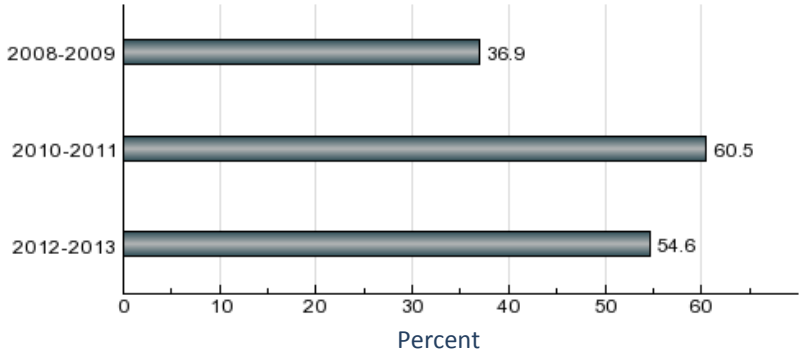
Hawaii has been experiencing an unprecedented shortage of psychiatrists in community mental health statewide, but especially in the rural areas. With higher salaries and benefits, psychiatrists are leaving the state system for more advantageous employment opportunities in the private sector. Another reason for the shortage of psychiatrists in Hawaii is that physicians are concerned about the inadequate reimbursement rate for Medicaid/Medicare populations and the high cost of living in Hawaii.

To address this deficiency, the AMHD is beginning discussions with the U.S. Department of Health and Human Services, National Health Service Corps (NHSC) to assist with recruitment and retention of clinicians and other licensed staff in identified designated mental health shortage areas. Individuals from the NHSC would make a commitment to work in these areas for two to three years.

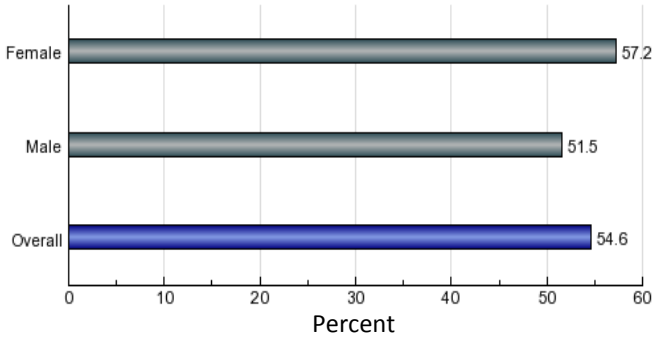
Other data that showed needs and gaps in the mental health system for adults is the Hawaii Health Matters Data Warehouse (provided by the Department of Health) which provides health objectives and targets that allow communities to assess health status and build an agenda for community health improvement. In Hawaii, 35,000 adults (3.5 percent of all adults) per year in 2009-2013 had a serious mental illness within the year being surveyed. Hawaii's rate of SMI among adults was similar to the national rate of 4.1 percent. However, among adults aged 18 or older only 30 percent received mental health treatment or counseling. This resulted in 54.6 percent, for which the target of 72.3 percent was not met (see tables below).

Effective September 1, 2014, the AMHD changed its eligibility criteria to expand its Category 1, Continuing Services by: 1) adding the following diagnoses: post-traumatic stress disorder, major depression, and substance induced psychosis, 2) developing specific eligibility criteria for individuals in Mental Health Court or Jail Diversion, and 3) adding specific screening codes for tobacco usage in its eligibility assessment to inform and plan for programs that address tobacco use within the mental health and substance abuse population.

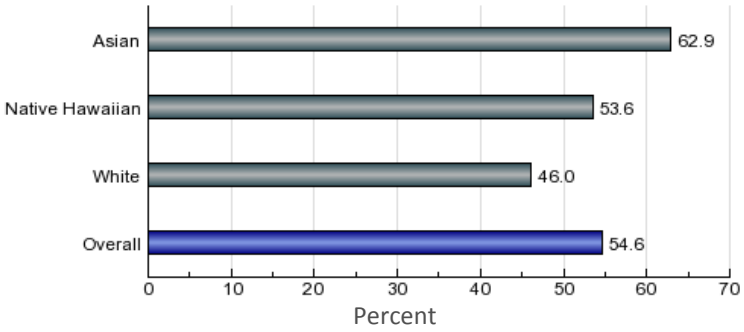
Adults with Serious Mental Illness who Received Treatment



Adults with Serious Mental Illness who Received Treatment by Gender



Adults with Serious Mental Illness who Received Treatment by Race/Ethnicity



Geriatric Mental Health

There is a need to address the unique needs of the older adult and/or geriatric mental health population. From inpatient care to community-based rehabilitation and support services, the aging population, which includes individuals 60 years old and above, have a growing need for biological and psychological dual care. Coordination of these aspects of care and addressing acute and chronic mental illness will continue to increase as the population ages.

The Hawaii State Department of Business, Economic Development and Tourism (DBEDT) data on population and economic projections estimates that by the year 2020, there will be approximately 382,799 older adults 60+ years old living in Hawaii. That population number increases to approximately 455,039 older adults in 2030, representing 28.4% of the of Hawaii's adult population. The Adult Mental Health Division (AMHD) serves approximately 1035[7] consumers 65 years old and older.

Availability of state and federal funding as well as resources including staffing and facility requirements are challenges that the Adult Mental Health Division (AMHD) continues to address. As an identified service gap within the AMHD's current service array, knowledge of potential partnerships within the area of long-term care is a priority. Agency partners such as the Hawaii State Department of Health, Executive Office on Aging (EOA) and the City and County Aging and Disability Resource Center (ADRC) will be included in the planning of geriatric mental health services. Advocates and stakeholders including legislators, non-profit organizations and corporations will also be included.

[7] Hawaii 2014 Uniform Reporting System (URS) Table 2A.

Child & Adolescent Mental Health Division

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 Center[8] estimated that in 2011-2012, 36,000 children in Hawaii have one or more emotional, behavioral, or developmental condition. According to the Centers for Disease Control and Prevention[9], 5.5% of children under age 18 in the United States experienced serious emotional or behavioral difficulties during 2011-2013. From data collected from a variety of data sources between 2005-2011, children aged 3-17 had: Attention-deficit/hyperactivity disorder (6.8%), 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).[10]

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 Program Improvement and Communications 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

[8] Retrieved August 7, 2015, from The Annie E. Casey Foundation, KIDS COUNT Data Center, http://datacenter.kidscount.org

[9] Centers for Disease Control and Prevention. Health conditions among children under age 18, by selected characteristics: United States, average annual, selected years 1997-1999 through 2011-2013. Available at: http://www.cdc.gov/nchs/hus/contents2014.htm#039

[10] Centers for Disease Control and Prevention. Mental health surveillance among children — United States 2005–2011. MMWR 2013;62(Suppl; May 16, 2013):1-35. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w

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 Central 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 Section maintains a database of sentinel events based on incident reports submitted by providers. The CAMHD Program Improvement and Communications Office (PICO) was responsible for merging and validating information from these databases.

In FY2014, CAMHD registered 2,225 youth into its system, with a subset of 1,337 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-one percent of the youth were served by the four community-based Family Guidance Centers on the most populous island of O'ahu. Eleven percent and ten 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 Center[11], 69% of Hawaii's children age 0-17 live on Oahu, 14% on the Big Island, 12% on Maui County and 5% on Kauai.

In 2010, KIDS Count reported that for the Big Island, 4.3% of the children under age 18 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.

In 2014, the average age for youth served by CAMHD dropped below 14 years, to 13.9 years. CAMHD has employed multiple strategies to increase early detection and intervention, which has slowly decreased the average age of admission. Sixty-two percent of the registered youth served at CAMHD are male, while 38% are female. The ethnic distribution is 61% Multi-racial; 14% White; 14% Native Hawaiian or Pacific Islander; 8% Asian; 1% Black or African-American and .3% American Indian or Alaskan Native. While the majority of youth present with co-morbid conditions, the most frequent primary diagnoses are disruptive behavior disorders (30%), 18.5% mood disorders, 19% attentional disorders, 12% anxiety disorder and 1% pervasive developmental disorders.

The Department of Education's School-based Behavioral Health program primarily serves youth with less intense needs while CAMHD serves the youth who are SED. During School Year 2013, 9,647 students received SBBH services. The distribution of youth who were registered with and received procured services through CAMHD in FY2014:

[11] Retrieved August 6, 2015, from The Annie E. Casey Foundation, KIDS COUNT Data Center, http://datacenter.kidscount.org

Geographic Region	Registered Youth	Youth with Procured Services
Honolulu	273	189
Central/Windward Oahu	320	214
Leeward Oahu	305	199
Hawai'i	801	464
Maui	248	180
Kauai	225	87
Family Court Liaison Branch	53	4
Statewide TOTALS	**2,225**	**1,337**

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

In the 2013 fiscal year, a large majority (70%) of the 13,639 individuals who received shelter and/or outreach services were served on Oahu, followed by Maui County (17%), Hawaii County (8%), and Kauai County (5%). Twenty five percent of the homeless are children, with 1,766 (13%) who were newborn to 5 years old, and 1,577 (12%) from 6 to 17 years old. Young adults age 18 to 24 years accounted for another 8% (1,154)[12]. According to the 2014 Statewide Homeless Point-in-Time Count, homelessness is growing and the percentage of those who live unsheltered is rising. During the 2009-2010 school year, the state Department of Education found a 71% increase from the year before in school children identified as homeless.

A University of Hawai'i Center on the Family study 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. Findings included:

- 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.

[12] Homeless Service Utilization Report – Hawaii 2013. University of Hawaii at Manoa, Center on the Family. Available at: http://uhfamily.hawaii.edu/publications/brochures/402d5_HomelessServiceUtilization2013.pdf

- 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 contracts with another provider to provide mental health services to homeless families on the Waianae Coast of the island of Oahu, an enclave of the Native Hawaiian community.

Trauma and Justice

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

Table CAMHD3. Psychiatric Disorders Among Youth in Juvenile Detention

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

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

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

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.

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 age of 14 years). 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

[13] 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.

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 sheet[14], the effects of stigma against gay, lesbian, bisexual, or transgender (GLBT) youth may make them more vulnerable to mental health problems such as depression, anxiety, substance abuse and suicide.[15] 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.[16] 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

[14] Bostwick, W.B., "Mental Health Risk Factors Among LGBT Youth" (Arlington: National Alliance on Mental Illness, 2007), available at http://www.nami.org.

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

[16] 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.

because of their gender expression.[17] 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.[18]

Recently, the Safe Spaces 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

CAMHD is continuing in its efforts to support parents in a model of participant-directed care. According to CAMHD's 2014 Consumer Survey findings, participation in their child's mental health treatment was the primary predictive factor in consumer satisfaction.[19] 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 newly appointed family support organization to represent families in the mental health system and whose parent partners engage parents in advocacy 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 new family support organization will need to develop accountability and evaluation systems and begin to pursue Medicaid reimbursement to sustain the organization.

The parent partners will 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

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[17] 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

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

[19] Cultural sensitivity was the second 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.

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.

Primary Care Integration

In 2013, CAMHD initiated two Primary Care Integration projects. The projects were designed to assess the receptivity of Federally Qualified Health Centers (FQHC) to partner with CAMHD to integrate behavioral health into primary care for the Medicaid-eligible pediatric population. Each project recruited two FQHCs and matched them to the corresponding CAMHD Family Guidance Centers to work with. The partners were encouraged to establish bi-directional communication and information sharing, and the FQHCs were encouraged to begin screening for emotional and behavioral challenges. Some of the sites make great progress in developing relationships and even shared cases. The model was designed to be a "curbside consultation" model, where the FQHCs could consult with Family Guidance Center staff (child psychiatrists, child psychologist and mental health care coordinators) about specific situations. In addition to the consultative goal, capacity building was also a goal. Training was provided to primary care clinicians, as well as adult behavioral specialists, about managing mild to moderate pediatric cases and appropriate use of psychotropic medications. Through the partnerships, a small number of cases were referred to CAMHD for more intensive mental health services.

After two years of the pilot project stage, and based on the results and feedback, CAMHD is considering re-organizing the projects to maximize the best attributes of the two contractors. Block grant funds will continue to support the evolution of the two primary care projects.

First Episode Psychosis

In late 2014, CAMHD contracted with the University of Hawaii Department of Psychology to develop a Coordinated Specialty Care Program. Advantageous to Hawaii was the University's recent hiring of a clinician with experience with First Episode Psychosis. During the past few months, the University of Hawaii has focused on developing the policies, procedures and protocols into an Operational Manual and training staff on the evidence-based model. The University also successfully applied for Institutional Review Board approval. It is anticipated that the Coordinated Specialty Care program will begin offering services as early as this fall. On this initiative, the Hawaii Department of Health is dedicating an ever-increasing proportion of Block grant funds to support this very needed level of service.

Public Health Education and Promotion

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. 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.

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 national Children's Mental Health Awareness Week, and at the annual Keiki (Child) Caucus-sponsored 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."

The self-reported prevalence for considering, planning and attempting suicide of Hawaii students was greater than that for the US for all survey (odd) years between the periods of 2005-2013. 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 disparate health information systems. Electronic Health Records and Data Systems, and increasing usage of Telehealth were significantly identified as key initiatives in CAMHD's current and previous strategic plans. CAMHD seeks to develop interoperable, linked data systems with the ability to provide real-time data that shows

standard metrics and youth progress on longitudinal outcome measures. 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. Providers only currently get summary data from CAMHD twice per year on the services, characteristics, and outcomes of their youth. There is additionally 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 CAMHD is engaging in EHR and systems planning with the goals of including all providers and their information sets in the data systems. The future vision is for all CAMHD providers and clinical and administrative staff to have role-appropriate access to daily-updated metrics and data dashboards for improving patient care. Providers are to have the ability to document in CAMHD's EHR or submit structured data from their systems through interoperability solutions. CAMHD clinicians, care coordinators, providers, program administrators, financial and quality assurance staff, are to have different data dashboards available to them based on functional roles. CAMHD is engaged in a robust strategic business, data, and IT systems planning and implementation initiative to enable this functional change in operations to a data-driven ecosystem. A considered technical architecture of data systems providing EHR, enhanced care management utility, data interoperability and information exchange, structured data warehousing, analytics tools, data dashboards, metrics and reporting, is planned. The net result of this more connected environment is strategically calculated to increase the visibility and availability of near-real time data for those making and monitoring patient care and program decisions. The goals of this initiative align with CAMHD's reorganization, and are to allow increased time-sensitive information for a focus on clinical services delivery and outcomes measurement.

The ability to be highly responsive to changes in fiscal and services utilization areas also requires efficient, rationalized EHR and data systems. There is a need to centralize, restructure, and integrate disparate datasets and metrics on care processes and outcomes in a set of interoperable IT systems so authorized users can analyze data on a highly configurable, as-needed basis. While CAMHD has already developed some basic Electronic Health Record infrastructure, advanced planning, development, and implementation is needed to create systems that serve up the information required for the clinical, program, program integrity, financial, and quality assurance needs of CAMHD and the population it serves.

The Block Grant has supported the development of CAMHD's Telehealth systems, which are now used very heavily operationally for clinical sessions between guidance center sites, providers, and associated clinical staff. 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. The telehealth model as demonstrated has exhibited significant utilization and successes. As such CAMHD continues to expand and refine the telehealth solutions available for clinical use, including planning for capacity development and augmentations to ease of use.

CAMHD is continuing to utilize block grant funds to advance technological innovations into a sophisticated solution suite that provide time-sensitive information for data-driven clinical decision making, and supports increased use of evidence-based care, and development of further promising practices.

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 are improving the quality of client care by being more directly involved in individual cases and encouraging more use of evidence based services. The enhanced data and reporting environment is planned in part to incorporate the evidence-based goals of CAMHD.

As CAMHD further refines its staff responsibilities and workflow into a more clinically-driven decision-making system, CAMHD will dedicate block grant funds to training and education so that the mental health workforce will have the skills and tools to provide the best possible care.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

Adult Mental Health Division

1. **Briefly describe the state's data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider and /other levels).**
   The AMHD Management Information System (MIS) team collects client, program and provider level data through the use of Interactive Communication Technologies. The AVATAR and eCURA systems are used to collect unduplicated client level data. The data reporting systems collect client data containing demographic data, services provided, and information for federal and state reporting, such as Treatment Episode Data Set (TEDS), Block Grant Reports and the Uniform Reporting Systems tables.

2. **Is the states' current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g. Medicaid, child welfare, etc.)**
   The data collected in the reporting system is specific to only mental health services clients. This data is collected for the four community mental health centers and for AMHD's contracted purchase of service providers.

   The System Improvement Project (SIP) was initiated in 2011 to achieve system and operational improvements within the AMHD Managed Care Administration, i.e. billing, claims process, utilization management and electronic medical records. The goals of the project is to transition to a single platform for core business functions that will result in improved efficiency of administrative oversight and clinical care while reducing overhead expenses. Another goal of the project is to transition to HIPAA 5010 transaction format and ICD-10 diagnosis and procedure codes by October 2015 that will result in improved Federal and State compliance with regulatory and contractual requirements.

   The AMHD plans to implement Netsmart's Consumer and Provider Connect web-based applications. The plan is to capture quality and outcome information through building data capture screens and training staff in its usage. This project began as part of the Trauma-Informed Care Grant where providers enter assessment information into the system. Plans are in place to expand the program to include the Quality of Life Inventory and to measure acuity levels for consumers.

3. **Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?**
   Yes, through the AVATAR and eCura data systems the MIS staff is able to collect client level data with a unique identifier that does not identify the client by name.

   AMHD is expanding the use of tele-psychiatry services to rural areas with an initial focus on the neighbor island. Due to geographic distances and air travel required between

islands, both scheduled and unscheduled psychiatry services are provided more effectively and efficiently between the consumer and the physician.

4. If not, what changes will the state need to make to be able to collect and report on these measures?
N/A

Child & Adolescent Mental Health Division

1. Briefly describe the state's data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider, and/or other levels).

CAMHD has developed a broad statewide data collection and reporting structure that can provide a predefined list of reports at the client, program, provider, and statewide levels. As of this past fiscal year, CAMHD is able to provide client-level data on all of the fields required by the BHSIS state contracts. However, CAMHD has been in transition to a new Electronic Health Record (EHR) system that currently maintains clinically-related data at the client level. This system is planned to expand to incorporate more information such as registration, demographic and billing data. A separate, more useable case management tracking and data reporting system is currently in the planning stages for data monitoring and structured information management. This structured data management and data reporting system is planned to increase the effectiveness of storing, managing, analyzing, and viewing data. The system is to incorporate dashboards and custom configurable reports on detailed CAMHD trend information such as service utilization, service metrics, cross-program data elements, and patient outcomes, and to provide comprehensive care systems reporting capability. Thus, CAMHD is able to meet all current reporting requirements, and anticipates a period of transition onto new systems over the next 1 to 2 years. The expected result of this transition is to incorporate rapid-cycle information feedback on youth services and trends, via role-based dashboard and report formats to line staff and administrators. The goals of this project are to foster a data-driven culture of service improvements for CAMHD youth. CAMHD reports at the conclusion of this project are to incorporate standardized quality metrics such as National Behavioral Health Quality Framework NBHQF metrics, and local service process and outcome metrics, in alignment with national initiatives for health systems measurement and improvement.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

CAMHD's system is specific to mental health services clients and includes substance abuse if it is a secondary diagnosis. The Department of Health's Alcohol and Drug Abuse Division manages the substance abuse prevention and treatment services, and maintains their own substance abuse data system. Future data systems are planned to incorporate an extensible, cross-

program data architecture, with system interoperability a core tenet to increase appropriate access to structured data and metrics across client-serving programs, groups, and services.

3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?

CAMHD is currently unable to collect and report on any of the draft measures except for Living Situation and Homelessness in the past 30 days. CAMHD collects data similar to the Average Daily Attendance draft measure, but instead collects whether the youth attended any school in the past 30 days. These data are currently being collected on a monthly basis through the administration of the Ohio Scales assessment tool.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Major system efforts will need to be undertaken at the Department and cross-Department levels to obtain necessary agreements and assurances for CAMHD to access data from other State agencies and divisions, in Education, Human Services (Medicaid), Juvenile Justice, Alcohol and Drug Abuse, and primary care. The CAMHD system modernizations planning process includes technical architecture interoperability mechanisms to securely incorporate and manage cross-program data, as it becomes available. CAMHD is engaged in planning efforts to pilot data sharing across other CAMHD-patient-serving entities within the State of Hawaii. Significant forces would be necessary to permit data sharing projects with all the above agencies, however current efforts are seeking to pilot initiatives in this area as a proof of concept. Interagency MOA are to be required between the Department of Health (CAMHD, AMHD, and Substance Abuse); Department of Human Services (Medicaid, Child Welfare Services, and Office of Youth Services); Courts (Juvenile Justice); and primary care (Community Health Centers, private providers). Based on CAMHD attorney general counsel, certain existing MOA among agencies may allow for more accelerated signing of Data Sharing Agreements and information sharing on cross-program metrics.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

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: MHS

Population(s): SED

Goal of the priority area:

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of mental health assessments to court-encumbered juveniles

Baseline Measurement: 30 mental health assessments

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

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

Data Source:

Narrative reports from the First Circuit Court combined contract (includes Girls Court and Juvenile Drug Court)

Description of Data:

Report on number of mental health assessments

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of homeless youth outreach contacts

Baseline Measurement: 2,000 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:

Narrative reports from Hale Kipa's YO! Program

Description of Data:

Number of youth outreach contacts

Data issues/caveats that affect outcome measures::

Priority #: 2

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth screened for emotional or behavioral challenges in primary care settings

Baseline Measurement: No uniform data available at this time

First-year target/outcome measurement: Uniform or comparable screening data will be collected

Second-year target/outcome measurement: Baseline measure to be determined

Data Source:

Narrative and numeric reports from the Hawaii Primary Care Association's annual report

Description of Data:

Number of youth screened for emotional or behavioral challenges at the FQHCs

Data issues/caveats that affect outcome measures::

Priority #: 3

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of persons enrolled in the First Episode Psychosis Program

Baseline Measurement: None available at this time

First-year target/outcome measurement: To be established

Second-year target/outcome measurement: To be established

Data Source:

Narrative and numeric reports from the University of Hawaii, Department of Psychology First Episode Psychosis Program

Description of Data:

Number of enrolled

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: To improve the effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services statewide

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of CAMHD staff trained in evidence based and effective behavioral health promotion, treatment and recovery support services

Baseline Measurement: In 2015, 150 CAMHD staff were trained in evidence-based and effective behavioral health promotion, treatment and recovery support services

First-year target/outcome measurement: 100 CAMHD staff will undergo training in evidence-based and effective behavioral health services

Second-year target/outcome measurement: 100 CAMHD staff will undergo training in evidence-based and effective behavioral health services

Data Source:

CAMHD training attendance logs and training requests

Description of Data:

Number of CAMHD staff who underwent evidence-based behavioral health training

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Employment: Persons with SMI who are employed.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Re-establish relationships with community partners involved in employment activities for adults with SMI.
Increase the number of consumers with SMI to be gainfully employed.

Objective:

Promote a recovery-oriented service system that includes coordinated treatment, recovery support services, and employment opportunities.

Strategies to attain the objective:

Conduct a Supported Employment Readiness Assessment.
Conduct Chart Reviews.
Review the State's data on employment.
Re-connect with and collaborate with the Vocational Rehabilitation Program at the University of Hawaii to provide supported employment consumer trainings.
Set goals with the provider agency to provide more opportunities for consumers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of persons with SMI who are employed.
Baseline Measurement:	According to the 2014 URS Tables, only .8% of AMHD consumers served were employed.
First-year target/outcome measurement:	Increase the number by 5%.
Second-year target/outcome measurement:	Increase the number by 5%.

Data Source:

The Uniform Reporting System (URS) Tables.
Client Level Data
MHSIP Survey
Quality of Life Assessment Data

Description of Data:

According to the Hawaii Health Matters Dashboard the target for 2020 of the number of individuals with SMI who are employed is 61.6%.

Data issues/caveats that affect outcome measures::

Providers not completing the QOLI Assessment every 6 months or upon a consumer's discharge from AMHD services.

Priority #:	6
Priority Area:	Treatment: Consumers 18 years and older with serious mental illness.
Priority Type:	MHS
Population(s):	SMI

Goal of the priority area:

Increase the proportion of adults aged 18 years and older with serious mental illness who received treatment in the past 12 months.

Objective:

To increase the number of adults with SMI to become eligible for AMHD services.

Strategies to attain the objective:

Develop a media campaign to attract individuals who may need mental health services.
Restart the Consumer Speakers Bureau where consumers share their story with community audiences.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of individuals living with mental illness to become eligible for mental health services.
Baseline Measurement:	The current target is 72.3 percent
First-year target/outcome measurement:	The 2013 data reflect 54.6 percent of eligible individuals living with mental illness receiving mental health services

Second-year target/outcome measurement: Increase the data by 5% for the second year.

Data Source:

The Uniform Reporting System tables.
Data Through the MHSIP Survey.

Description of Data:

Through client level data that is required by SAMHSA.

Data issues/caveats that affect outcome measures::

Inaccurate information entered in AVATAR during registration.

Priority #: 7

Priority Area: Homelessness: Adults 18 years and older

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Reduce the number of individuals with mental health challenges living on the streets.

Objective:

Increase the number of homeless individuals receiving mental health services.
Provide or assist homeless individuals with appropriate housing and/or shelters.

Strategies to attain the objective:

Conduct Chart Reviews.
Provide more educational materials for homeless outreach.
Encourage outreach workers to enroll more individuals into AMHD services.
Set goals for providers in their outreach effort.
Learn more about the Voucher Program to assist consumers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of homeless persons aged 18 years and older with mental health problems to receive mental health services.

Baseline Measurement: The 2006 baseline was 37%; the target for 2020 is 41%

First-year target/outcome measurement: Increase the baseline measure by 10%.

Second-year target/outcome measurement: Increase the baseline measure by 10%.

Data Source:

The State of Hawaii Homeless Management Information System.
The Projects for Assistance in Transition from Homelessness (PATH) Data Exchange.
The Uniformed Reporting System.

Description of Data:

The State of Hawaii HMIS system is now functional and outreach workers are fully engaged in entering the data into the system.
The AMHD PATH providers are required to enter the number of individuals that they enroll into mental health services.

Data issues/caveats that affect outcome measures::

Homeless providers within the AMHD system of care are required to enter data per their contracts.

Priority #: 8

Priority Area: Treatment: Older Adults, 60+

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the number of older adults 60+ who receive mental health treatment.

Objective:

To plan for mental health services for the 60+ population.

Strategies to attain the objective:

Hire a Long-Term Care Coordinator.
Complete a Needs Assessment to identify level of care for individuals 60+.
Collaborate with hospitals, community groups that serve the senior population.
Collaborate with the Office on Aging to identify senior individuals that may meet AMHD criteria.
Develop a media campaign to attract the senior population that need mental health services.
Attend the Senior Fair to distribute AMHD brochure and other materials on mental health services.
Use the SAMHSA Toolkit for the Aging Population.
Identify and determine AMHD 60+ population that are medically fragile.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Identify and determine the number of senior adults who may need mental health services.

Baseline Measurement: Establish baseline after the Needs Assessment is completed.

First-year target/outcome measurement: To be determined after baseline is established.

Second-year target/outcome measurement: To be determined after baseline is established.

Data Source:

Uniform Reporting System.
Client Level Data.

Description of Data:

Data will be attained from the Statewide Needs Assessment.

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: Smoking Cessation: Adults living with mental illness.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Promote community-based efforts to reduce tobacco usage among consumers through education, policy, development, and advocacy.

Objective:

Reduce the smoking status of the adult population in Hawaii with severe and persistent mental illness.

Strategies to attain the objective:

Refine and expand the AMHD facility-based tobacco free environment policy.
Expand the tobacco treatment and assessment policy.

Develop legislative proposal that all healthcare facilities/campuses will be tobacco and smoke free.
Train consumers/Peer Support in Brief Intervention Training.
Create a mental health/tobacco cessation training hui.
Develop a Point-In-Time Provider Survey for Smoking Cessation.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Reduce the number of adults with SMI who currently smoke.
Baseline Measurement:	40.8% of the Adult Population in Hawaii with SMI currently smoke.
First-year target/outcome measurement:	Reduce the smoking status of consumers by 6.8%.
Second-year target/outcome measurement:	The target is for smoking cessation to be reduced by 34% in the year 2020.

Data Source:

Data from Hawaii's Leadership Academy.
Uniform Reporting System.
Client Level Data.

Description of Data:

Since 2014, the AMHD is now capturing tobacco usage in the Clinical History Evaluation during eligibility assessments.

Data issues/caveats that affect outcome measures::

Errors in data entry.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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			$0	$0	$52,941,867	$0	$0
6. Other 24 Hour Care		$175,000	$5,825,755	$0	$50,488,595	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$1,616,926	$11,937	$394,695	$46,840,293	$0	$0
8. Mental Health Primary Prevention**		$30,000	$0	$32,754	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$255,048	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$281,474	$1,557,255	$2,045,815	$19,181,817	$0	$0
13. Total	$0	$2,358,448	$7,394,947	$2,473,264	$169,452,572	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

$10,243.00 MHBG funds in Column B for CAMHD is not yet assigned.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	$230,000
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	$120,000

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
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	$635,000
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$337,897
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	$370,000
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	$150,000
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$20,000
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
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	$200,000
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$20,000
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$285,794
Total	$2,368,691

Footnotes:

$10,000 Public education activities
$175,474 IT Technical Assistance
$13,800 Provider Business Practices
$26,000 Workforce Development
$20,200 State Council support
$40,320 Network of Care Contract

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	$210,320
MHA Planning Council Activities	$20,200
MHA Administration	$92,000
MHA Data Collection/Reporting	$229,118
MHA Activities Other Than Those Above	$10,000
Total Non-Direct Services	$561638

Comments on Data:

$13,800 Provider Business Practices

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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 charged with coordinating 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 consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. The Health Care System and Integration

Adult Mental Health Division

Beginning in January 2014, Medicaid-eligible individuals with a diagnosis of SMI/SPMI and who are enrolled in the behavioral health system began receiving mental health services through the Community Care Services (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 State Insurance Commissioner's Office.

The State Insurance Commissioner is responsible for full regulatory jurisdiction over the Health Plans and the Hawaii State Department of Commerce and Consumer Affairs (DCCA) also play a role in the monitoring process. The AMHD has supported the enactment of legislative efforts to convene a working group or task force to be composed of representatives from the State House or Representatives and Senate; the Directors of designees from the Departments of Human Services, Health and Public Safety; the Hawaii Paroling Authority; the Hawaii Psychiatric Medical Association and other members from the community. The working group would be charged with: reviewing and recommending policy changes to publicly-funded services for substance use disorders; exploring approaches for integrating healthcare with addiction treatment; ensuring publicly-funded substance treatment and mental health services are available and accessible to subpopulations; and determining the level of resources needed to improve outcomes.

The DCCA and the Regulated Industries Complaints Office protects consumers' insurance interests by investigating "violations" of state consumer protection laws to stop unfair or deceptive practices in the market place and promoting consumer education and awareness. The office works to ensure that consumers are provided with insurance services which meet acceptable standards of quality, equity and dependability at fair rates by enforcing laws and consumer protection.

In June 2013, the DOH entered into a collaborative agreement with Kalihi-Palama Health Center (KPHC), a private, non-profit, Federally Qualified Health Centers (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 Hawaiʻi 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 Hawaiʻi 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 Hawaiʻi Project services began in January 2014.

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

In 2006, the Hawaiʻi State Legislature passed Act 295 (Hawaiʻi 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 Hawaiʻi. 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.

The AMHD has also begun the Hawaii Leadership Academy for Wellness and Tobacco Cessation Program. In December 2014, the AMHD held a summit in partnership with SAMHSA to design an action plan for Hawaii to reduce smoking and nicotine addiction among individuals with mental illness and addictions and to create an environment of collaboration and integration among the fields of public health (including tobacco control and prevention), mental health and substance abuse services. Participants in the summit represented state, and local agencies, including mental health, addictions, consumer, community services, non-profit, academic, and chronic disease prevention organizations. At the end of the summit, Hawaii's partners adopted three baseline measures on the following data: 1) The smoking rate of the adult population in Hawaii with frequent mental distress is 24 percent; 2) The smoking rate of the adult population in Hawaii with severe and persistent mental illness (SPMI) is 40.8 percent; and 3) The smoking rate of adult population in Hawaii who are heavy drinkers is 33 percent. The partners set a target of five percent reduction by 2020 for the frequent mental distress and heavy drinking baseline measures, and a 6.8 percent reduction by 2020 target for the SPMI measure. Smoking cessation classes, patches and gum will be made available to consumers shortly.

Finally, in the Peer Specialist Certified trainings, Wellness Recovery Action Planning is offered, which encompasses quit smoking using peer support along with other wellness oriented activities.

Child & Adolescent Mental Health Division

The Hawaii State Department of Human Services, Med-QUEST Division (MQD) administers Hawaii's Medicaid and other health insurance programs. In FY 2014, the Hawaii MQD expended approximately $2.1 billion (including $ 1.2 billion in federal funds) for benefits and administration of the state Medicaid program. The MQD provides health coverage through several Medicaid programs under Title XIX of the Social Security Act (SSA). The coverage includes the Hawaii QUEST Integration, Medicaid Fee-For-Service (FFS) programs and the State Children's Health Insurance Program (S-CHIP).

The State Children's Health Insurance Program (S-CHIP) was created to help states expand health coverage to more children whose parents may be working but do not earn enough to pay for private health coverage for their children. In Hawaii, SCHIP was implemented as a Medicaid expansion program.

At the close of FY 2014, the MQD was providing health care coverage to more than 325,510 eligible residents statewide. All islands, except Molokai, saw double-digit increases in the number of recipients and an overall increase of 11% over the previous year. The MQD Eligibility Branch continues to actively work with community agencies and groups to ensure access to health coverage and problem resolution. The MQD accepts and processes applications throughout the year. If an applicant is not eligible for an MQD program, their application information is automatically sent to the Hawaii Health Connector (health insurance exchange).

The Connector offers a variety of health plans and determines individual eligibility for tax credits and other help affording health insurance.

Community Care Services (CCS) Program. The QUEST Integration plan provides a full array of behavioral health services through the health plans for individuals over 18 years old. Adults with serious mental illness (SMI), serious and persistent mental illness (SPMI), who require support for emotional and behavioral development (SEBD), or who need additional specialized behavioral health services can access additional services through a carved out Community Care Services (CCS) program contract. Prior to the March 2013 implementation of the new CCS contract program, mental health services were fragmented between the DHS QUEST Integration plan, and the DOH Adult Mental Health Division (AMHD). With this new contract, services are provided through a single vendor making it easier for recipients and behavioral health providers to navigate the system. Medicaid recipients from AMHD and the QUEST plans that need specialized behavior health services have been transitioned to the new contractor. Upon meeting criteria for additional behavioral health services, an individual will have access to intensive case management, biopsychosocial rehabilitation, crisis management, crisis residential services, hospital-based residential services, intensive family intervention, intensive outpatient hospital services, and therapeutic living supports/foster care supports. The MQD added clubhouse, peer specialist, representative payee, supportive housing, and supportive employment services in March 2013. The assigned CCS case manager assures that patients have access to the behavioral health services they need.

For youth under 21 years old who require support for emotional and behavioral development, CAMHD is the MedQUEST carve out. CAMHD services include mental health evaluation; psychological and psychiatric assessments; intensive case management; individual, group and family therapy; intensive in-home therapy; Multisystemic Therapy; Functional Family Therapy; independent living skills; therapeutic respite home; transitional family home; community-based residential; partial hospitalization; hospital-based residential; medication management; ancillary services, and respite support. Recently CAMHD and MedQUEST began coordinating care on emerging adults with MedQUEST approving overlap of services in order to coordinate care during the transition process to CCS.

The MQD coordinates with health insurers to ensure that Medicaid QUEST Integration recipients who have other health insurance coverage exhaust those benefits and reimbursements before Medicaid pays for recipient services (Third Party Liability).

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.

The Hawaii Primary Care Association (HPCA) began the project in late 2012. Their tasks were to identify potential FQHCs and initiate two pilot integration projects. At the pilot sites, HPCA

began to facilitate routine screening for children's mental health issues, coordinate the development of a consultation and referral system, provided training opportunities, and assisted 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 project was initiated at two other FQHCs. The project was successful in sharing some joint cases and providing psychiatric consultation and training in mental health issues.

CAMHD is now in the process of melding the two projects with the Hawaii Primary Care Association providing administrative and model support and UH JABSOM utilized primarily for clinical resources in a consultative model.

Overview of Behavioral Health Service Delivery in Medicaid

	QUEST Integration	AMHD	CCS	CAMHD
Standard Behavioral Health Services				
Acute Psychiatric Hospitalization	HP	HP	CCS	HP
Evaluation and Management	HP	HP	CCS	CAMHD/ HP
Methadone Treatment	HP	HP	CCS	HP
Prescription Medications	HP	HP	CCS	HP
Substance Abuse Treatment	HP	HP	CCS	HP
Transportation	HP	HP	CCS	HP
Specialized State Plan Behavioral Health Services				
Biopsychosocial Rehabilitation	n/a	AMHD	CCS	n/a
Community Based Residential Programs	n/a	n/a	n/a	CAMHD
Crisis Management	n/a	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	AMHD	CCS	CAMHD
Therapeutic Living Supports /Therapeutic Foster Care Supports	n/a	AMHD	CCS	CAMHD
Clubhouse	n/a	AMHD	CCS	n/a
Peer Specialist	n/a	AMHD	CCS	n/a
Representative Payee	n/a	AMHD	CCS	n/a
Supportive Employment	n/a	AMHD	CCS	n/a
Supportive Housing	n/a	AMHD	CCS	n/a

Legend:

AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. 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, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and 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. 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. For states to address the potentially disparate impact of their block grant funded efforts, they will 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).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. 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 National Standards for Culturally and Linguistically Approved Services (CLAS) in Health and Healthcare are used in developing policy to advance health equity, improve quality, and help to eliminate healthcare disparities by establishing a blueprint for the Division. 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 Wellness Recovery Action Plan 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.

The AMHD collects and reports on a variety of information relevant to the state' behavioral health system including access, enrollment in services, types of services received, and outcomes by race, ethnicity gender and age. This information is collected through the AVATAR system which also includes clinical and service data from the four Community Mental Health Centers (CMHCs) and from other contracted community-based providers.

As Hawaii gets more organized in collecting homeless data through the Homeless Management Information System (HMIS), community providers will be in a better position to collect data geographically and demographically. The data from the 2014 Hawaii Annual PATH Report will be used to identify individuals served and underserved that were enrolled in the PATH program. This data is a good indicator for outreach efforts in Fiscal Year (FY) 2015.

In the FY2014 AHAR to Congress, 58 percent of homeless veterans were living in unsheltered locations. The low rate of enrollment (data above) for veterans (7%) receiving Adult Mental Health Division (AMHD) services is cited as the highest percentage of disparity for this population and the LGBT (0%) population. Consequently, outreach efforts by providers will be more focused on these populations. In addition, with the passage of the Hawaii Marriage Equality Bill, which legalized same-sex marriage, and which was enacted November 15, 2013, Hawaii's LGBT population may feel more comfortable in self-identifying their sexual orientation and gender identity when accessing mental health services. The AMHD will collaborate with Purchase of Service providers to add demographic information on their screening and outreach service forms to identify these individuals.

The following performance indicators and monitoring questions will be required of all AMHD providers during the next 6-months of FY2015 to develop goals and monitor progress:

a) The number and percent of homeless persons contacted through outreach and enrollment that are identified as veterans and LGBT.
b) The number and percent of veterans receiving behavioral health services through AMHD.
c) The number and percent of providers currently collecting LGBT demographic information.
d) Is there evidence that an agency staff development program is in place, and the number and percent of staff members trained in cultural competence?
c) Are there policies and procedures in place that state how staff providing services to the target population will be sensitive to age, gender, racial/ethnic differences, and sexual orientation.

Through collaboration with providers, programmatic strategies will be implemented at the state and local level to ensure adherence to the CLAS Standards for this population to receive culturally-based services and treatment. For instance, PATH providers will be encouraged through performance improvement standards and training to be responsive to an individual's racial and ethnic cultural traditions, beliefs, and values, and primary language. As part of the assessment, diagnosis, and treatment planning (e.g., during the outreach and intake processes, the following will be emphasized:

a) A systematic review of the consumer's cultural background;
b) The role of the cultural context in the expression and evaluation of symptoms;
c) Develop culturally sensitive self-assessment tools for consumer evaluation;
d) The effect that cultural differences may have on the relationship between the consumer and the outreach worker; and
d) A formulation on how cultural considerations specifically influence diagnosis and treatment.

To ensure culturally-informed and appropriate services, the treatment planning teams, will consider the individual's preference for therapeutic linkages with traditional healers, religious and spiritual resources, alternative or complementary healing practices, natural supports, bilingual services, self-help groups, and consultation from culturally and linguistically competent independent practitioners, except when clinically or culturally contraindicated. Providers will be encouraged to develop policies and procedures that address disparities to improve knowledge and evidence-based practices. As consumers enter the AMHD system, AMHD will ensure that data on race, age, ethnicity, primary language and sexual orientation are collected and integrated into the electronic medical record.

Since Hawaii is such a diverse state with several different languages and cultural practices, linguistic disparities and language barriers are identified, monitored and addressed within the CMHCs. The CMHCS have policies and procedures in place for non-English speaking consumers to receive interpreters and translated materials should the need arise or if consumers request such materials. In addition, the AMHD contracts with the Susannah Wesley agency to provide language assistance services.

Child & Adolescent Mental Health Division

CAMHD tracks enrollment to services by types of services received, by age and gender, and by race and ethnicity. However, the race and ethnicity data are problematic. Every year there are youth who are registered into the CAMHD system without a race (25% in FY 2014) and/or ethnicity (41% in FY 2014) recorded in their file. CAMHD reports this number to staff every year as an introduction to reminding staff of the importance of including race/ethnicity information into the clients' files. CAMHD does not yet collect LGBT information. CAMHD's Program Improvement and Communications Office produces annual reports that provide cross-comparisons by these variables along with others, and summarizes and disseminates key findings across the system to assist in system improvement efforts.

CAMHD continuously monitors access into its system and whether disparities in access exist across subpopulations. Overall in Hawaii, like most of the nation, the number of mental health services available does not adequately cover the estimated number of youth and families who need help. In FY 2014, there were 2,225 youth registered in CAMHD at some time during the year, while there is an estimated 12,545 youth aged 5-19 with serious emotional disabilities in Hawaii. Various efforts have been underway to address this gap.

CAMHD is working towards the utilization of technology to increase efficiency of administrative processes in order to increase the proportion of staff time spent on clinical services for youth and increase the rate (speed) of improvement. CAMHD is also emphasizing greater monitoring of lengths of service, to prevent over-servicing and the possibility of doing harm. These efforts are expected to open more bed space and therapist time to serve more youth in need. Technology is also increasing access to care in remote and shortage areas with the use of a statewide video teleconference system. Furthermore, part of the state plan is to increase

collaborations with other agencies to increase their referrals to mental health services for youth. Currently, CAMHD is focusing on increasing Juvenile Justice and primary care referrals.

The primary care initiative, in particular, in addition to increasing access for more youth, seeks to reach younger youth in need of services. CAMHD's average youth age is 14 years old, and its goal for a long time has been to help youth earlier and prevent more serious problems for them and their families.

Another priority is reducing disparities in gender and in the types of youth problems addressed. CAMHD's population has for a long time consisted of about two-thirds male youth. In addition, youth with internalizing problems tend to be underserved (Milette-Winfree et al., 2014), particularly those with trauma. To address this need, CAMHD's Project Kealahou (a System of Care grant) has been helping to improve the system's identification of and services for girls with trauma. In addition, Project Laulima (another System of Care grant) has been implemented to increase access to care for youth with both mental health and developmental disabilities, another historically underserved population.

These populations are the current priority, although CAMHD has also been monitoring other areas of potential disparities such as race.

The recent implementation of the Ohio Scales (OS) Parent form has resulted in a discovered need for translation of the survey into at least one language other than English. Honolulu has a significant Chuukese population and several Care Coordinators have reported that they cannot conduct the assessment with these Chuukese parents due to their inability to read English. CAMHD has secured the funding to have the form translated into Chuukese and is also working toward the addition of an Hispanic version of the OS Parent form.

Also, in CAMHD's annual Consumer Survey, Care Coordinators are asked to monitor which parents cannot complete their survey due to language issues and to also note what language they would need in order to be able to compete it. These results will be used to determine what other languages the Consumer Survey needs to be available in for the coming years.

CAMHD provides language assistance on an individual basis. In the past, CAMHD has provided language assistance and translations for Micronesians, Chuukese, Marshallese, Palauan, Korean and American Sign Language. CAMHD has referred youth to a local clinical psychologist who is fluent in American Sign Language and can sign directly with the youth.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

The Adult Mental Health Division requests Technical Assistance related to this section.

Footnotes:

3. 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).

In the Request for Proposals, the AMHD requests that providers implement evidence-based programs, strategies and promising practices that are based on research, literature, national consensus, and conformance to professional standards that effectively address service needs identified in the proposals.

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 and encourage the Service Coordinators to provide training on EBPs during clinical training with providers. The HHS Publication No. (SMA) 09-4205, Identifying and Selecting Evidenced-Based Interventions, Revised Guidance Document for the SPF-SIG Program, SAMHSA, (January 2009), SAMHSA's National Registry of Evidence-Based Programs and Practices will be used during these trainings.

Child & Adolescent Mental Health Division

Science to Service

In 1999, CAMHD established what is now called the Evidence Based Services Committee for the purpose of identifying the science to improve children's mental health services. The overarching goals of the EBS Committee are to broaden and update the summary of scientific information used to guide decisions about children's care. Using a methodology similar to the American Psychological Association Task Force on Psychological Intervention Guidelines, the interventions reviewed were evaluated with respect to efficacy and effectiveness. The EBS Committee ranked interventions in order of their relative likelihood to be helpful and provided detailed information about the studies in which the interventions were found to work. A significant component of this research is in discovering "practice-based evidence," or finding practices that are successful with CAMHD's population of youth, including practices that might not yet have an evidence base behind them. The Committee pays particular attention to the appropriateness of particular interventions for various ethnic groups of various ages in various settings, the recentness of the literature, the magnitude of treatment effects, and the "trainability" of the programs. To move the science into service, the EBS Committee holds

quarterly roundtable discussions, often featuring presenters with expertise on topics relevant to CAMHD's evidence-based services. The Committee also maintains a website for parents, based on parent input that aims to educate consumers and empower them to demand evidence-based services. Committee members have included parents, providers, educators, university faculty and health administrators with backgrounds in nursing, social work, psychology, psychiatry and special education.

Within CAMHD, the Clinical Services Office and Practice Management Section are responsible for disseminating information about effective and evidence-based clinical practice and providing training system-wide. The Program Improvement and Communication Office also supports evidence-based practice by 1) facilitating the collaboration with UH Manoa, 2) providing analyses and reports for various CAMHD evaluative and quality improvement efforts, and 3) disseminating system level findings, including findings regarding the system's use of 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 contracts with multiple Purchase Of Services (POS) provides to provide an array of services 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/dochs/mentalhealth/docs/CR%20Psychosocial%20Interventions.F.0503.pdf

Evidence-Based Practice

CAMHD reimburses it's 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. 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. 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:

1. General Services Research - data typically found in peer-reviewed scientific journals (e.g., in the form of randomized clinical trial outcomes).

2. Case-Specific Historical Information - case-specific data from repeated clinical interactions in the form of standardized (e.g., Ohio Scales, CAFAS) or idiographic (individualized) assessment strategies (e.g., MTPS ratings, mood or SUDS ratings, etc.).

3. Local Aggregate Evidence - case-specific data aggregated across numerous youth into meaningful composite units. These types of data are sometimes referred to as practice-based evidence.

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.

CAMHD convenes a Utilization Management Committee quarterly to review how efficient and effective services are across all levels of care for youth being served in all services, including those that are recognized as evidence-based package programs (MultiSystemic Therapy, Functional Family Therapy). Great care goes into making sure that all programs are not missing opportunities to treat more youth and that the resources available for youth meet the needs in the community. Data are provided at these meetings help inform discussions and final decisions.

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. Utilization management is now being implemented at each local Family Guidance Center by the CAMHD Clinical Leads.

CAMHD's Program Improvement and Communications Office conducts separate analyses that studies how outcomes for youth (as measured by assessments and discharge status) can be improved. Examples of these analyses include: a) the impact of treatment length of stay on assessment outcomes and b) the use of initial and early assessment scores (as measured by the CAFAS) to predict the probability of successful discharge. Both of these studies help CAMHD staff and contracted providers of services to understand the types of issues to consider when planning the most appropriate treatment (and timeframe for that treatment) for youth. In fact, basic timeframes for length of stay were developed by level of care that were then integrated into CAMHD's 'Orange Book' which is essentially the agreement between CAMHD and our contracted providers specifying how the services to be offered to CAMHD youth will be

implemented and authorized. In this way, CAMHD has developed its own set of best practices based on the results of data analyzed using the local youth served here in Hawaii.
CAMHD also convenes an Outcomes Assessment Workgroup whose mission it is to develop, test, and improve outcome measures to improve the use of data feedback in treatment planning (an evidence-based practice) and to strengthen evaluation and quality improvement efforts.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

4. Prevention for Serious Mental Illness

Adult Mental Health Division

The AMHD is committed to increasing awareness to mental illness prevention, treatment and recovery support as part of its coordinated service array. Mental Health Block Grant funds are used to support the National Alliance on Mental Illness-Hawaii in its efforts to provide Mental Health First Aid Training to provide the families with skills to help a person who is developing or experiencing a mental health or a mental health crisis. Periodically, staff members within the AMHD system are invited to speak on mental health issues, which stem stigma in the community.

The AMHD has decided to collaborate with the CAMHD to provide recovery-oriented treatment to young people, aged 15 through 25 years old who have begun experiencing psychotic systems. This has resulted in AMHD transferring five percent of its MHBG funds to CAMHD to pilot the First Episode Psychosis Initiative.

Child & Adolescent Mental Health Division

In 2014, CAMHD completed a re-organization of its structure and functions toward a more clinically-driven model of care. CAMHD's clinical leads—child psychiatrists and clinical psychologists, will now provide more intense hands-on clinical direction of every case. With the new clinical lead-driven services, CAMHD will be able to identify prodromal behavior earlier and refer to the newly established Coordinated Specialty Care program and/or other services within CAMHD's service array. The goal in early sub-threshold identification is to normalize behavior as soon as possible and support the youth to get back into school or back on the job. CAMHD is currently in the discussion phase of establishing supportive vocational services with the Department of Human Services Vocational Rehabilitation Division. It is anticipated that the collaboration will be articulated in an MOU this year.

To increase early identification and intervention in young children, CAMHD initiated a primary care integration initiative with Federally Qualified Health Centers (FQHCs). The goal of the pilot project is to integrate behavior health into community health centers into a medical home model. After issuing a Request for Proposals, two contracts were awarded. For its two pilot sites, the Hawaii Primary Care Association selected the rural West Hawaii Community Health Center on the Big Island and Kokua Kalihi Valley in a low-income, high immigrant neighborhood on the Oahu. The University of Hawaii, John A. Burns School of Medicine (JABSOM) Department of Psychiatry selected for its two pilot sites the rural Malama I Ke Ola FQHC on the island of Maui, and the low-income, rural Waimanalo Health Center. Over the past two years, the projects worked with the FQHCs to increase the early identification of children with emotional and/or behavioral challenges, increase engagement between the FQHCs and the

neighborhood CAMHD Family Guidance Centers, increase curbside consultations, increase referrals of high intensity cases to the CAMHD Family Guidance Centers, and increase capacity of the Primary Care Providers to manage mild to moderate mental health issues. After two years of experience, CAMHD will ramp up the block grant funded initiative into the next phase of implementation. Project management of all four sites will be managed by the Hawaii Primary Care Association in a learning collaborative model. Meanwhile, expert psychiatric resources from JABSOM will provide clinical services with psychiatric resources from CAMHD in a group practice model to the four sites.

Since 2005, CAMHD has been providing block grant support to the state's Suicide Prevention Program for the implementation of the Statewide Suicide Prevention Plan. The Plan called for identifying the prevalence and incidence of completed suicides, suicide attempts and suicidal ideation through epidemiological studies including the Youth Risk Behavior Survey System. The Suicide Prevention Program identified gatekeeper training as a major goal to preventing suicides. The upcoming 2015-2018 Strategic Plan for Suicide Prevention focuses on three priority areas:

- Enhance ongoing suicide prevention training for gatekeepers
- Develop and implement a public awareness campaign
- Develop and promote effective clinical and professional activities.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. Evidence-Based Practices for Early Intervention

An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

CAMHD contracted the University of Hawaii, Department of Psychology to implement a full-fidelity Coordinated Specialty Care (CSC) clinic following the principles outlined by the Recovery after Initial Schizophrenia Episode (RAISE) project. The clinic is a collaboration between the University of Hawaii, Department of Psychology, University of Hawaii John A. Burns School of Medicine Department of Psychiatry, the Child and Adolescent Mental Health Division, and the Adult Mental Health Division. It will be staffed by six professionals, including Dr. David Cicero as the director at .35 FTE, a project coordinator at 1.00 FTE, a psychiatrist at .20 FTE, two mental health professionals at .50 FTE, and an administrative assistant at .50 FTE. In addition, the project will include a full and an associate professor from the University of Hawaii, Department of Psychology, at .05 FTE each, who will consult on the project.

An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.

Since October 1, 2014, the project has made considerable progress on the implementation of the CSC clinic. These accomplishments are outlined in a comprehensive policy and procedures manual that were developed to adapt the CSC model to the mental health institutions and consumers in Hawaii. This manual includes sections detailing 1) adaptation of the CSC program design, 2) the CSC program organization and responsibilities, 3) a communication plan among the parties involved in the collaborative effort, 4) CSC program intervention, administration and duration 5) a staff training plan, 6) the selection and enrollment of participants, 7) informed consent and Health Insurance Portability and Accountability Act (HIPAA) policies, 8) medication plan, 9) safety reporting, 10) measurements and procedures, 11) quality control procedures, and 12) data collection and study forms.

The first major accomplishment in FY15 was to recruit and hire staff who will supervise and provide services in the clinic. Dr. David Cicero was hired as the clinic director. Dr. Cicero is a clinical psychologist and an assistant professor at the University of Hawaii. Prior to taking his position at the University of Hawaii, he completed a clinical internship at the University of Maryland-Baltimore/Maryland Veterans Affairs Health Care System internship consortium where he trained with many of the PIs on the RAISE project. Thus, he was already familiar with many of the aspects of the model and led our effort to adapt the program for Hawaii. Dr. Cicero will continue on the project as the director of the clinic at .35 FTE for 2016 and 2017. In addition, two mental health professionals at .50 FTE will be hired to provide individual therapy at the clinic.

The services of Dr. Steven Williams from the University of Hawaii, Department of Psychiatry at .20 FTE will be secured to provide medication management for the clinic. Dr. Williams is an attending psychiatrist at an acute inpatient unit and has experience working with young people

with psychosis. He has published work on structural differences in the brains of people in their first episode of affective or non-affective psychosis.

In addition to designing the program, outreach was conducted during this fiscal year. As clinic director, Dr. Cicero made presentations about the program to the Evidence Based Services (EBS) Committee Quarterly Roundtable; Department of Health, Child and Adolescent Mental Health Division; Hawaii Psychological Association Annual Meeting; Honolulu Family Guidance Center; Adult Mental Health Division All-Staff Meeting; John A. Burns School of Medicine, Department of Psychiatry Grand Rounds, and the CAMHD 2015 Summer Conference on Transitioning Youth to Adult Heath Care Systems in Hawaii. These presentations have ensured that mental health care professionals are aware of the program and have allowed us to establish referral networks in the community. Following the RAISE model in New York, University of Hawaii decided to name the clinic "OnTrack Hawai'i." They developed a logo, brochure, flyer, and website (http://www.psychology.hawaii.edu/ccbt/ontrack-hawaii.html) for the clinic. This will also help with outreach in 2016 and 2017.

This past year, significant progress was made in training staff for the clinic. Dr. Cicero attended the International Early Psychosis Association Conference and heard some of the preliminary reports on the efficacy of the RAISE model. The clinic staff attended SAMHSA's Pacific Jurisdiction Training in Honolulu, which was conducted by staff from OnTrackNY, New York City's iteration of the RAISE model. At that training, Dr. Cicero presented the plans for Hawaii. He has since set up a listserv to facilitate communication between Hawaii and the Pacific jurisdictions so that he may help the jurisdictions plan the use of their funds. In addition, clinic staff have access to the Center for Practice Innovations (CPI) learning community from OnTrackNY. With the help of CPI staff, UH developed specifically-tailored training plans for each staff member and are completing those in preparation for the opening of the clinic.

Furthermore, a comprehensive system for data collection and forms was developed. The majority of these forms were adapted from manuals provided by RAISE, including forms to document individual sessions, group sessions, supported education and employment, and others. The clinic plans to use all of the assessment instruments recommended by the RAISE project including PTSD screening measures, suicide assessment risk measures, evaluation forms, psychosocial and needs assessments, and family member interviews, among others. The clinic has also prepared all necessary consent for treatment, notice of privacy practices, and HIPAA forms.

Finally, a physical location for the clinic was secured. The clinic will be housed within the Center for Cognitive Behavioral Therapy at the Department of Psychology at the University of Hawaii. The space was renovated and prepared for clinic operations.

Change in the Block Grant Plan

During the initial stages of the Coordinated Specialty Care program start up, the budget ($91,473) did not exhaust the full 5% set-aside for Hawaii ($117,600). Therefore, the balance of the set-aside was used to disseminate information at CAMHD's Summer 2015 Evidence Based Conference. The target audience of the training included children's and adult mental health

providers, health providers, health plans, child-serving agencies and academia. Included on the agenda were CAMHD's new evidence-based clinical model and workflows. The new evidence-based clinical model emphasizes the formation of Clinical Management Teams and their key roles in clinical decision-making and management. Revised workflows were rolled out to illustrate a new model of youth and family clinical care coordination. It was stressed that key features in the new workflow were first proven in the scientific literature to improve outcomes:

- Clinical feedback has been demonstrated to increase positive outcomes in randomized trials and meta-analyses. The only way to collect consistent and reliable data is by standardizing and systematizing CAMHD's workflows.

- Family engagement has been empirically demonstrated to improve retention and outcomes and the new CAMHD model is aimed towards increased family engagement.

- There is an evidence-base for interagency collaboration to increase success in transition to adulthood for emerging adults.

The afternoon track emphasized transitions to adult care. Dr. Cicero provided a presentation of the new Coordinated Specialty Care program. His presentation generated much interest at the conference, particularly among the health plans. Additional presentations by the Adult Mental Health Division, the Department of Human Services Med-QUEST (Medicaid) program, and several health plans provided insight into the coverage and service options.

The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

The target start date to have the CSC clinic fully operational is early in the Fiscal Year 2016. The clinic is anticipating a full caseload of up to 20 clients by the end of FY16. That caseload will be maintained throughout FY17.

Next, a full time project coordinator and a .50 FTE administrative assistant will be hired in early FY16. The 1.0 FTE project coordinator will assist the director with community outreach, develop agreements with other agencies for transition of youth out of the clinic, and manage the day-to-day operations of the clinic. The project coordinator will provide supported education and employment, case management services, and individual therapy to a small number of clients.

Dr. Cicero will continue to present the clinic to mental health care professionals. In 2016, these presentations will focus on treatment centers where young people with psychosis are currently receiving care, such as the Family Guidance Centers, inpatient facilities, and community care services programs. A conservative estimate from our original analysis in 2014 suggests that at least 40 people between the ages of 15 and 24 develop psychosis every year in the area the clinic will serve (Honolulu County).

Dr. Cicero will determine whether referred youth are appropriate for the clinic and either enroll them or refer them for appropriate treatment. He will also provide family psychoeducation and therapy to youth and their families.

Clients enrolled in the program will be considered for discharge following the recommendations in the RAISE manuals. It is expected the most clients will be in the program for approximately two years. In 2016, the clinic will develop memoranda of agreement with community organizations to transition clients when they no longer need CSC services. It is expected that the first clients will be transferred out of the clinic late in the 2017 fiscal year.

The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Data will be collected from several sources in this initiative. The majority of clients receiving care in the clinic are expected to be referred from CAMHD. The first data collection priority will be to collect data on CSC clients that can be compared to treatment as usual for clients enrolled in CAMHD but not in the CSC clinic. All providers in the CAMHD system complete a monthly report called the Monthly Treatment Progress Summary (MTPS). The MTPS documents the type and frequency of services, treatment targets, and treatment interventions used. These data will allow us to demonstrate the impact of the initiative by documenting the services that are provided as part of the clinic.

All clients in the CAMHD system are also rated on the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS includes subscales for Role Performance: School/Work, Role Performance: Home, Role Performance: Community, Behavior towards Others, Moods/Self-Harm: Moods/Emotions, Moods/Self-Harm: Self-Harm Behavior, Substance Use and Thinking. Finally, all clients in CAMHD complete the Ohio Scales, which measure problem severity, functioning, and satisfaction with treatment. The parent and youth version of the scales will be used in the clinic. The benefit of using the Ohio Scales to measure problem severity and function is that it will make it easier to compare outcomes from the CSC clinic to other clients in CAMHD.

In addition to measures completed as comparison to other CAMHD clients, clients will complete several other assessments to monitor their treatment progress. First, clients' cognitive functioning will be measured with the MATRICS Consensus Cognitive Battery (MCCB). The MCCB is intended to provide a relatively brief evaluation of key cognitive domains relevant to schizophrenia and related disorders. The MCCB was designed to address the following purposes: an outcome measure for clinical trials of cognition-enhancing drugs for schizophrenia, an outcome measure for studies of cognitive remediation, a measure of cognitive change in repeated testing applications, and a cognitive reference point for non-intervention studies of schizophrenia and related disorders. The MCCB will be given to clients at the beginning of treatment and repeated every six months throughout treatment. The MCCB has alternate forms for repeated administrations.

Symptoms will be rated monthly with the Positive and Negative Syndrome Scale (PANSS), which will be especially important for medication management. However, following the general principles of the RAISE project, the primary outcome goals for CSC clients will be social and role functioning, as measured by the Global Assessment of Functioning scales, and client goals derived from the shared decision making process.

The clinic director will present quarterly reports on these outcome measures to the CAMHD and AMHD administration, including the CAMHD Planner. In addition, the clinic director is an active researcher focusing on the assessment and treatment of early psychosis. The outcome data will be reported in a manuscript that will be submitted for publication in a peer reviewed journal such as *Schizophrenia Bulletin* or *Schizophrenia Research*.

A budget showing how the set-aside and additional state or other supported funds, if any, were used for this purpose.

Hawaii First Episode Psychosis - 100% Block Grant Funds	
PERSONNEL COST	
Salaries	$51,302.00
Fringe Benefits	$11,171.00
TOTAL PERSONNEL COST	$62,473.00
OTHER CURRENT EXPENSES	
Airfare, out-of-state	$1,850.00
Insurance	$300.00
Mileage	$1,000.00
Subsistence/Per Diem	$2,319.00
Supplies	$9,175.00
Transportation	$250.00
IT Site License/Software	$300.00
Parking	$345.00
Conference Registration	$840.00
Equipment	$4,500.00
TOTAL OTHER CURRENT EXPENSES	$20,879.00
Federal Indirect Costs @13.0%	$8,121.49
TOTAL	$91,473.49

CAMHD 2015 Summer Evidence Based Conference	
Facilities Rental	$15,433.00
Neighbor Island air/ground travel	$10,545.00
Supplies	$662.00
TOTAL	$26,640.00

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

The AMHD will seek Technical Assistance related to this section.

Footnotes:

6. Participant Directed Care

Adult Mental Health Division

The AMHD is not involved with any programs, such as waiver programs, which emphasize self-direction to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment and recovery services. The AMHD will seek Technical Assistance to create housing voucher programs for eligible adults with serious mental illness or co-occurring disorders.

Child & Adolescent Mental Health Division

One of the core components of CAMHD's system of care is a commitment to the Ten Hawaii Child and Adolescent Service System Program (CASSP) principles. The CASSP principles that relate to participant directed care are:

- Families or surrogate families will be full participants in all aspects of the planning and delivery of services.
- As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.
- The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.
- The rights of children will be protected and effective advocacy efforts for children will be promoted.
- The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.
- Access will be to a comprehensive array of service that addresses the child's physical, emotional, educational, recreational, and developmental needs.
- Family preservation and strengthening along with the promotion of physical and emotional well-being shall be the primary focus of the system of care.

These CASSP principles are imbedded throughout CAMHD's services and system and are codified in CAMHD's Child and Adolescent Mental Health Performance Standards (also known

as the “Orange Book”). Self-directed care is evident in the service planning section of the Orange Book. For example, the Orange Book states that, “CAMHD service planning is an individualized and ongoing process that is youth guided and family/guardian centered”. The “Coordinated Service Plan process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key individuals involved in the youth’s life including existing or potential service providers” (page 9). Similarly, the Mental Health Treatment Plan should be “individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth....” “It is the role of the contractor to regularly monitor and adjust treatment plans, with input from the youth, family/guardian, CC and other members of the youth’s team” (page 10).

A PDF of the Orange Book can be downloaded from: http://health.hawaii.gov/camhd/
To encourage families to select evidence-based services in the planning process, the CAMHD-sponsored Evidence Based Services Committee developed the “Help Your Keiki” website for parents. The website provides information about various treatment options, so that parents and youth may be fully informed before making treatment decisions.
The website is available at: http://helpyourkeiki.com/

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (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 use of behavioral health benefits in light of utilization review, medical necessity, etc. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity

Adult Mental Health Division

The AMHD has a program integrity plan for use of Block Grant funds. Through the MHBG Oversight Committee which includes: the Administrator for AMHD, 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. The committee also ensures block grant proposals reflect one or more of the Block Grants four purposes.

- To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- To fund 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.
- To fund primary prevention: universal, selective, and indicated prevention activities (Alcohol and Drug Abuse).
- To collect performance outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services.

The AMHD has developed a written policy and procedure for implementation of the Block Grant for the use in the reviewing services within the mental health division. A written policy for oversight of services purchased from subcontracted entities is being developed. Also, the Block Grant Oversight Committee will add a consumer and a Planning Council representative to review all proposals received through the State's Request for Proposal process. External measures are performed through fiscal audits conducted by a Certified Public Accountant to address adherence to service, statutory and regulatory requirements for all providers receiving federal funding. The AMHD is in the process of developing a systematic approach to conduct program fidelity reviews of documentation necessary to support billing claims for Block Grant funds.

Hawaii recently received its 2013 Core Tech Review results. Several monitoring activities were cited for its Block Grant oversight practices, such as no fiscal controls are in place to ensure the state's methodologies for managing cash, preparing federal financial reports, monitoring providers and resolving provider audit findings. In response to the report, Hawaii has developed a corrected action plan to address deficiencies. See attached Action Plan.

Child & Adolescent Mental Health Division

At CAMHD, the children's planner in the Program Improvement and Communications Office provides oversight of the children's portion of the Community Mental Health Services block grant and has established procedures for assuring the appropriate use of block grant funds. Each year, and now biennially, the planner meets directly with the CAMHD Administrator to develop the priorities, programs and budget for the block grant. Based on those discussions, the planner assures that the block grant priorities align with the needs and gaps identified in CAMHD's annual evaluations, SAMHSA funding priorities, national and local trends, and with the SAMHSA and CAMHD strategic plans. Gaps and needs are identified by the Program Improvement and Communications Office, which annually analyzes CAMHD data to assess performance on key indicators. These performance data include, but are not limited to, number and geographic distribution of youth served, rate of youth improvement, primary diagnosis, age and gender distribution, length of stay by level of service, direct service provision, clinical staff activities, turnover of clinical positions, utilization of evidence based services, use of treatment progress data, Medicaid reimbursement, family engagement, school attendance, youth arrests, and number of youth with trauma. Based on this type of comprehensive analysis, the SAMHSA block grant has been instrumental to the State of Hawaii in addressing workforce shortage issues in geographic areas of growing need, increasing parents' awareness of evidence based services, initiating primary care integration projects to increase early identification, increasing the utility and timeliness of treatment progress data, and supporting family engagement.

Once the block grant plan is approved, the planner convenes a multidisciplinary team to implement the plan. For ongoing projects, the contracts section is notified to extend or modify contracts and agreements. To establish new programs, the planner has primary responsibility for program development and will develop a scope of services designed to achieve goals and meet needs. The CAMHD contracts section places the scope of services into the proper format with the appropriate state and federal assurances and attachments. It is CAMHD's standard practice to include the federal regulatory requirements in all block grant-funded contracts. The contracts section assures that all state and federal procurement rules have been complied with and secures review and approval of the contract language by the Department of the Attorney General.

All state purchases must follow strict procurement rules. Vendors, contractors and service providers must be compliant with statutes and administrative rules. State agencies are required to verify compliance. In order to comply with Section 6, Act 52, Hawaii State Legislature 2003, which amended section 103D-310, Hawaii Revised Statutes (HRS), the contractor must provide as proof of compliance with the requirements of section 103D-310 (c), HRS, the following documents:

a. A tax clearance certificate from the State Department of Taxation and the Internal Revenue Service, subject to section 103D-328, HRS, current within six (6) months of the issuance date;

b. A certificate of compliance for chapters 383, 386, 392, and 393, HRS, from the State Department of Labor and Industrial Relations, current within six (6) months from the issuance date; and

c. A certificate of good standing from the Business Registration Division of the State Department of Commerce and Consumer Affairs, current within six (6) months from the issuance date.

Fiscal oversight is provided by CAMHD's fiscal section which is staffed with several accountants and account clerks. The accountants review the initial and subsequent budgets for appropriateness and will work with the provider agencies to adjust and modify budgets, invoices, and expenditure reports.

CAMHD follows the State's Cost Principle and Payment Guidelines from Procurement and Payment Handbook. The cost principles provide uniformity among state purchasing agencies in procuring health and human services under HRS Chapter 103F, Purchase of Health and Human Service. The cost principles represent guidelines for determining which types of expenditures will be allowable and should be used to guide decisions regarding:

- Proposal budgets submitted by providers in response to Request for Proposals;
- Contract budgets and unit costs negotiated between state purchasing agencies and providers;
- Financial reporting requirement established by state purchasing agencies; and
- Fiscal monitoring requirements established by state purchasing agencies.

The Fiscal section follows the state's Payment Guidelines from the Procurement and Payment Handbook before processing any payments. The guidelines describes State of Hawaii Payment Processing Requirements and DAGS (Department of Accounting and General Services) - Administrative Services Office Internal Payment Processing Requirements

Management of the block grant throughout the year is conducted through monthly team meetings. The meetings, convened by the planner, tracks the outgoing contracts, incoming invoices, and remaining balance of block grant funds. The fiscal office prepares a monthly project-by-project expenditure report. This allows the team to identify problem areas that would inhibit the full expenditure of the federal funds. When those circumstances occur, the contingency plans developed by the planner are put into action. The reporting section of the contracts require that contractors provide quarterly and annual cumulative narrative and numeric reports, including client encounters and other performance data. Through desk reviews and direct conversation with providers, the planner monitors program integrity. Together with the fiscal oversight of financial transactions, CAMHD assures that the federal funds are being used in accordance with federal regulations.

CORRECTIVE ACTION PLAN FOR CORE TECH REVIEW

Behavioral Health Administration (BHA)

BLOCK GRANT FOR COMMUNITY MENTAL HEALTH SERVICES

NO.	FINDINGS	RECOMMENDATIONS	CORRECTIVE ACTIONS TO BE TAKEN	RESPONSIBLE PARTY	TARGET DATE
	• BHA to convene a workgroup to address the recommendations. • Participants to be an Administrative Services Office Budget Analyst, AMHD and CAMHD Public Health Administrative Officers (PHAOs).				
1	No fiscal controls and accounting procedures are in place to track and ensure funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.	Establish a process to ensure that only Allowable Activities and Costs are paid for with block grant funds.			
2	No documentation for earmarking requirements of MHBG funds.	Establish written polices and procedures to ensure that only allowable costs are used to meet earmarking requirements.			
3	The BHA had no documented written fiscal P&Ps related to cash management.	Develop written policies and procedures for Cash management drawdown which requires: (1) Limited to the minimum amounts needed to cover allowable program costs; (2) Timed in accordance with the actual immediate cash requirements of carrying out the approved program; (3) Restricted from covering future expenditures; and (4) Expended within 72 hours.			

Behavioral Health Administration (BHA)

BLOCK GRANT FOR COMMUNITY MENTAL HEALTH SERVICES

NO.	FINDINGS	RECOMMENDATIONS	CORRECTIVE ACTIONS TO BE TAKEN	RESPONSIBLE PARTY	TARGET DATE
4	The BHA had no documented written fiscal P&Ps related to preparation of the federal financial reports (SF 425).	Develop written policies and procedures for preparation of federal finanical reports (SF 425) to: (1) Resolve any discrepancies ; and (2) Ensure the accuracy of the federal expenditures and unobligated balance identified in the federal financial report.			
5	The BHA had no documented written fiscal P&Ps related to fiscal monitoring of MHBG providers and resolution of audit findings for the providers.	Develop written policies and procedures to conduct on-site reviews of its MHBG providers to: (1) Ensure actual allowable expenses are being submitted for reimbursement, not budgeted expenses; and 2) The subrecipients' (that are non-profit organizations) compliance with the Sarbanes-Oxley Act - with regard to the charging of auditors (partner or firm), 45 CFR Part 92.35 - with regards to debarred and suspended parties, and 45 CFR 92.36(b) - with regards to conflict of interest situations.			

Behavioral Health Administration (BHA)

BLOCK GRANT FOR COMMUNITY MENTAL HEALTH SERVICES

NO.	FINDINGS	RECOMMENDATIONS	CORRECTIVE ACTIONS TO BE TAKEN	RESPONSIBLE PARTY	TARGET DATE
6	Ensure the obligations and expenditures for its MHBG program are recorded within two-year period of availability of federal funds or within 90 days after proper preparation of the federal financial reports (SF 425).	Develop written fiscal P&Ps to ensure the obligations and expenditures for its MHBG program are accrued within the two-year period of availability of federal funds.			
7	The BHA did not have written procedures to support the methodologies it used to compute the maintenance of effort expenditures reported to SAMHSA.	Develop written policies and procedures to support the methodologies used to compute the expenditures for the state expenditures for community mental health centers.			
8	The BHA did not identify in its POS contracts, the specific Federal and State laws and regulations that are imposed on them for the MHBG program.	Identify in its POS contracts (original and amended) the specific Federal and State laws and regulations that are imposed on them for the MHBG program. BHA can also consider including the laws and regulations in an attachment or reference to a website.			

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] 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.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds 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 and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

8. Tribes

Adult Mental Health Division

Hawaii has many interracial groups that the Behavioral Health System engages with and provides mental health services; however, Hawaii does not have a recognized group that meets the true definition for tribal affiliation.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, 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, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and 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 to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

10. Quality Improvement Plan

Adult Mental Health Division

The AMHD has developed a 5-year Strategic Plan to guide policy and keep its system accountable. The Strategic Plan is combined with the Quality Improvement Plan due to the limited amount of staff that can implement both plans. The AMHD Strategic Plan provides direction for both short and long-term decision-making to fulfill the mission and vision of the Division and to make choices among competing demands for shrinking financial and human resources. This plan is a "living" document that serves to effectively move the Division forward into the year 2020 and beyond, and provides a unified vision and framework for action. The draft mission, vision and guiding principles were developed during the summer of 2015 as part of the Division's planning effort. The mission, vision and guiding principles will be refined as different role groups revisit them. 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 draft Strategic/Quality Improvement Plan is attached.

Child & Adolescent Mental Health Division

The CAMHD is currently engaged in a strategic reorganization and realignment of all quality assurance and quality improvement activities. A committee comprised of the CAMHD quality assurance, clinical, research, and system and billing operations staff is presently drafting a new, comprehensive Quality Improvement Plan. This is to be based on Continuous Quality Improvement and Total Quality Management (CQI/TQM) principles. The planned CAMHD systems modernizations are architected in a manner to produce role-specific reporting and dashboards. These reporting systems are to be developed incorporating both national and state-program specific quality and performance metrics. CAMHD's Health Systems Management Office, and Research and Evaluation Section are collaborating on this design, to ensure that an extensible and easily adjustable set of performance measures are to be available. This is envisaged to include role-based dashboards feeding performance data to patient care staff, clinicians, contractors, quality assurance teams, and program administrators. This effort encapsulates the new paradigm for CAMHD, to increasingly develop information maturity, and implement it in operations. Thus CAMHD is planning to move away from inaccessible unstructured data and simple reports, towards warehoused structured data, custom reports, and predictive metrics on youth care and outcomes, for evidenced-based decision making. Under the aegis of CAMHD's Quality Improvement Plan, development of these systems and metrics is planned to generate enhancements in identification of care trends, program integrity concerns, administrative oversight, and overall quality advancement. This recognition via metrics of program effectiveness is set to enable further utilization and

continuous improvement of CAMHD's evidence based practices, and promising practices in the clinical setting.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Draft Mission	The Adult Mental Health Division provides integrated, high quality, mental health services for individuals in crisis, the uninsured and underinsured consumers with serious and persistent mental illness, and individuals with court orders for evaluation, care and custody by the Department of Health. The Strategic/Quality Management Program (SQMP) supports the draft mission of the AMHD.
Draft Vision	The Adult Mental Health Division strives to be a national leader in providing an accessible, comprehensive, and quality focused system of mental health services at the state system level by implementing the following: 1. A mental health safety net that provides crisis services for the general population and integrated mental health services for uninsured and severely under-insured consumers with severe and persistent mental illness. 2. Adequate service provision for consumers who are seriously mentally ill in our communities through direct provision of services and partnerships or integration with federal, other state or local health care resources. 3. Innovative strategies and methods to reduce the involvement of consumers with mental health illness in the criminal justice system. 4. Integration and collaboration with the courts, correction system, law enforcement agencies, and third party payers, reflecting the development and provision of forensic service Best Practices. 5. Effective forensic mental health programming and a modern State Hospital system with adequate capacity to provide court mandated care. 6. Promotion of the integration of health services including: a. Integration of behavioral health and treatment of substance use disorders with primary care; b. Access to and inclusion of preventative services addressing mental health and substance abuse population needs; c. Comprehensive wrap-around services for consumers who predominantly use emergency services (super users); d. Provision of training and public health workforce development consistent with the mission; e. Clinical and forensic community-based services with appropriate levels of care and services accessible across all counties and in Hawaii's rural areas.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Draft Guiding Principles	1. We serve consumers with severe and persistent mental health illness who are likely to have other co-occurring challenges, such as: a. Intellectual disability; b. Physical health conditions; c. Substance use disorders; and/or d. Be at risk for inadequate housing and criminal justice involvement. The complexity of our consumers requires integration across disciplines, agencies, and providers. 2. We value the following: a. Consumer involvement in treatment plans and service system design; b. Empathic and hope instilling relationships for consumers and colleagues; c. Healthy relationships and striving to maintain family and community relationships for our consumers; d. Recovery based programming; e. Cultural diversity and striving to increase our knowledge and skills to respond in a culturally informed, sensitive manner to our consumers and colleagues; f. Providing services in a setting that supports the most freedom and autonomy possible; g. Educating our employees and colleagues in the importance of evidence-based practices, professional ethics, and national standards for mental health professionals; and h. Our staff members and make a commitment to their ongoing professional development. 3. The Department of Health, Adult Mental Health Division, has a role to play in collaborative approaches to address the over-representation of individuals with mental illness in the criminal justice system and to reduce their involvement. 4. We recognize the importance of comprehensive mental health services with appropriate levels of care and service programs available in all counties and in rural areas. 5. We acknowledge the need for qualified, competent, well-trained professionals to address the mental health needs of Hawaii's citizens. 6. We recognize the need to address the current shortage of health care providers, and strive to collaborate with educational institutions in Hawaii to address this chronic shortage through the development of future workforce.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Population Covered by the Strategic Quality Management Program	The AMHD provides intensive mental health services to a population with diagnoses identified in AMHD Eligibility Policy and Procedure that result in emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with one's capacity to remain in the community without treatment, Psychosocial Rehabilitation Services (PSR) and other community supports of a long-term or indefinite duration. The mental disability is severe and persistent resulting in a long-term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment and recreation. Individuals within the AMHD are primarily the legally encumbered or uninsured/underinsured.
Strategic/Quality Management Program Scope	The Adult Mental Health Division (AMHD) operates its programs through an improvement approach that is directly linked to its core values, guiding principles and strategic organizational goals. The scope of the AMHD Strategic/Quality Management Program (SQMP) encompasses processes and monitoring occurring at all levels of the organization and network on an ongoing basis. It improves and monitors consumer outcomes; monitors the implementation and impact of best evidence-based and promising practices; and communicates the results of the SQMP to all stakeholders. The SQMP establishes specific annual goals, priorities, key initiatives and measures that will track and assure access and availability of appropriate and effective services and supports. A formal evaluation of the SQMP will be conducted on quarterly to establish priorities and make adjustments to the SQMP as indicated. The SQMP is structured and designates specific responsibilities for governance, reporting, documentation, committee roles, training and staffing resources. Purchases of Service providers (POS) have an opportunity to dialogue with the AMHD Clinical Coordinators at monthly meetings. These meetings are informational and used to discuss current initiatives so providers are aware of the services AMHD provides and how providers and consumers access these services. Providers include physicians and non-physicians. Individual reports will be mailed to the provider agency, which presents information about performance results specific to the provider. AMHD providers currently receive frequent information about quality improvement activities. This information is sent to them in the form of a newsletter or by Performance Improvement monitoring reports. AMHD consumers participate through direct representation by the Consumer Affairs Chief and attendance at consumer forums. Consumer involvement in committees and Quality Improvement Teams is expected. Consumers and consumer advocates will have access to an informational copy of the SQMP Evaluation Summary and Work Plan. This will be accomplished through inclusion on the AMHD website and targeted mailings to consumer advocates, such as AMHD Chief's Consumer Roundtable, Service Area Boards and the State Council on Mental Health.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION

Strategic/Quality Improvement Committee	The Strategic/Quality Improvement Committee (SQIC) will meet at least once a month.
	• The focus of the SQIC is:
	  • Oversight of Dashboards for 1) AMHD administration, 2) Hawaii State Hospital, 3) Community Mental Health Center Systems Administration, and 4) Providers.
	  • Dashboard focus areas are: 1) Fiscal, 2) Customer service, 3) Internal processes, 4) Staff learning and growth
	  • Dashboards will be developed for all major areas in AMHD administration: Service Coordinators, Utilization Management, Performance Improvement, Fiscal, Contracts, MIS, Personnel, etc.
	  • Oversight of Strategic/Quality Improvement Initiatives.
	
	Advisory Groups are to ensure provider and consumer input about relevant performance improvement activities. The following is a list of the advisory groups and where they connect:
	• State Council on Mental Health via the Administrator of AMHD
	• Chief Provider Roundtable via the Administrator of AMHD
	• Chief Consumer Roundtable via the Administrator of AMHD
	• Medical Executive via the AMHD Psychiatry Chief
	• Service Area Boards on Mental Health and Substance Abuse via the Service Area Administrators
	
	There are two workgroups that can forward information to the SQIC for further discussion or approval.
	• The Clinical Operations Team (COT) Workgroup is responsible for assuring that all services in the community that become part of the array of AMHD services, and promotes optimal utilization of AMHD clinical and operational standards.
	
	• The Business Operations Team (BOT) Workgroup is responsible for assuring that all services subject to reimbursement are proper and in compliance with all applicable payer and contractual guidelines, rules and regulations.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Strategic/Quality Management Program Goals, Strategy and Objectives	The Strategic/Quality Management Program goals, strategy and objectives are: **GOAL 1: Promote an integrated public health system.** Strategy: Promote efforts to reduce and eliminate health disparities in access to, quality of, and outcomes of the Adult Mental Health services. Objectives: 1.1 Strengthen data reporting to all constituents, i.e. providers, consumers, external and internal stakeholders. 1.2 Implement tools, processes and methods that support accountability and transparency in management information systems. 1.3 Develop interoperability and interfaces with other services providers to share treatment information electronically. 1.4 Provide consumers and families with an internet portal to communicate with their service providers. 1.5 Work with community partners to enhance opportunities to support consumers in employment through the Clubhouses and in the Peer Specialist programs. 1.6 Develop agreements with the Federally Qualified Health Centers to collaborate with the Community Mental Health Centers to provide physical and mental health services to consumers. 1.7 Provide effective, integrated and coordinated forensic mental health services that are implemented consistently in both community settings and within a modern state hospital system providing court mandated care. 1.8 Review and enhance policies, structures, and processes across the Division that affects consumers living with mental health illnesses. **GOAL II: Promote the need for and development of innovative strategies to reduce the involvement of individuals with mental illness in the criminal justice systems.** Strategy: Develop a more robust suite of community-based psychiatric services that include community-based fitness restoration, outpatient civil commitment, liaison with law enforcement, and effective jail diversion and re-entry services from correctional facilities. Integrate and collaborate with the courts, correction system, law enforcement agencies, and third party payers, reflecting the development and provision of forensic service Best Practices. Objectives: 2.1 Develop and implement best practices in providing forensic services. 2.2 Develop a new state of the art Hawaii State Hospital with integrated forensic service lines developed to address the needs of those patients with criminal justice involvement.

ELEMENTS	DESCRIPTION
	2.3 Develop forensic community-based services that are available across all counties and in Hawaii's rural areas. 2.4 Collaborate with external agencies to promote, develop and provide oversight for jail-based fitness to stand trial restoration program. 2.5 Strengthen integration, coordination, and collaboration with the courts, corrections system, law enforcement agencies and insurance providers. **GOAL III: Enhance population-based services to promote recovery, resiliency and positive outcomes for individuals living with mental illness.** Strategy: Strengthen recovery based practices to promote optimal lengths of stay and facilitate transitions to the community. Objectives: 3.1 Examine the advantages and disadvantages on increasing inventory of services through 1) additional State-operated facilities, 2) community hospital beds, and 3) community-based services that describe the need for inpatient treatment. 3.2 Identify key external activities, projects, and agencies to collaborate with and develop projects that support AMHD's objectives. Develop funding streams to support these activities. 3.3 Integrate preventive crisis services into the entire service system. 3.4 Develop and implement consumer-run programs to promote consumer empowerment, resiliency, and recovery in their community. **GOAL IV: Create a Strategic Division Workforce Plan.** Strategy: Build a sustainable workforce to ensure partnerships, systems and processes are in place to support the future workforce. Objectives: 4.1 Attract, recruit and retain a competent, credentialed workforce. 4.2 Strengthen research, education and training linkages to the University of Hawaii to support developing innovations, best practices, and workforce capacity and development. For example, (John A. Burns School of Medicine, School of Social Work, Psychology, Management, etc.) 4.3 Monitor and assess the needs of peer specialist communities and health professionals in meeting behavioral health needs in America's transformed health promotion and health care delivery systems. 4.4 Develop mentoring, training, and internship programs and implement succession planning. 4.5 Create a systematic process to appreciate, recognize and acknowledge the Division's workforce.

ELEMENTS	DESCRIPTION
	4.6 Develop an effective and efficient certification process that meets statutory requirements related to forensic examiners. 4.7 Strengthen the peer-support workforce. **GOAL V: Promote Communication throughout the Division relating to outcomes and improvements.** Strategy: Improve internal and external communication strategies and plans. Objectives: 5.1 Develop a statewide communication plan. 5.2 Standardize communication based on agreed upon goals and performance measures to allow employees and stakeholders regular access to information and provide consistent and regular quality reports. 5.3 Support unified messaging within the Division for its mission, vision and guiding principles. 5.4 Evaluate internal and external communications tools and resources.
Annual Work Plan	A Work Plan will be developed within the next two months.
Methodology	The **PDCA** will be used as an approach to quality improvement throughout the organization. This approach will be included in new staff orientation to introduce the concept of a scientific, applicable method to collect, analyze and evaluate data so that continuous improvement can be realized. Quality Improvement Process **P** Plan the Improvement: Description of plan for action – who, what, where, when, how. **D** Do the Improvement: Dates of implementation; description of any variation from the plan. **C** Check the results: Data collection and display; lessons learned. **A** Act to hold the Gain: Comparison to initial data; assessment/conclusions, action plan.
Implementation of the Strategic/Quality Management Program	There will be three work groups to oversee the implementation of the AMHD Strategic/Quality Management Program. These work groups will be staffed by a cross-section of staff at various levels of the organization that will be accountable to the Executive Team. The three groups are: 1) Communications, 2) Evaluation of Outcomes, and 3) Organizational Development.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
	The Communications Group will: 1. Develop a Communication Plan to build awareness, understanding and communicate to internal and external stakeholders about the planning process, the progress and outcomes of the Strategic Plan. 2. Develop frequently asked questions (FAQs) about the strategic plan to be posted on the AMHD and Hawaii State Hospital websites. 3. Coordinate AMHD's Communication Plan with the Department of Health's communication staff. 4. Propose updates to the AMHD and HSH websites. 5. Develop a You-Tube video of the AMHD administrator to share the importance of the strategic plan with internal and external stakeholders. The Evaluation of Outcomes Group will: 1. Develop an Evaluation Plan that will measure the strategic plan's successes on many levels including practice, program, and policy levels. The Evaluation Plan will help to translate the strategic plan into measurable actions and will demonstrate accountability and value for the actions taken. 2. Develop key performance measures based on the objectives for each Priority Theme that are specific, measurable, achievable, relevant, and time-based. 3. Report on achievements to be developed via the Results-Based Accountable software, which will provide dashboard reports to demonstrate key accomplishments for internal and external stakeholders. The Organizational Development Group will: 1. Revisit and revise the AMHD's newly formed mission statement. 2. Revisit and revise the Goals, Strategies, and Objectives component of the Plan. 3. Develop and revise a charter for the AMHD Executive Team (see draft preliminary below) 4. Reorganization related activities: a. Review the organizational models of service delivery within the Department of Health i.e. Social Work Model; Public Health Model, Other States' Delivery Models to identify best practice models. b. Develop a proposed model for the AMHD's organizational structure and develop a reorganization plan that is consistent with that model. c. Review the AMHD's service array and recommend additional services to support achieving the AMHD's mission, or the removal of services that are not cost-effective. d. Review the AMHD's current revenue funding streams and identify possible alternatives. e. Review the status of current reorganization proposals and develop a strategy and timeline for development. f. Receive monthly presentations from the Communications and Evaluation and Outcomes work groups to present progress reports on the strategic plan and allow sufficient time for questions and feedback/guidance.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
	The Executive Team's primary role is decision-making. As the strategic planning process is implemented over time, this group will be making important decisions related to: reorganization, functional structure, position control, contracts and maximizing of resources for the Division. Since the strategic plan is an overarching document that should drive the Division's plans for such areas as quality improvement, the hospital and community mental health centers, community health improvement, capital financing, information systems, facilities planning, medical and health professions education, and human resources, the Executive Team is responsible for providing leadership and decision-making in the progress or lack of progress of the strategic plan. For the short term task of finishing the work of the strategic planning process, the Lead Group proposes that the Organizational Development Group be populated with the members of the Executive Team. These members of the Organizational Development Group will complete the tasks of the initial strategic planning process and then guide and support ongoing implementation of the strategic plan over the intermediate and long term as members of the Executive Team. There will be continuity between the work of the Organizational Development Group and the Executive Team. A related logistic is to decide and determine whether the ongoing meetings of the Organizational Development Group will take the place of weekly Executive Team meetings after the current membership of the Executive Team is revised. **Draft Preliminary Charter** The charter for the Executive Team: 1. Provide leadership, direction, advice, and feedback about state policies and programs relevant to service delivery, data collection, and quality improvement and is the decision-making authority that codifies who is responsible for making key decisions. 2. Assure that the operation of the Division's programs is responsive to stakeholders' needs. 3. Responsible for making decisions about the statewide mental health system in the BHA. 4. Review and approve system-wide policies and procedures that guide practice. **Draft Preliminary Set of Responsibilities:** 1. Review progress on implementation of the Plan showing progress toward the key goals and measures in the Plan. 1. Continuously monitor changes in the Plan as well as the Division's actual performance in achieving its strategic goals. A material change in actual performance may prompt a recalibration or revision of the Plan at any time. Plan an annual team retreat on annual strategic planning and education.

ADULT MENTAL HEALTH DIVISION
Draft Strategic/Quality Management Program

ELEMENTS	DESCRIPTION
Results/Outcomes	The AMHD Work Groups will be using the Results-Based Accountability software to design, track data, and to tell the story behind the data. Data collected will be communicated to internal and external stakeholders by providing real-time intelligence on performance data and greater insight into our measures of success. In an effort to promote accountability, the scorecards in this software are embedded with live data, which can be uploaded on the AMHD website and/or shared with public links to communicate with internal and external stakeholders on the progress/non-progress that AMHD is making. Another benefit of using this software is that AMHD is embarking on an initiative to improve its service delivery and focus its work so that services are responsive to the unique needs of its service recipients who, in addition to having a serious mental illness, are concerned about receiving excellent care.

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To 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 approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] 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 supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

Adult Mental Health Division

The State Department of Health's AMHD developed a policy to include screening of clients for a personal history of trauma. The AMHD has developed a Trauma Informed Policy and Procedure to promote the provision of a trauma-informed system of care and to connect individuals with trauma histories to trauma-focused therapy. The policy informs awareness, knowledge and skills into the organizational culture and practices.

Specifically, the policy is written to ensure that AMHD services and programs are supportive of trauma-informed care to avoid re-traumatization of all persons served by the AMHD. Based on the understanding of the triggers of trauma, the AMHD will identify and provide services that are sensitive and responsive to the needs of survivors of trauma. The AMHD policy also states that Division will create and maintain a safe, nurturing and secure environment with supportive care, a system-wide understanding of trauma prevalence and impact, recovery and trauma-specific services that are recovery-focused and consumer-driven.

All public and private contracted agencies within the AMHD's array of services are encouraged to develop policies that are both trauma-informed and trauma-specific. This includes developing sensitive and effective methods for assessing consumers for trauma and consumer-directed treatment interventions.

Through the 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 are 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. Statewide trainings are occurring for AMHD's CMHC staff in trauma-informed care, and 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. There has been a significant amount of training of clinical staff at the CMHCs and several contracted agency clinical staff in Seeking Safety. The TIC-IT project also supports provider training in Seeking Safety treatment delivery, which is aligned with workforce development activities.

Child & 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 cadre of 70 therapists statewide in an evidence-based trauma treatment for children and adolescents, Trauma-Focused Cognitive Behavior Therapy to better serve children and youth with trauma histories. 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.

CAMHD also has a policy regarding seclusion and restraint that is based on the principles of trauma-informed care, and have trained extensively on this topic. CAMHD is committed to fostering violence-free and coercion-free treatment environments for children and adolescents. As part of this commitment, CAMHD advocates that our providers seek to minimize the use of restraint and seclusion, and work to increase the effective use of positive behavioral support strategies. As required in the Orange Book, CAMHD and all our providers must have internal policies and procedures regarding restraints and seclusion. 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 CAMHD has a standard safety plan that providers are encouraged to use.

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. This format allows the dissemination of trauma-informed care to the wider mental health community, with conference participants from the Adult Mental Health Division, school-based behavioral health personnel, academia, health and medicine and private practice.

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

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 use 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.[80] [81] 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. 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 a 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 consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate 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. Are cross-trainings provided 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?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] 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.

[82] 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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Description of Hawaii's Criminal and Juvenile Justice System

Written by the Hawaii Planning Council

Hawaii's Adult Criminal and Juvenile Justice System have some processes in place to identify or prescreen adults and youth for mental health problems, including suicidal/homicidal risk, and vulnerable population identification. In the past two years, legislation has moved forward to fund diversion programs, decrease the number of reoffenders, and build a more efficient adult criminal justice system. In addition, the PEW foundation has been working with the juvenile justice system to assist in the development of policies, procedures, and trainings that are instrumental in laying the foundation for a trauma informed care juvenile justice system.

Hawaii's Adult Criminal System

The adult criminal system in Hawaii uses the Level of Service Inventory (LSI-R), a screening tool that helps to determine the level of supervision and risk factors that would need to be addressed to minimize the risk for recidivism. The Adult Substance Use Survey (ASUS) is also used to screen for substance use. Hawaii also has special courts or programs that are specifically equipped to provide assistance to specialized populations of offenders. These programs include the Jail Diversion Program, Mental Health Court, Drug Court, and most recently Veteran's Treatment Court which started in 2013.

1. **Jail Diversion Program** - Screens individuals on the cell block to identify any acute mental health issues.

2. **Mental Health Court** - Offenders referred to the Mental Health Court are provided community based treatment to help issues related to severe mental illness. Participants in the Mental Health Court are assigned a case manager and a probation officer with regularly scheduled court appearances to provide updates on progress to the court.

3. **Hawaii's Drug Court** - Offers participants' access to treatment services in the community while avoiding jail time. Qualified offenders are provided community supervision, a drug and alcohol counselor and a case manager that assists the individual with life skills.

4. **Veteran's Treatment Court** - Established in 2013, Defendants selected for this court have served in the United States Armed Forces. The participants have been diagnosed with mental health issues and are challenged by substance abuse issues. Partnerships with US Vets and the Salvation Army Treatment Services provide assessment and evaluation services with referrals to treatment services for mental health and substance abuse. In addition, the court will assist participants in finding housing and obtaining job training. There are plans to expand The Veteran's Treatment Court to all islands.

Coordination efforts between state agencies help to implement the identified needs of the participants in the specialty courts described above. Specifically, the Jail Diversion Program coordinates closely with

the Criminal Justice System and the Mental Health Court maintains constant coordination with the Adult Mental Health Division. At this time, adult offenders are not enrolled in the Medicaid, however, some are covered under the state's Quest health insurance program.

In 2013, Hawaii enacted comprehensive criminal justice legislation with the goal of improving public safety. Act 139 (SB2776) and Act 140 (HB2515) were designed to lower recidivism, decrease identified inefficiencies in the adult criminal justice system, and hold offenders accountable to victims for their crimes. Hawaii's Interagency Council on Intermediate Sanctions, with members from the Department of Public Safety, the Judiciary, the Department of the Attorney General, the Department of Health, Office of the Public Defender, Hawaii Paroling Board Authority, and the Honolulu Police Department, are working to reduce recidivism and prevent future victimization by adult offenders. The Council's strategic plan identifies the following goals:

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

The Hawaii's Interagency Council on Intermediate Sanctions continues to move forward in efforts to meet their goals. Updates on data collection and recidivism rates can be found on their website and through periodically released publications.

Finally, the Assisted Community Treatment Program (ACT), which began in July of 2015 establishes a precedent under Hawaii Revised Statutes 334-121, where persons may be court ordered to obtain assisted community treatment if specific conditions are met.

Hawaii's Juvenile Justice System

The Juvenile Justice system in Hawaii has been in a state of constant reform and restructuring for the past decade. Various administrators and proponents of juvenile justice reform have led the strategic planning and activities in Hawaii through a grass roots implementation process. Those activities have reduced the census at the Hawaii Youth Correctional Facility, provided more integrated care, and developed a process for access to mental health services. Most recently, two bills were passed through the legislative process that required a risk and needs assessment to be conducted on each youth entering into the system and allowed for screening and further referrals to services that youth may need help/treatment with. It also reconvened the establishment of the Cluster Paradigm, providing coordinated services within the family court system and allowed for the establishment of a Juvenile Justice Oversight Advisory Council.

Youth in the juvenile justice system in Hawaii are often struggling with substance use, academic failure, complex trauma, disruptive behaviors, and family discord. Locking them up without preventive services

exacerbates the issues and does not solve the underlying problems with the youth, family, and community. Keeping youth in a correctional facility more much of their adolescent life, for status offenses, inhibits their development at all levels. Without juvenile justice reform, we are transitioning youth from one correctional system to the next and without the necessary life skills to become successful adults.

The juvenile justice system in Hawaii has several specialty courts that divert juvenile offenders from commitment to the Hawaii Youth Correctional Facility or detainment at the Kapolei Detention Home – Juvenile Drug Court, Girl's Court, and Family Drug Court. The Hawaii Family Court in each circuit (Oahu, Maui, Hawaii, and Kauai) handles juvenile matters which come under its jurisdiction. The following services are provided specific to each circuit:

1. **Juvenile Client Services, Juvenile Specialized Services Section** - Provides intake, screening, and counseling services to juveniles and their families.

2. **Juvenile Drug Court** – Is a post-adjudication treatment based drug court program for substance abusing juveniles and their families with gender-specific, culturally competent, family-based, and juvenile justice appropriate interventions.

3. **Family Drug Court** – Is a comprehensive approach to helping parents break the cycle of addiction and child abuse & neglect through monitored service delivery. Includes substance abuse treatment and parent education.

4. **Hawai`i Girls Court** – Provides a positive, pro-active, gender-specific and strength-based program for female juveniles with active family participation. Includes family and individual counseling, community service, educational and recreational activities, and group court sessions.

In Hawaii, the Juvenile Accountability Block Grant (JABG) Program has assisted in the development and implementation of programs that hold youth accountable for delinquent behavior through the imposition of graduated sanctions that are consistent with the severity of the offense and strengthen the juvenile justice systems' capacity to process cases efficiently and work with community partners to keep youth from re-offending.

In the state of Hawaii JABG activities are as follows:

1. **County of Hawaii, Office of the Prosecuting Attorney** - The county sub-contracted Hale Kipa, Inc., a non-profit community-based organization to implement a family management program for youth on probation. Program Coordinators with Hale Kipa are responsible for developing a team of community-based youth mentors capable of connecting and establishing strong relationship with youth and families and trained to provide a positive influence. Working as a team with probation officers and assigned youth monitor, a broad range of support services are coordinated and afforded to all participating youth and families. A total of 98 youth has been served as of date.

2. **County of Maui, Police Department** - The Maui Police Department offers a diversionary program that allows a youth arrested to participate in P.O.I. (Positive Outreach Intervention) Project. The project addresses the lag time between arrest and the youth's initial court hearing that could take up to 3 – 6 months. During the youth's participation, they must remain arrest free. A total of 107 youth has been served as of date.

3. **City and County of Honolulu, Department of Community Services** - Department of Community Services established the Juvenile Justice Center to divert first-time youth offenders referred by Honolulu Police Department and status offenders referred by the Family Court, 1st Circuit. The youth are held accountable for their action commensurate with the severity of their offense by making them aware and answerable for the loss, damage, or injury caused upon the victim and/or community. Services include counseling, life skills training, cultural activities, and other related activities. A total of 932 youth has been served as of date.

4. **County of Kauai, Office of the Prosecuting Attorney** - The county subcontracted with Hale Opio, Inc. to operate a Teen Court Program for youth offenders. Youth offenders who volunteer participate in a court of their peers rather than the traditional court system. A volunteer judge oversees the hearings and consequences include letters of apology, community service, and other character building skills development. A total of 49 youth has been served as of date.

The Juvenile Detention Alternative Initiative Program funded by the Casey Family Program continues to pilot a wraparound project which is serving youth involved in multiple systems across the state. Other grant funded diversion projects include *Reporting Center, Kupuna Program, Youth-on-Probation Program, Big Island Assessment Center, and Ho'opon Mamo.*

Beginning in FY2014, the Office of Youth Services and the Child and Adolescent Mental Health Division (CAMHD) entered into a Memorandum of Agreement to fund treatment services for those youth who are involved with law enforcement and/or probation that do not meet eligibility criteria for CAMHD Services through the SEBD process. Youth involved with the Juvenile Justice System can be referred by a probation officer and can access treatment services provided by CAMHD contracted service providers. These youth do not meet eligibility criteria for CAMHD services; do not qualify for SEBD services through CAMHD; are not eligible for QUEST; and/or private insurance does not cover requested treatment services. This preventive measure referred youth access to both community and residential services providing treatment for mental health issues.

Hawaii's Governor appointed Juvenile Justice State Advisory Council (JJSAC) continues to comply with federal statue requirements that protects youth physical and/or psychological harm in the juvenile justice system by requiring Hawaii (and all states) to adhere to the following core requirements:

1. Deinstitutionalization of Status Offenders;
2. Sight and Sound Separation of juvenile offenders from adult criminal offenders;
3. Removal of juvenile offenders from adult jails and/or lockups; and

4. Reduction/Elimination of the disproportionate contact of minority youth in all decision points of the juvenile justice system.

Summary

In conclusion, the adult criminal justice and juvenile offender systems in Hawaii continue their efforts in reducing the number of offenders with mental health issues and substance abuse in detainment facilities. Through their collaborative efforts with state agencies and national advisory boards, innovative programs serving at-risk populations have been created and more diversion programs are evident in both the adult and juvenile systems. It is imperative that these efforts are not halted or stalled. Diversion programs are essential and alternative placing individuals in locked facilities, services need to be developed to better meet the needs of the adult and juvenile population. More preventive measures would continue to see a decrease in recidivism and transitional services that identify prior release the specialized needs of the individual. Front line police officers would continue to benefit from specialized training in mental health identification for both the adult and juvenile population, far exceeding the few hours that are provided to them currently. Efforts must continue at all levels – screening, assessment, treatment, and detainment – to ensure that those individuals who need mental health assistance/treatment are provided and every effort is made to help them become healthy, productive citizens.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

The Planning Council requests Technical Assistance related to this section.

Footnotes:

STATE PARITY EFFORTS

Written by Hawaii Planning Council

The issue of parity in the field of mental health took center stage in 2008 with the enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA). The 2014 Affordable Care Act expanded on the MHPAEA by ensuring federal parity protections to those living with mental illness and addiction. The resulting benefits include 1) inclusion of mental health and substance addiction in the "essential health benefits" category; 2) inclusion of insurance coverage in the individual and small group insurance markets; and, 3) increased access to health care for this population.

Although the issue of parity in terms of insurance coverage for those with mental illness and/or substance addiction has been around for at least a decade, few in Hawaii know about what has been implemented to address parity discrepancies. On the surface, it appears the state has relegated the responsibility to educate the community about parity primarily to the insurance providers, many of whom speak "insurance-ese," and often require a skilled translator.

When the Hawaii Health Connector was in existence, members of the community who were computer savvy had easy access to information regarding the full range of benefits available through each of the insurance providers. Those who had questions were able to either speak with a warm body or to ask a question on-line. However, since mid-2015, when the state relinquished this role due to cost overruns and insufficient enrollment, the transition to the national Affordable Care Act has been a challenge for many.

In all fairness, the state has not had sufficient time to organize and implement a statewide information plan nor have policy makers been able to keep the community informed of next steps in terms of parity laws and how they impact the individual's access to medical services. The state has not fully recovered from the 2008 recession and it does not appear the state has transitioned from recession thinking to recovery thinking, approaching decisions from a glass half empty frame of reference.

One recommendation the Council made in 2014 is worth revisiting, that being the approval of the website. The website, once live, can be a user friendly portal for anyone to learn about the requirements of MHPAEA, policy decisions made on behalf of consumers and strategic goals and objectives, to name a few. The Council acknowledges may not meet everyone's needs and that not everyone has access to a computer or have basic computer skills. However, the global trend in information distribution is decidedly clear, we must develop and establish the Council as a viable source of information and education through a computerized venue.

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Adult Mental Health Division

In the Hawaii Revised Statutes (HRS), §334-3, the Department of Health is required to provide emergency crisis services to all residents of the state. Also, the Hawaii Revised Statutes states that the Director of Health shall designate mental health crisis workers. Crisis Services are defined as those unscheduled activities for the purpose of resolving an emergency or an urgent situation requiring immediate attention. Services include assessment, diagnosis, crisis counseling, treatment and/or referral during crisis interventions and admission screening to ensure rapid referral and linkage to appropriate interventions.

It is the policy of the AMHD that all persons statewide may contact the Crisis Line of Hawaii 24-hours a day, seven days a week, to request crisis services due to an urgent or emergent situation. A trained telephone staff member will screen every request for crisis services and all urgent and emergency inquiries will receive an immediate response. When face-to-face crisis services are warranted, the Crisis Mobile Outreach Team is dispatched to assist the individual. All crisis services will be with the consent of the person, parent, or guardian, unless the person is being evaluated for involuntary hospitalization according to the findings of a Mental Health Emergency Worker or other qualified professional as outlined in HRS 334.59. The services within the crisis services program are listed below:

Crisis Line of Hawaii: This is a 24-7 Crisis and Suicide Hotline with membership in the National Suicide Prevention Lifeline (SAMHSA). The Crisis Line staff provides supportive listening and crisis counseling, dispatch and authorization of 24-hour crisis services, and serves as the after-hours link for oral Ex-Parte orders.

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

Crisis Support Management (CSM): CSM provides time-limited support and intervention services to individuals who are in crisis and not linked with services or who do not have a Division-assigned case manager. Services assist the individual in returning to a pre-crisis state and gaining access to necessary services.

Licensed Crisis Residential Services (LCRS): The LCRS offers short-term, acute interventions to individuals experiencing or recovering from a psychiatric or behavioral health crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS services are for individuals who are experiencing a period of acute stress that significantly

impairs the capacity to cope with normal life circumstances. This program provides services which address the psychiatric, psychological, and behavioral health needs of the individual.

Pre-Booking Jail Diversion: This program operates as a joint effort between the AMHD and the Honolulu Police Department (HPD). When a person is suspected of mental illness at a crime scene, the HPD officer can request consultation from one of three HPD-employed psychologists who have been designated by the Director as Mental Health Emergency Workers and who are available for consultation 24-hours a day.

Central Receiving Division Project: This project provides Advanced Practice Registered Nurses (APRNs) for up to 80 hours per week (2 FTE) at the HPD's Central Receiving Division (CRD). The APRNs work in partnership with the Crisis Line of Hawaii, which provides the capability to cross-reference individuals and determine if they were currently receiving AMHD Services. Information about arrests is relayed from the Crisis Line of Hawaii back to the case management team for follow-up. Major activities include reviewing medication and medication needs and making recommendations to the court on behalf of the consumers, and providing the court with community treatment alternatives to hospitalization. Data was also collected on the frequency of mental health consumer arrests and rates of homelessness among persons arrested.

For FY2014, the State paid for the following services out of general funds:

- CMO only, 2,711 distinct clients for crisis services $1,889,525; CMO base payments of $449,244;
- CSM only, 1,947 distinct client for crisis services $1,957,021;
- CMO and CSM 2,842 distinct clients for crisis services $3,846,546; CMO base payments of $449,244;
- LCRS only 701 distinct clients for crisis services $1,788,016 and lodging per diem cost; and
- 4,352 persons received crisis services from the Mobile Crisis Teams.

Child & Adolescent Mental Health Division

CAMHD has three emergency services:

The Crisis Line of Hawaii is a telephone stabilization service that is staffed twenty-four hours/seven days a week. An initial assessment is made over the phone regarding the nature of the mental health crisis. Crisis workers specially trained to work with pediatric patients provide support, consultation and referral services. The aim is to provide the caller with sufficient information or guidance to dissipate crisis.

If at least one of the following criteria is met, the crisis worker will authorize Crisis Mobile Outreach:

1. The youth demonstrates suicidal/assaultive/destructive ideas, threats, plans or attempts which represent a risk to self or others as evidenced by the degree of intent, lethality of plan, means, hopelessness or impulsivity;
2. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable; or
3. The youth evidences lack of judgement, impulse control, or cognitive/perceptual abilities.

Crisis Mobile Outreach provides mobile outreach assessment and stabilization services face-to-face for a youth in an active state of psychiatric crisis. Services are provided twenty-four hours/seven days a week and can occur in a variety of settings including the youth's home, local emergency facility and other settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, immediate crisis resolution/stabilization and de-escalation if necessary.

Therapeutic Crisis Home provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. Youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in his/her natural setting are appropriate for Therapeutic Crisis Home. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth's functioning and return them to their natural setting.

Additionally, for youth who are receiving Multisystemic Therapy (MST), CAMHD standards require that MST therapist be available to their clients twenty-four hours/seven days a week. MST services include consultation with the youth, parents or other caregivers regarding behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers. These services, including crisis response and management, must be available twenty-four hours/7 days a week.

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, 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.

Recovery is based on the involvement of consumers/peers and their family members. States should 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 engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. 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?
4. 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? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. 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 and in the development and implementation of its Strategic Plan. 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 has developed 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 & Adolescent Mental Health Division

The Child and Adolescent Mental Health Division's efforts in the field of recovery generally focus on participant-directed care, peer providers in the continuum of services and family peer advocacy.

With the Child and Adolescent Service System Program (CASSP) principles as a foundational underpinning, CAMHD has a strong commitment to self-directed care. (See also: Participant Directed Care.)

CAMHD's System of Care grant, Project Kealahou provided CAMHD with its first opportunity with peer specialist positions. The peer specialists were recruited from among young women with histories of trauma in their lives. As the grant nears its conclusion, CAMHD is working with state legislators to sustain the program with state general funds.

CAMHD recently issued a Request for Proposals for Family Support Services. The new services began on August 1, 2015. The new Family Support Services provider shall develop a strong network of mutual support among the parents of youth experiencing mental health challenges. Services are to include extensive outreach to support and assist families statewide in accessing appropriate mental healthcare and building collaborative relationships with Mental Health Professionals. The contractor shall have a hiring preference for adults who have experience as caregivers for children or youth with mental health challenges.

CAMHD's family support contract requires that Parent Partner positions be established 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 7 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. Activities of Parent Partners shall include: providing and document direct parent support services to parents (50%); planning and providing educational programs for the community (20%); training, supervision, and administrative meetings (25%); and other advocacy activities (5%).

The provider shall promote family engagement at all levels of the CAMHD system. At the individual case level, the provider shall help engage families as the primary decision-makers in the care of their own children. The Parent Partners shall participate in case-oriented meetings and case reviews. The provider shall assist CAMHD with engaging family members to serve as advisors on policy development, service design and staff training. The provider shall send one of its leaders to participate regularly in CAMHD's monthly Leadership meetings; one staff to participate in the monthly Hawaii Interagency State Youth Network of Care; and one staff to participate in meetings of the State Mental Health Council.

For this contract, CAMHD is promoting revenue diversification by requiring the contractor to acquire the technical ability to submit bills for Medicaid reimbursement. One of the steps to toward qualifying for federal CMS reimbursement is to certify their staff through the national parent support provider certification program. The contract directs that each staff should be certified within one year of being hired. By the end of the third contract year, the Provider should be submitting enough billing to allow CAMHD to recoup at least twenty percent (20%) of the contract costs from MedQUEST.

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Olmstead Task Force
P.O. Box 339
Honolulu, Hawaii 96809-0339

January 12, 2005

The Honorable Linda Lingle
Governor of Hawaii
415 South Beretania Street
Hawaii State Capitol
Honolulu, Hawaii 96813

Dear Governor Lingle:

Back in January 2004 you asked us to develop an Olmstead Implementation Plan for the State of Hawaii. A group of approximately 70 individuals were invited to participate, but only a small group of individuals consistently worked over the past months to provide you the enclosed recommended plan. In December 2004 we held our final meeting at which we voted to send the recommended plan to you and your designated representatives for the Olmstead Implementation Plan, Lillian B. Koller, Director of Human Services, and Dr. Chiyomi Fukino, Director of Health. Each organization, including the major divisions within each state department, or individual advocate was allowed a vote. The final tally of votes is provided in the attachment to this letter.

The vote was not unanimous. State department personnel largely voted to move the plan forward while advocates and advocacy organizations largely voted to continue working on the plan. Concerns related to the recommended plan, as expressed by those voting against submittal of the plan in its present form, are summarized below:

Appearance of lack of commitment. There was active participation by staff representing the Department of Human Services and the Department of Health and their attached agencies - Housing and Community Development Corporation of Hawaii, Developmental Disabilities Council and Disability and Communication Access Board. However, there was either no or minimal participation by the other state departments, and completion of the recommendations required us to assign tasks to parties who had not been "at the table." In order to implement the recommended plan, it is important to receive commitment from all of the state departments, and individual counties. We urge you to educate and commit the state departments to the plan and to request the counties to do the same.

Budgetary concerns. The Olmstead Implementation Plan does not have any recommended budgets because none of the Task Force members could develop, authorize or commit to a new budget. While some action items do not require a budget, many actions may require new or additional funds. To demonstrate

commitment to the Olmstead principles and to the recommended plan, it is important that your administration support additional funding, if needed, to the effort to maintain individuals in the community.

Need for an assigned oversight organization. The Olmstead Task Force members want assurance that the plan will be implemented. Thus, the Task Force feels that one of the most important recommendations is the identification of an organization to serve as an oversight entity monitoring progress on implementation and communicating regularly with the Task Force.

The Task Force devoted substantial time and energy in developing the recommended action steps and want to continue its involvement in the implementation. We understand that you must share the plan with your department directors, and determine whether the proposed action steps can be implemented. We would appreciate this letter accompanying the referral of the plan to the department heads so that they are aware of our concerns and expectations. If you need to change some of the recommended actions and timetable, we would like to be informed of the change and the reason(s) for the change. This will help us to understand the situation and to assist in implementation. Please communicate to us your decision to accept or modify the plan by April 15, 2005.

We recognize that the Olmstead Implementation Plan will be a work in process. Over the course of a year, action steps may be implemented, revised, or delayed. Whichever the case, we want to be involved. We urge you to establish a regular process for reviewing actions to date and for making suggestions for new actions. We have individuals with significant and valuable experience that can help develop new or revise existing programs and services, and we encourage you to find ways to continue our participation.

We believe we all want the same thing - to work together to develop a better place for all Hawaii residents. We look forward to hearing from you and receiving feedback on our recommendations.

With much hope and gratitude,

The Olmstead Task Force

c: Honorable Lillian B. Koller, J.D., Director, Department of Human Services
Honorable Chiyomi Fukino, M.D., Director, Department of Health

Enclosures

Olmstead Task Force "Voting"*

Name	Organization	Yes	No
Patty Johnson	Social Services Division, DHS	X	
Al Arensdorf	Child and Adolescent Mental Health Division, DOH	X	
David Fray	Developmental Disabilities Division, DOH	X	
Doran Porter	Statewide Independent Living Council	X with reservations	
Waynette Cabral	Developmental Disabilities Council, DOH		X
Debbie Jackson	Disability Access and Communications Board		X
Pat Sasaki	Executive Office on Aging, DOH	X	
Betsy Whitney	Advocate		X
Pat Lockwood	Hawaii Centers for Independent Living		X
Bill Lennox	Adult Mental Health Division, DOH	X	
Mark Romoser	Advocate		X
Sheryl Nelson	Advocate		X
Becky Ozaki	Center for Disability Studies, University of Hawaii	X	
Leolinda Parlin	Family Voices	X	
Roseanne Poyzer	Healthcare Association of Hawaii	X	
John Noland	Vocational Rehabilitation and Services for the Blind, DHS	X	
Alan Matsunami	Med-QUEST Division, DHS	X	
Total		11	6

*Only those present at the meeting were allowed a vote. Each organization, including the divisions of the large departments, was allowed one vote.

Hawaii Olmstead Implementation Plan
October 1, 2004

INTRODUCTION

In June 1999, the United States Supreme Court, in Olmstead v. L.C., 119 S. Ct 2176, ruled that it is a violation of the Americans with Disabilities Act (ADA) for states to discriminate against people with disabilities by providing services in institutions when the individual could be served more appropriately in a community-based setting. States are required to provide community-based services for people with disabilities if treatment professionals determine that it is appropriate, the affected individuals do not object to such placement, and the state has the available resources to provide the community-based services. The Court suggested that a state could establish compliance with the ADA if it has 1) a comprehensive, effective working plan for placing qualified people in less restrictive settings, and 2) a waiting list for community-based services that moves at a reasonable pace.[1]

To meet its obligation, the state created an Olmstead Task Force comprised of people with disabilities, their family members, advocacy groups, non-profit agencies, businesses and government agencies. The Department of Human Services, Department of Health and the Hawaii Centers for Independent Living led a series of meetings with the Task Force members to identify the principles, goals and objectives, and strategies of the Hawaii Olmstead Plan. In October 2002, Hawaii's Olmstead Plan was finalized and delivered to Governor Cayetano, who in turn, transmitted it to the Legislature via the Senate President and Speaker of the House on November 29, 2002.

In January 2004, the Olmstead Task Force was reconvened by Governor Lingle to identify specific actions, assignments and timelines to implement the Hawaii Olmstead Plan. The same Task Force members from the earlier planning process were all invited to participate in the Olmstead Implementation planning process. Nearly every month and sometimes two times per month, the Olmstead Task Force convened to discuss and decide on the various recommended actions. The attached Implementation Plan represents the final work product of the group and establishes the actions for the state for the next three years. As with other plans, it is critical that the Plan be reviewed regularly and adjusted for changes.

OLMSTEAD IMPLEMENTATION PLANNING PROCESS

When Governor Lingle reconvened the Olmstead Task Force, she assigned the task of finalizing the Implementation Plan to Dr. Chiyomi Fukino, Director of Health, and Lillian Koller, Director of the Department of Human Services. Each, in turn, assigned individuals within their departments to lead and work on the Olmstead Implementation Plan. In January 2004 the original membership of the Olmstead Task Force was invited for an introductory meeting at the State Capitol. There, it was agreed that the Hawaii Olmstead Plan developed in 2002 was still appropriate and applicable, and therefore, would remain unchanged. The reconvened Task Force would then concentrate its efforts in identifying specific actions to support the implementation of the Plan. Towards this end, the Olmstead Task Force organized itself into four work groups

[1] Rosenbaum Sara, The Olmstead Decision: Implications for Medicaid, for the Kaiser Commission on Medicaid and the Uninsured: Washington, DC, March 2000

consistent with the four goals identified in the Olmstead Plan. The four groups worked to develop priorities, action steps, timelines and assignments for the following goals:

- Information, Education and Self-Empowerment
- Individual Equity, Assessment and Planning
- Financial Empowerment
- Infrastructure Development (housing, workforce, employment transportation, human services)

The individual work groups met on their own to develop recommended action items for each specific area. Although each group was able to provide recommended actions, in some instances, the work groups felt they lacked the necessary information or expertise to develop appropriate action items. In other cases, the work groups felt that the entire Task Force should be involved in the decision-making for the recommended actions. In the end, these issues and questions were discussed along with the specific work group recommendations with the Olmstead Task Force. The Task Force met formally eleven times to discuss and refine the recommendations of the four groups holding its final meeting in late September 2004.

Although the Olmstead Task Force membership was extensive (Appendix A), only a limited number of individuals actively and consistently participated in the planning process. Despite the smallness of the group, there was good participation and representation from individuals with disabilities, family members, advocates, providers, and state agencies. For this reason, the Olmstead Task Force feels confident that proposed Implementation Plan is one that can be largely supported by the state agencies and Hawaii's residents.

HAWAII OLMSTEAD IMPLEMENTATION PLAN

The Olmstead Implementation Plan is presented in Appendix B and is organized by the original four goals and the individual strategies. For each individual strategy, the Plan identifies the specific recommended action item, the lead agency, other assisting agencies and organizations responsible for the action, and the timetable for completion. The state Department of Health and Department of Human Services (DHS) are most predominantly listed as the lead agencies because both have responsibility for administering programs that support persons with disabilities. DOH operates programs to assist persons who have developmental disabilities/mental retardation, adults who are seriously and persistently mentally ill and children/youth with disabling conditions. As the state's Medicaid agency, DHS oversees the Medicaid/QUEST programs and the home and community-based waiver programs. It also has responsibility for the vocational rehabilitation program and has the state housing agency administratively attached.

The Plan recognizes that implementing real system changes to enable more people to live successfully in the community requires the contribution of many more state agencies and community groups. The administratively attached agencies such as the Executive Office on Aging (EOA), Disability and Communications Access Board (DCAB), Developmental Disabilities Council (DDC), and Housing and Community Development Corporation of Hawaii (HCDCH) are identified separately in the Plan since the departments do not have a direct supervisory responsibility over these agencies. Other agencies that are less commonly named, but assigned responsibilities, include the Department of Transportation, Department of Labor and Industrial Relations and the Department of Education. Finally, although consumers, advocates

and providers are not specifically identified for each action item, the Olmstead Task Force expects that these groups will be involved throughout the implementation process. This is more fully discussed under Guiding Principles.

The Task Force began the planning process with the intention to establish a budget for each of the action items. However, at the end, most participants felt that they were not in a position to determine the budget amount, and needed to leave the budget development with the lead agency. With two exceptions, the Implementation Plan also does not specify whether additional staffing or other resources are required to implement the action item. Again, this is left to the discretion of the lead agency. The two exceptions are the recommendations for positions to implement the actions for Strategy 4d6 (to assign a disability access liaison from the Disability and Communication Access Board (DCAB) to assist with the developing and implementing a unified transportation plan) and for Strategy 5a1 (to identify a quality assurance entity to assume responsibility for monitoring and evaluating implementation of the Olmstead Plan). Sufficient funding to assume these additional new functions is necessary for whichever organization receiving these assignments. The Olmstead Task Force is aware that the Legislature will determine whether permanent civil service positions are established and/or whether other resources (e.g., to contract services) will be provided.

All of the action steps in the Implementation Plan are identified with a timetable for immediate, intermediate and long-term. Immediate actions are those that can begin within six months of the implementation plan being accepted by the Governor. For the most part, these actions require no additional financial resources and can be performed by existing state agency staff. Additionally, the assigned tasks are consistent with the agency's current mission, objectives and responsibilities and may require only administrative action. If any data analysis is required, the data should already be available within the department. Intermediate actions will take place between six to eighteen months, and long-term actions are those which may take between eighteen months and three years to implement. Intermediate and long-term actions may require legislative changes, federal approvals, and/or additional funding from the Legislature. Certain long-term actions are reflective of the length of time required to implement new programs or to develop an appropriate infrastructure in the community to service persons with disabilities.

Throughout the various Olmstead Task Force meetings, there were many discussions on a variety of difficult topics. Although it is not possible to summarize all discussions, the following are some of the "themes":

- Available data and common sense dictate that we acknowledge a significant portion of Hawaii's population is living with a disability. In addition to individuals living longer, new treatments and technology are saving many more lives. Despite the increasing number of persons with disabilities, Hawaii's bed count in hospitals and nursing homes have remained stable. This situation poses both a challenge and opportunity for the State. Because the number of institutional beds is limited, there is a built-in incentive for the community to encourage individuals to live as long as possible either in their own or other homes in the community. The challenge, however, is find infrastructure solutions that support individuals with disabilities to live in the community as independently as possible. This means tackling difficult issues related to housing, transportation, support services, and work opportunities. The Task Force recognizes that addressing these issues will require more information, more time, more funds, and improved coordination between government agencies and private sector. The resulting Plan reflects this understanding and provides a realistic timetable for accomplishing the proposed actions.

- As noted previously, the state is not burdened with a large number of institutional beds and the infrastructure is not yet sufficiently developed that every individual with a disability can be cared for safely and appropriately in the community. Therefore, the Task Force accepts the fact that some individuals today and into the foreseeable future, will be placed in institutions. Given the current situation, it is important that activities are in place to educate and offer choice at the point of entry into the institution, and to regularly review the health status of individuals living in institutions and to plan, if appropriate, for the individual's eventual discharge.

- Information is the key to making an informed choice or decision, and the Real Choices website is a significant accomplishment in consolidating the vast range of information on long-term care and alternative community placements. The Plan supports the Real Choices website, but recognizes that additional work is needed to maintain accurate and current information and to improve accessibility. It also recognizes that Real Choices is one of many alternative information sources and that other formats and venues must be continually explored to reach the greatest number of individuals.

GUIDING PRINCIPLES

The Hawaii Olmstead Plan adopted the following guiding principles from the federal guidance communicated from the Centers for Medicare and Medicaid Services (CMS) to the State Medicaid Directors.[2]

Principle 1: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings.

Principle 2: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.

Principle 3: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.

Principle 4: Ensure the availability of community-integrated services.

Principle 5: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

Principle 6: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

[2] Olmstead Plan State of Hawaii, October 16, 2002

These same principles were considered in the development of the action steps for the Implementation Plan. The Olmstead Task Force added the following principles to guide the state agencies as they implement the action items of the Plan.

- Seek participation from consumers and providers, as well as councils and advocacy organizations statewide.

- Provide these participants access to meetings and agency activities where Olmstead action items are discussed.

- Identify opportunities and to the extent possible, establish reimbursement mechanisms to compensate participants for their expertise and/or provide paid staff whose primary responsibility is to advocate for consumers.

PROGRESS TO DATE AND NEXT STEPS

Long before the Olmstead decision, Hawaii had implemented programs to service persons with disabilities in the community. In addition to institutional care, the Medicaid program covers home health, hospice care and medical transportation to enable individuals to remain in their homes. The State also had elected and implemented several Medicaid home and community-based services waiver programs which include, but are not limited to, Nursing Home without Walls, HIV Community Care Program and the Medically Fragile Community Care Program. The state closed Waimano Home, the only state-operated ICF-MR facility, in June 1999. It continued to operate a crisis shelter and residential homes on the property, but these too were closed by December 2002 and all previous Waimano residents were transitioned into community placements. Prior to the Waimano closing, the Developmental Disabilities Division (DDD) of the Department of Health increased the number of community-based services and has significantly reduced the waitlist for DD/MR waiver services. DDD continues to examine and look for ways to provide more and a broader array of services to sustain current and future clients in the community.

The Adult Mental Health Division (AMHD) of the Department of Health has also been active in the recent years developing and expanding services in the community for adults who are seriously mentally ill. Most recently, AMHD began the process for discharging persons who are dually diagnosed with either mental retardation or developmental disability and a mental health diagnosis from the State Hospital into the community. Both Divisions are working jointly with the Med-QUEST Division (MQD) of the Department of Human Services to create an infrastructure to support these individuals in the community.

The Department of Human Services implemented the “Going Home” project which allows the transfer of Medicaid state plan funds (from MQD) to Medicaid home and community based waiver programs operated by the Social Services Division (SSD). This “money follows the person” concept has been applied to individuals in acute hospital beds waitlisted for skilled nursing level of care. Persons waitlisted in hospital beds are allowed to enter “slots” in the Residential Alternatives Community Care Program (RACCP), if they so choose. Previous to the funds transfer, new admissions to the RACCP would have been restricted due to funding constraints.

Despite these efforts, more work is needed to improve the delivery system. The State agencies recognize that some individuals who desire to return to the community still remain institutionalized because either the infrastructure or the technology is not yet available to safely and economically sustain the individuals in the community. Many providers do not have the array of services nor the knowledge, experience and ability to service people with complex needs. Addressing these capacity issues will require new funding and new innovations to cover the cost of more complex plans of care. Finally, more money and effort are required to prepare, consolidate, summarize and disseminate information, establish consumer-directed programs and to assist individuals to transition from institutions to communities. The state has received a number of grants to support these system change efforts. Most notably, is the $1.35 million Real Choices grant awarded in 2001 to develop and implement a web-based single entry point system. The website was successfully launched in February 2003 and now provides information on a wide array of service options including long-term care.

Refer to Appendix C for a description of the living options and support services available through current government sponsored programs. Appendix D provides a baseline of the number of persons served and dollars expended for government sponsored services, and Appendix E provides a more complete description of other Olmstead-related activities.

ACRONYMS USED IN OLMSTEAD IMPLEMENTATION PLAN

ADA	Americans with Disabilities Act
AG	Department of Attorney General
AMHD	Department of Health, Adult Mental Health Division
B&F	Department of Budget and Finance
DCAB	Disability and Communications Access Board (administratively attached to Department of Health)
DCCA	Department of Commerce and Consumer Affairs
DDC	Developmental Disabilities Council (administratively attached to Department of Health)
DDD	Department of Health, Developmental Disabilities Division
DHHL	Department of Hawaiian Home Lands
DHS	Department of Human Services
DLIR	Department of Labor and Industrial Relations
DOE	Department of Education
DOH	Department of Health
DOT	Department of Transportation
EOA	Executive Office on Aging (administratively attached to Department of Health)
H&CBS	Home and community-based services
HAH	Healthcare Association of Hawaii
HCDCH	Housing and Community Development Corporation of Hawaii
HCIL	Hawaii Centers for Independent Living
HDRC	Hawaii Disability Rights Center
HLTCA	Hawaii Long-Term Care Association
HUD	Federal Department of Housing and Urban Development
OHA	Office of Hawaiian Affairs
SILC	Statewide Independent Living Council
U.S.D.A.	United States Department of Agriculture
UH CDS	University of Hawaii, Center of Disability Studies
VRSBD	Department of Human Services, Vocational Rehabilitation and Services for the Blind Division

Appendices

A Olmstead Task Force Membership

B Olmstead Implementation Plan

C Description of Living Options and Community Services

D Baseline Information

E Olmstead-Related Activities

APPENDIX A

OLMSTEAD TASK FORCE MEMBERSHIP

Title	Last Name	First name	Agency
Ms.	Anderson	Suzie	Social Security Administration
Dr.	Arensdorf	Alfred	DOH/CAMHD
Mr.	Balayan	Oscar	United Cerebral Palsy Association of Hawaii
Ms.	Bender	Janet	Alzheimer's Disease & Related Disorders Assoc.
Ms.	Byers	Terri	Vice President, Healthcare Association of Hawaii
Ms.	Cabral	Waynette	Developmental Disabilities Council
Ms.	Canuteson	Deann	Full Life
Interim DIR	Chandler	Susan	University of Hawaii, Public Policy Center, College of Social Sciences
Dr.	Conner	Angie	
Ms.	Donkervoet	Christina	DOH/Chief, Child & Adolescent Mental Health Division
Mr.	Flores	Mike	U. S. Dept of Housing & Urban Development
Ms.	Fouts	Donna	United Cerebral Palsy Association of Hawaii
Mr.	Fray	David	DOH/Chief, Developmental Disabilities Division
Dr.	Fukino	Chiyome	Director of Health
Ms.	Fukunaga	Cheryl	U. S. Dept of Housing & Urban Development
Mrs.	Gillette	Kaanoi	DOH/AMHD
Ms.	Grossman	Naomi	Autism Society of Hawaii
Mr.	Gusman	Les	Mental Help Kokua
Ms.	Hawkinson	Kari Jo	Assist Guide
Ms.	Hill	Michelle	DOH/DDIR, Behavioral Health Administration
Ms.	Hiramatsu	Aileen	DHS
Ms.	Ihu	Liz	Family Member/Ho'oheno Inc.
Ms.	Jackson	Debbie	Disability & Communications Access Bd. (DCAB)
Ms.	Johnson	Patty	DHS/SSD/ACCSB
Ms.	Kaito	Gail	City & County, Dept. of Community Services
Mr.	Kanno	David	DOH/DD Division
Mr.	Kawakami	Norman	Easter Seals
Ms.	Kofel	Sandy	University of Hawaii, Center on Disability Studies, c/o CPASS
Ms.	Koller	Lillian	Director of Human Services
Mr.	Kula	Steve	The ARC in Hawaii
Ms.	Lee	Lynn	U. S. Dept of Housing & Urban Development
Mr.	Lennox	William	DOH/Chief, AMHD Consumer Affairs
Hon.	Lingle	Linda	Governor, State of Hawaii
Ms.	Lockwood	Patricia	Hawaii Centers for Independent Living
Ms.	Lundstrom	Joanne	Mental Health Kokua

APPENDIX A

OLMSTEAD TASK FORCE MEMBERSHIP

Title	Last Name	First name	Agency
Ms.	Maluafiti	Alicia	AARP
Mr.	Matsunami	Alan	DHS/MQD/PPDO
Ms.	Maunakea	Lynn	Institute for Human Services
Ms.	Medeiros	Nani	Policy Analyst, Office of the Governor
Ms.	Miyake	Karen	Elderly Affairs Division
Ms.	Molloy	Beth	American Association of Retired Persons
Ms.	Murray	Julie	Winners at Work
Ms.	Nelson	Sheryl	Open Access
Mr.	Nitta	Al	Planner, Housing & Community Development Corporation
Mr.	Noland	John	DHS/VRSBD
Mr.	Obatake	Mark	
Ms.	Ogawa	Sharon	Hawaii Long Term Care Association
Ms.	Ota	Charlene	
Ms.	Ozaki	Becky	CDS/University of Hawaii
Ms.	Parlin	Leolinda	
Ms.	Poirier	Marion	National Alliance of the Mentally Ill
Mr.	Porter	Doran	Statewide Independent Living Council
Mr.	Powell	Sam	Winners at Work
Ms.	Poyzer	Rose Ann	Healthcare Assoc. Of Hawaii, Home Care & Hospice
Ms.	Ramsey	Mildred	Residential Choices
Mr.	Romoser	Mark	HCIL
Dr.	Rosen	Linda	DOH Deputy Director/Health Resources Admin
Ms.	Rydell	Mary	Pacific Area Rep for Center for Medicaid/Medicare Services
Ms.	Sasaki	Pat	DOH/EOA
Mr.	Shacter	Joe	DOH/DD Council
Ms.	Shin	Rose	DOH/DD Council
Ms.	Smalley-Bower	Helen	Individual Care Planners, Inc.
Mr.	Spector	Richard	CMS, Region IX
Mr.	Smith	Gary	Hawaii Disability Rights Center
Mr.	Sted	Charles	Housing & Community Development Corp HI
Director	Stodden	Robert	Center for Disability Studies, University of Hawaii
Mr.	Sypeniewski	Kevin	AssistGuide
Ms.	Tizard	Diane	
CEO, Pres.	Tsuji	Marian E.	Lanakila Rehab Center, Inc.
Mr.	Tyler	Curt Sr.	
Mr.	Ueki	Darren	Housing & Community Development Corporation

APPENDIX A

OLMSTEAD TASK FORCE MEMBERSHIP

Title	Last Name	First name	Agency
Ms.	Wada	Edna	Certified Peer Specialist
Ms.	Wai	Francine	Disability & Communication Access Board
Dr.	Whelley	Teresa	CDS, BBC on Employment, HCIL
Ms.	Whitney	Betsy	
Mr.	Wilson	Ken	Mental Health Association in Hawaii
Ms.	Wong	Stella	Catholic Charities Elderly Services
Ms.	Yamamoto	Susan	Staff Support DHS
Ms.	Yokota	Tessy	Social Security Administration
Mr.	Yoshimura	Dana	Housing & Community Development Corporation

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Goal 1: Each individual will be informed and educated to make choices and decisions.					
Objective 1a: Increase people's knowledge about choices and rights.					
Strategy 1a1: Gather information on all available community-based living options, support services and individual rights.	The Real Choices website, www.realchoices.org, has been established to provide information on services to assist persons with disabilities. It includes a database of a variety of community and long-term care living providers. The following tasks will help to maintain complete and accurate information:				
	1. Identify state executive departments and agencies with responsibility for licensing/certifying providers.	DHS, DOH	CDS, AssistGuide	N	Done
	2. Develop a process for updating license/certification information.	DHS, DOH	CDS, AssistGuide	N	Done
	3. Develop a process for state executive departments and agencies to encourage providers to register and maintain information.	DHS, DOH	DLIR, CDS, AssistGuide	N	Done
	4. Identify community-based living options (programs as opposed to providers) and support services, and consolidate information into a chart.	DHS	DOH, DLIR	N	Done
	5. Work with AssistGuide to determine how to present information on options on website.	DHS	CDS	N	Immediate

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	6. Each department updates the information annually.	DHS, DOH	DLIR, AssistGuide	N	Intermediate
Strategy 1a2: Make this information accessible to individuals with disabilities, their families, their caregivers, and service professionals on a statewide basis.	The Real Choices website has made the information accessible.				
	1. Prior to the termination of the Real Choices grant in May 05, convene a workgroup to identify future developments to improve/enhance the website. Prioritize activities in order of importance to consumers.	DHS	CDS, AssistGuide	N	Immediate
	2. Identify and apply for grants to improve accessibility of the Real Choices website and development of new features.	DHS	CDS	N	Intermediate
	3. Publicize information in other formats and obtain necessary funding.	All state executive departments and agencies, in particular DHS, DOH, DCAB, DLIR with HDRC, HCIL, SILC, DDC		Dependent on each dept's approach	Intermediate
	Seek grant to develop a model one-stop center in Honolulu to serve older adults, caregivers and persons with physical disabilities.	EOA	Elderly Affairs Division, C&C of Honolulu Elderly Affairs Division		Intermediate Pending RFP from US Administration on Aging
Strategy 1a3: Implement an education campaign targeting the public that will increase knowledge about choices and rights.	A training and education campaign has been a part of the implementation of the Real Choices website.				
	1. Conduct press releases and obtain free publicity about the website (e.g., news shows, Olelo program, highlights in newspapers and MidWeek, etc.).	DHS	CDS	N	Immediate

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	2. Print and distribute rack cards to case managers, physician offices, others who may interface with individuals with disabilities.	DHS	CDS	N	Done
	3. Continue to publicize Real Choices website once the grant ends (e.g., public service announcements, health fairs, kiosks, yellow pages, distribution of materials, etc.).	All state executive departments and agencies, in particular DOH, DHS, DCAB, DLIR	HDRC, HCIL, SILC, DDC, AssistGuide	Dependent on each dept's approach	Intermediate
	Seek federal grant(s) to simplify Medicare information for adults with limited proficiencies in English.	EOA	Maui County Office on Aging, Alu Like, Inc., Maui Economic Opportunity, Inc., Maui Community College Media Center	N	Intermediate
Strategy 1a4: Provide a mechanism for users to give feedback on the accuracy, content, completeness, accessibility, and presentation of the information.	Develop an online survey that will allow users to evaluate the Real Choices website.	DHS	CDS, Maui Long-Term Care Partnership Project, Olmstead Work group	N	Intermediate
	Seek grants to expand and report on survey results.	DHS	CDS, AssistGuide	N	Intermediate
Strategy 1a5: Prepare and make available periodic evaluations of the state's information delivery system. The evaluation must integrate community feedback.	Assuming a sufficient amount of data is collected through the online survey instrument noted in Strategy 1a4, "mine" the data and prepare a summary of the results.	DHS	CDS, AssistGuide	N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Objective 1b: Assist people with using the information to make effective and informed decisions.					
Strategy 1b1: Foster individual and group discussions that share information among people with disabilities, by encouraging agencies to coordinate peer support and mentoring activities.	Develop a plan to implement this strategy. Report on progress two times per year.	DOH	All departments with responsibility for coordinating peer support and mentoring activities	N	Intermediate
	Coordinate with Kokua I Holomua project regarding the one stop center(s) for services and supports for individuals with DD and their families. Note: Phase I Kokua I Holomua project has ended 09/30/04. A new grant was received for development and implementation and will continue to 2007.	Office of Community Services	CDS, DDD, DDC, HDRC	N	Ongoing
	The CPASS grant provides training to individuals and families who participate in consumer direction. Individuals participating in the grant will be able to select their own services and service providers.	DOH	CDS, CPASS Council	N	Ongoing
	Expand or seek additional grants to continue peer support and consumer directed activities.	DOH	CDS	N	Intermediate
Strategy 1b2: Develop and implement a training initiative that teaches service professionals to effectively use the statewide information system to assist people with disabilities to make informed decisions.	The Real Choices grant trained approximately 2,300 individuals including self-advocates, service providers, state executive departments and agencies, case managers, non-profit agencies, employers, insurance agencies, financial planners, etc. on the Real Choices website. The following tasks will continue to support training efforts.				

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
	1. Orient new employees on the Olmstead principles, and provide training on accessing statewide resources such as using the Real Choices website.	All state executive departments and agencies, in particular DHS, DOH, DOT, DLIR, HCDCH, DOE		Y	Immediate
	2. Annually, provide training updates to its employees.	All state executive departments and agencies, in particular DHS, DOH, DOT, DLIR, HCDCH, DOE		Y	Intermediate
	Coordinate with Komo Kaulike Project to train One-Stop Center employees to develop a better understanding of accessibility and accommodation issues for persons with disabilities.	DOL	One-Stop Centers	N	Ongoing through 9/05
Strategy 1b3: Ensure that all individuals and organizations that provide services, including labor, education, transportation and health and human services, or that receive state contracts for such services to individuals with disabilities have demonstrated their commitment to Olmstead principles.	1. Define the Olmstead principles to be printed on department brochures and other material.	DOH, DHS	Olmstead Task Force	N	Immediate
	2. Publish the Olmstead principles on department materials.	DOH, DHS	DLIR, DOT, DOE	Y	As publications are printed.
	3. Revise request for proposals or new provider contracts to include information on Olmstead, and require providers to support the Olmstead principles, as deemed appropriate.	DOH, DHS	DLIR, DOT, DOE, AG	N	As contracts are renewed or new RFPs are issued.
	4. Work on revisions to statewide service contracts, as deemed appropriate.	AG	DOH, DHS, DLIR, DOT	N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Goal 2: Each individual will be supported in finding an appropriate, affordable and accessible home of their choice in a timely and efficient manner.					
Objective 2a: Undertake periodic assessments of all individuals in institutions, in a timely and efficient manner, to determine whether they choose to remain in the care facility or move to more independent community-based living alternative. In addition, prior to their institutional placement, undertake assessments of all individuals planning to enter a care facility.					
Strategy 2a1: Develop assurances and requirements to periodically assess, in a timely and efficient manner, individuals in all care facilities, institutions and hospitals – and to initially assess individual planning to enter such facilities – to identify their choice of community-based living. The written policy will require a neutral assessor.	Convene a workgroup to review the existing forms and processes for discharging individuals from institutions such as nursing homes and hospitals to the community. The group may choose to create a supplemental form or revise procedures to include more client participation when developing a plan to return the individual to the community.	DHS, DOH	HLTCA, HAH, individual providers such as hospitals and nursing homes, SILC, HCIL	N	Immediate
	Until a budget can be established or a grant obtained for neutral assessors, the workgroup will identify a process for including advocates and peer counselors to assist clients and facilities in the discharges. Look for pilot project to test revised process.	DHS	HLTCA, HAH, individual providers such as hospitals and nursing homes, SILC, HCIL	N	Immediate
Strategy 2a2: Develop a standardized personal choice assessment for interviewing care facility residents about their choice for community-based living.	Look for grants to support development of a standardized form. Grant money will be used to establish a process for identifying individuals to be assessed, individuals doing the assessment and training of the assessors.	DHS	CDS	N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 2a3: Develop a standardized assessment for identifying community-based living goals, personal and environmental strengths and needs, barriers to accomplishing goals, and an individualized plan for achieving the goals when the person wants to transition from the care facility.	Look for grants to support development of a standardized form.	DHS, DOH	CDS	N	Intermediate
Strategy 2a4: Use qualified service professionals and qualified peer advocates to facilitate the periodic assessments. Qualifications should be based upon knowledge and practice of informed choice, self-determination, person-centered planning principles and neutrality (i.e., lack of a conflict of interest).	Look for grants to support the development of position descriptions and minimum qualifications.	DHS, DOH	CDS	N	Intermediate
Strategy 2a5: Provide training opportunities for service professionals and peer advocates to learn how, while using the standardized assessment tool, to practice principles of informed choice, self-determination, person-centered planning, and neutrality.	Look for grants to develop training curriculum and to establish training program.	DHS, DOH	CDS	N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Objective 2b: Create effective ways for people with disabilities, their family members and caregivers, to evaluate and report on the assessment process for quality improvement.					
Strategy 2b1: Develop a system to collect feedback from people with disabilities, their families and caregivers, to improve, simplify and better coordinate the assessment process. In developing such a system, the state will seek input from people with disabilities, their families and caregivers, to ensure that the system is responsive.	Use the same workgroup(s) noted in Strategy 2a1 to identify the types of feedback from families and caregivers that are important. Look for grants to develop a system to collect feedback.	DHS, DOH DHS, DOH	HLTCA, HAH, individual providers such as hospitals and nursing homes, SILC, HCIL	N N	Immediate Intermediate
Strategy 2b2: Maintain an effective connection between consumer feedback and the monitoring of state contracts for assessment services, so as to make competency in effective assessments a requirement of all service professionals who facilitate assessments of individuals in institutions and individuals who are planning to enter institutions.	Look for grants to develop monitoring systems for state contracts for assessment services. Ideally, this would be a part of the grant that would also be funding the development of the assessment tool and training of assessors.	DHS, DOH		N	Intermediate
Objective 2c: People in institutions who have had assessments that identify them as candidates for community living will transition from institutions into the homes of their choice.					
Strategy 2c1: Contract with service providers to act as gate-openers who will assist people with disabilities with implementing their individualized plans for community-based living.	Look for grants to pilot "gate-openers" and to determine the cost for continued employment. When funding becomes available, recruit, train and supervise "gate-openers". Consider possible certification.	DHS, DOH DHS, DOH		N N	Intermediate Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Goal 3: Each individual will have access to and will direct financial resources to meet their identified goals in a timely manner.					
Objective 3a: Maximize the use of existing financial benefits and resources.					
Strategy 3a1: Identify all presently available funding streams, both public and private, for people with disabilities, including the elderly, with special emphasis on general financial assistance, housing, health care, personal assistance and chore services, assistive technology and employment training.	Collect information on available resources. Update annually for hard copy and on Real Choices website.	DHS DHS	CDS, DOH, DLIR and other governmental agencies.	N N	Done Intermediate
Strategy 3a2: Identify all eligibility and other criteria governing the use of funding sources.	Collect information on available resources. Update annually for hard copy and on Real Choices website.	DHS DHS	CDS, DOH, DLIR and other governmental agencies.	N N	Done Intermediate
Strategy 3a3: Establish a mechanism for disseminating information on funding sources and eligibility and continuing to update this information on an ongoing basis.	1. Work with AssistGuide to determine how to present information on options and related funding sources. 2. Look at other alternatives to Real Choices website to disseminate same information. 3. State programs to maintain eligibility information on their websites.	DHS DHS	CDS All state executive departments and agencies, in particular DOH, DOT, DLIR, HCDCH, DOE		Ongoing Intermediate Ongoing
Objective 3b: Change policies for existing resources to increase flexibility in how funds are used and give authorization to people with disabilities to control how they use their own funds.					

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 3b1: Change policies so that public funding can be attached to, and follow, individuals rather than providers, services or settings. In cases where federal regulations prevent such changes, the state will work with federal agencies to encourage changes in federal policy and regulation and will incorporate these changes at the state level when federal obstacles have been removed.	Explore the possibility of expanding or adapting the Going Home project to other HCBS programs.	DHS, DOH	B&F	Y	Intermediate
	Following completion of the CPASS grant, explore implementation of a "cash and counseling" program as an option for all DD/MR waiver participants.	DOH, DHS		N	Intermediate
Strategy 3b2: Review state regulations so that people with disabilities, their families and caregivers, can decide how their individual benefits will be used for the home and services of their choice.	DD Council initiated SCR 79 to convene a Task Force to identify issues and solutions concerning individuals with Developmental Disabilities and their choice of residential setting. The resolution seeks to identify residential options and to identify ways to facilitate changes in statutes, policies and administrative rules in order to increase residential alternatives and allow individuals choice of residential setting.	DD Council			Immediate
	Hawaii State Legislature adopted HCR 103 2004 HD1 which asks the Departments of Health and Human Services to examine the Federal Independence Plus Initiative to determine if Hawaii can benefit for applying for and obtaining a waiver or waivers to provide individuals with disabilities with services in the community.		DOH, DHS		Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
	Several state departments and agencies have applied for grants including: CMS Real Choices LIFE Accounts CMS Real Choices Portals to EPSDT Administration on Developmental Disabilities Family Support 360 One Stop Center Grant				Done
Strategy 3b3: Identify policies that create disincentives to independent community living and consumer choice by establishing a mechanism for people with disabilities, their families and caregivers, to provide feedback.	Review and report this feedback to appropriate Departments.		DD Council, HI Disability Rights Center, DCAB, HCIL, SILC, Governor's Policy Office, HUD Fair Housing Grantee (Legal Aid Society)		
	Senate Concurrent Resolution 79 also seeks to advance self-determination as a means of increasing residential options.		DD Council, DOH, HI Disability Rights Center as additional resources		
	Identify a representative on the State Workforce Investment Board to present employment issues for persons with disabilities.	DLIR	DHS	N	Immediate
	Examine the process for discharging medically fragile children from the hospital. Involve parents, providers and state executive departments and agencies in identifying barriers.	DHS	MCH LEND Program, DOH, Skilled Nursing Agencies, Hospitals, Families	MCH LEND Grant	Immediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
	Identify best practices for transitioning children/youth into programs and settings.	DOH	DHS, Providers, Families		Immediate
	Each state department identifies a contact person who can be called when an individual is unable to be discharged from an institution to the community due to multiple and/or complex issues. The department receiving the call will coordinate a meeting of a group of representatives from the relevant state executive departments and agencies such as AMHD, SSD, MQD, AG, advocacy organizations such as HDRC and others such as hospitals. The purpose of the adhoc group will be to identify, discuss and resolve, if possible, issues preventing or restricting the discharge.	All state executive agencies and departments		N	Immediate
Strategy 3b4: Change policies that create disincentives for people with disabilities to use available benefits. In cases where federal regulations prevent such changes, the state will work with federal agencies to encourage changes in federal policy and regulation and will incorporate these changes at the state level when federal obstacles have been removed.	Respond to policies and barriers identified in Strategy 3b3.	DHS, DOH	Governor's Policy Office HCDCH, DOE, DLIR	Depends on solution	Intermediate
	For the two medically fragile case studies, make policy changes, if appropriate and possible.	DHS	LEND Program, DOH	Depends on solution	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 3b5: Address funding biases that privilege placement in an institution over community-based living, by advocating for changes in federal policy and by committing to increase funds for community-living services relative to funds traditionally allocated to institutional placement.	Current home and community-based waivers allow more consumer direction than other traditional programs and facility placement. Expand to other programs. Verify whether SSI funds can be used as match for Medicaid funds. – Response: NO.		DHS		Done
Objective 3c: Increase the availability of new financial resources to pay for community-based living services.					
Strategy 3c1: Establish new revenue sources through user fees, investment strategies, legislative appropriations and/or other mechanisms to fund community-based living options and services.	Explore cost share options to expand the pool of individuals who could be eligible for services.	DOH, DHS		Y	Intermediate
	Research feasibility of developing commercial package with an array of services (NHWW, MFCCP etc.) only currently available to persons who are Medicaid eligible.	DCCA	DOH, DHS, Governor's Policy Office	Y	Intermediate
	Encourage the development of a viable long-term care insurance market. Consider ways to guarantee that the insurance will be available when people need it (similar to FDIC guarantees bank deposits).	DCCA	Governor's Policy Office, DOH, DHS	Y	Long term
Strategy 3c2. Revise the state supplemental payment policy to allow recipients to live in the homes they choose.	Review and determine feasibility of revising the state supplemental payment policy.	DHS	DOH, DDC, legislature	N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 3c3: Work with Hawaii Congressional Representatives to re-define the formula for the federal Medical Assistance percentage for Hawaii and to increase federal funds.	Work with consultants to identify opportunities to increase FMAP.	DHS	HAH, HDRC	N	Immediate
	Educate congressional staff on the issues related to the financing of Medicaid services.	DHS	HAH, HDRC	N	Immediate
Strategy 3c4: Develop a unified, community-based living funding plan that maximizes and incorporates all funding streams to meet the needs of individuals with disabilities, particularly those identified as unserved or underserved.	1. Identify the funding streams.	B&F		N	Done
	2 Identify funding amount by type of fund (Medicaid, Title V, etc.).	B&F		N	Intermediate
	3. Identify the needs.	DHS, DOH	SILC, DLIR, Legislature	Y	Long term
	4. Correlate and cross reference to determine how to combine funds.	B&F		N	Long term
	5. Find and apply for grant(s) to perform the research and planning work.	DHS, DOH	Governor's Policy Office	N	Long term
Strategy 3c5: Establish an effective mechanism for people with disabilities, their families and caregivers, to provide regular feedback to appropriate policy makers on new fund development strategies.	Support development of Grants Office in Lt. Governor's office. Private and public agencies and individuals receiving information on new fund development activities report information to appropriate policy makers.	Lt. Governor's Office	DD Council, HI Disability Rights Center, DCAB, HCIL, SILC Governor's Policy Office, HUD Fair Housing Grantee (Legal Aid Society)	N	On-going

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Goal 4: Each individual will be able to locate housing, acquire personal support personnel, use transportation, and engage in employment to sustain community-based living.					
Objective 4a: Ensure the availability of suitable housing and enable people with disabilities to acquire the homes of their choice.					
Strategy 4a1: Increase the number of available, accessible and affordable homes. The state will specifically address the needs of rural communities.	Collect data to establish housing priorities. Conduct a housing survey to identify the housing needs for the persons with disabilities. Identify current accessible housing inventories, housing shortfalls and possible corrective actions. Review existing laws and introduce legislation to provide universal accessibility.	DHS, DOH HCDCH	HCDCH, Counties, HUD, U.S.D.A., DHHL, OHA and other housing agencies. State Housing Directors shall serve as the lead.	Y	Immediate for housing supply Intermediate for housing needs
Strategy 4a2: Develop financing mechanisms that make owning and renting such homes feasible for people with disabilities.	Partner with private agencies to provide first time home loans to people with disabilities to purchase accessible homes or to purchase and modify homes. Government agencies to coordinate with private agencies.	HCDCH	Counties, HUD, financial institutions, DHHL, OHA, CDS, and private agencies		Ongoing

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 4a3. Provide housing location and placement services that help people weave through the complexities of finding, converting, renting, financing, and/or securing the home of their choice.	Convene a workgroup that meets regularly to discuss and begin work on: 1. Identifying barriers to community placements; 2. Finding and implementing solutions to link persons with disabilities to available accessible public housing; 3. Researching what has been done in Hawaii (AMHD); 4. Designing a set of supports and service; 5. Identifying a pilot project; 6. Looking for and accessing grants money for planning grant and pilot.	HCDCH	HUD, CDS, non-profit organizations, other housing agencies such as DHHL, OHA, HCIL, DOH, DHS		Immediate
Strategy 4a4: Ensure that at least one full-time staff person will work with developers, banks, other financial institutions, housing agencies and individuals with disabilities and their caregivers, to demonstrate that developing accessible and affordable housing is feasible and advantageous for all involved parties. The individual will do this by securing actual homes for real people. The state may secure such individual(s) in the manner it finds most appropriate: Direct hire, contract, partnership with a financial institution or other private entity, or other mechanism.	Action item is reflected in strategy.	HCDCH	Counties, other housing agencies such as DHHL, OHA, non-profit housing agencies.	Y	Long-Term

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Objective 4b: Develop and maintain a suitable workforce for community-based living support personnel.					
Strategy 4b1: Establish a unified mechanism to identify workforce requirements for community-living personnel, using feedback from sources that include people with disabilities, their families and caregivers, service providers and public agencies.	Connect with and initiate discussions with governmental programs (First-to-Work, Oahu Worklinks, Neighbor Island employment centers) that provide employment programs.	DLIR	DOH, DHS, Counties	N	Intermediate
	Establish a work group to identify pay equity issues for contracted services for direct support workers (skills trainers, personal assistants, etc). 1. look at consistency at reimbursement by various state programs for similar services. 2. review salary to direct support worker and administrative costs ratios. 3. assess impact on consumer directed services. 4. Explore options for certification standards direct support workers.	DLIR	DOH, DHS, DOE, Counties	Y	Long term
Strategy 4b2: Identify all existing funding streams for workforce training and education and determine whether further appropriations are needed to meet anticipated workforce demands. Informal opportunities, such as those offered by churches and other civic groups, will be considered in the process.	Action item is reflected in strategy.	DLIR		N	Intermediate

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Strategy 4b3: Develop a unified community-living workforce development plan in partnership with key labor agencies, service providers and representatives from people with disabilities. The plan will specifically address the needs of rural communities.	Action item is reflected in strategy.	DLIR		Y	Long Term
Strategy 4b4: Establish a public-private partnership that will develop and implement a cost-effective insurance plan to cover professional liability for community-living support personnel.	Action item is reflected in strategy.	DCCA		Y	Immediate
Strategy 4b5: Encourage labor policy changes, both statutory and regulatory, that create incentives for people to become community-living support personnel and that help ensure their livelihood.	Review current policies and identify those that require changes, for example immigration requirements, training, background checks, etc.	DLIR	AG, DOH, DHS	N	Intermediate
Objective 4c: Enable people with disabilities to qualify for jobs and gain employment to help sustain their community-based living.					
Strategy 4c1: Establish a unified strategy to train, qualify and facilitate the placement of people with disabilities in the employment of their choice.	Develop and sustain capacity of the One-Stops to provide accessible employment services to persons with disabilities.	DLIR	DHS, counties	N	Ongoing.
	Implement activities under the Workforce Investment Grant (training, acquire equipment etc.).	DLIR	DHS	N	Ongoing. Activity to be completed by 9/05

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 4c2: Develop a mechanism to evaluate the progress of individuals enrolled in public or vendor training programs, to help ensure that they actually progress toward their stated goals and achieve their employment of choice. This evaluation mechanism should take into account the full spectrum of training, from remediate to graduate education.	VR and DDD employment services providers have service plans which track this.	DOE, DOH, DHS		N	Completed
Strategy 4c3: Support innovative employment strategies, such as transitional employment and community-driven micro-enterprise.	Develop a mentoring system for those who wish to start a small business. The mentors would be self-employed individuals with disabilities. Improve and expand transition services for individuals with disabilities as they move from school to work or higher education.	DHS DOE	Winners at Work DHS, DOH	N Depends on the transition	Immediate Intermediate
Strategy 4c4: Ensure full employment opportunities for people with disabilities for all government positions and enforce compliance with equal employment opportunity regulations among all private contractors.	Issue an executive order instructing all department heads to ensure job applicants with disabilities are assured equal employment opportunity. The order will include a goal (number employed) for each department to strive for.	DCAB, DLIR	Governor's Office, all State Executive departments and agencies excluding PSD.	N	Immediate
Strategy 4c5: For vocational services that choose applicants based upon a system of priority, give priority to people with disabilities who are transitioning from institutional living.	To the extent possible, priority will be given to those transitioning from institutional living.	DHS		N	Ongoing

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RECOMMENDED OLMSTEAD IMPLEMENTATION PLAN
As of December 30, 2005

Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 4c6: Ensure that vocational service personnel undergo the professional development necessary to interact effectively with people with disabilities and help people with disabilities achieve successful employment outcomes.	All state government offices which contract for employment services will require that all applicants for such contracts have taken a series of training programs from DCAB. DCAB to develop listing of programs provided, and to report attendance at such training to assure the department that contract personnel have been trained.	DHS, DOH	DCAB, DLIR	N	Immediate
Objective 4d: Optimize accessibility and mobility, by developing and implementing long-range, systematic plans, to enable people with disabilities to move throughout their communities, using all means of travel.					
Strategy 4d1: In cooperation with county transportation agencies, establish a unified mechanism to identify transportation requirements for people with disabilities in different communities, using feedback from sources that include people with disabilities, their families and caregivers, service providers and public agencies.	Provide information to counties on the Olmstead Plan's objectives related to transportation. Coordinate with and encourage counties to each conduct a standard customer needs assessment survey to determine the type of transportation service that will meet the needs of the target population.	DOT	County transportation providers.	Y	Immediate
Strategy 4d2: Develop a unified, community-based living transportation development plan with key federal, state, and county transportation agencies, service providers and representatives from people with disabilities. The plan will specifically address the needs of rural communities.	Work with individual counties to provide information on federal and state public transportation requirements. Utilize existing Rural Transportation Technical Advisory Committee (RTTAC) consisting of Neighbor Island Counties' public transportation agency directors to address Olmstead Plan objectives in their respective transportation plans and planning effort. This effort is totally dependent on each county. The focus is on rural areas (Big Island, Maui, Lanai, Molokai, Kauai).	DOT	County transportation providers, DCAB	Y	Immediate
Strategy 4d3: Ensure full access in all	Review existing contracts to insure that the	DOT	County transportation	N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
transportation projects by integrating ADA requirements into contracts with vendors.	ADA requirements are integrated and monitored.		providers, DCAB		
Strategy 4d4: In coordination with county agencies, appropriate and utilize the necessary funds to establish accessible transportation services for people with disabilities for rural communities on the islands of Hawaii, Maui, Kauai, Lanai, and Molokai.	Assist counties in identifying potential federal funds that could be used to establish accessible transportation services in rural communities.	DOT	County transportation providers, DCAB	N	Intermediate
Strategy 4d5: Work with county transportation agencies to ensure that public transportation personnel are effectively trained for interactions with- and safety protocols for services to persons with disabilities.	Procure funds to work with county agencies to train transportation personnel.	DOT, DCAB		Y	Intermediate
Strategy 4d6: Assign a disability access liaison from the Disability and Communication Access Board to assist with developing and implementing the unified transportation plan.	Procure funds to create a position in DCAB.	DCAB	DOT, Counties	Y	Intermediate
Objective 4e: Establish and maintain support service programs to assist people with disabilities to live in the homes of their choice.					
Strategy 4e1: Increase funding for community-based living support services.	Seek increased funding for chore services. Funding could be used to increase the hourly reimbursements and/or to provide more services to more people.	DHS		Y	Intermediate
	Seek increased funding for DD/MR waiver services. Funding could be used to increase reimbursements and/or to provide services to persons.	DOH	DHS	Y	Immediate and

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 4e2: Utilize funds appropriated for support programs within a reasonable timeframe.	Determine if current funding is being fully used.	B&F		N	Intermediate
	Target funding related to independent living supports.	DHS, DOH		N	Intermediate
	Track contract dollar amount versus actual amount expended at the end of the contract period.	DHS, DOH		N	Intermediate
Strategy 4e3: Develop and implement guidelines that balance quality of care, affordability, appropriateness of care and consumer responsibility.	Service providers and consumers collaborate on developing guidelines, beginning with the H&CBS Waivers through the Waiver Quality Framework.	DHS, DOH		Y	Immediate
	Expand Quality Framework to other programs.	DHS, DOH		Y	Intermediate
Strategy 4e4: Incorporate the principles of self-determination and consumer control into all state-funded support programs targeting individuals with disabilities.	Review and modify policies, procedures and practices to ensure consumer driven choices.	All state executive departments and agencies		N	Immediate
	Each state department serving persons with disabilities will orient its new employees on the self-determination and consumer control principles.	All state executive departments and agencies		Y	Intermediate
	Develop training and pilot projects, adjusting policies and procedures supporting self determination and consumer control.	All state executive departments and agencies		Y	Intermediate
	Incorporate the principles of self determination and consumer control in all state contracts, where applicable.	All state executive departments and agencies		N	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Goal 5: The State of Hawaii will coordinate an on-going, effective quality assurance program to monitor and assess the state's progress in meeting the goals and objectives of this plan.					
Objective 5a: Integrate people with disabilities, their families and caregivers, in the process of evaluating plan outcomes and the quality of community-based living services.					
Strategy 5a1: Identify a quality assurance entity to assume responsibility for monitoring and evaluating implementation of the Olmstead Plan. This entity may be a state agency or agencies, authorized private agency, a public-private partnership, or some other entity.	Designate an Olmstead Implementation Coordinator/Facilitator position with responsibility for ensuring the assigned Olmstead activities are implemented and reported.	All state executive agencies and departments		N	Immediate
	Identify and provide a budget for an organization (such as DCAB or SILC) to work with the group to resolve the issues (it is anticipated that this would require a temporary full time position for approximately 3 years). This organization will also document the issues and resolutions for purpose of educating others on existing barriers, options, and potential processes/considerations for future changes.	Governor's Office	All departments	Y	Intermediate

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Olmstead Goal	Action Item	Lead Agency	Assisting Agencies/Other Stakeholders	Budget Required Y/N	Time Frame
Strategy 5a2: Establish a unified mechanism for evaluating all goals, objectives and strategies of the Olmstead Plan. This mechanism will include 1) feedback from people with disabilities, their families and caregivers, service providers, public agencies, legislators, and other entities and 2) opportunities for these stakeholders to meet and address Olmstead implementation on a regular basis.	Identify an existing Council or Board (DCAB, SILC, HDRC, or HCIL) consisting of at least 51% individuals with disabilities to provide oversight of progress on the Olmstead Implementation Plan. Report to the Governor regularly on the status and provide recommendations for corrective actions.	Governor's Office		Y	Intermediate
Strategy 5a3: Take corrective action whenever evaluation and advice from the quality assurance entity recommends corrective action.	Action item is reflected in strategy.	Governor's Office	All Executive Agencies	Depends on corrective action.	Intermediate

APPENDIX C

COMMUNITY-BASED LIVING OPTIONS AND SUPPORT SERVICES

As of November 8, 2004

Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Financial (Cash) Assistance					
Social Security	Cash payments	Persons aged 62 and older	Worked for ten years and paid social security taxes.	Federal	Social Security Administration
Social Security Disability Insurance (SSDI)	Cash payments	People who are unable to work for a year or more due to a disability.	Worked or have worked in the past and paid Social Security taxes. Must meet the Social Security Administration (SSA) definition of disabled.	Federal	Social Security Administration
Supplemental Security Income (SSI)	Cash payments	Persons who are blind, disabled or at least 65 years old with limited work history	Income and asset limits. Must meet the Social Security Administration (SSA) definition of disabled.	State and federal funds	Social Security Administration
Temporary Assistance for Needy Families (TANF) and Temporary Assistance to Other Needy Families (TAONF)	Cash payments	Needy families with children	Income and asset limits depending on family size.	State and federal funds	DHS, Benefits, Employment and Support Services Division

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
General Assistance (GA)	Cash payments	Adults between the ages of 18 and 64, without minor dependents, who are disabled and do not qualify for Social Security.	Income and asset limits depending on family size, do not qualify for assistance from a federal program and certified by a DHS medical board to be unable to engage in substantial employment of at least thirty hours per week for at least 60 days.	State	DHS, Benefits, Employment and Support Services Division
Aid to the Aged, Blind, Disabled (AABD)	Cash payments	Persons aged 65 and older, or who are disabled.	Income and asset limits depending on family size. Must meet the Social Security Administration (SSA) definition of disabled.	State	DHS, Benefits, Employment and Support Services Division
Veterans Affairs (VA) Compensation	Cash payments	Veterans who are disabled by injury or disease that developed or worsened in the line of duty.	Veteran discharged under honorable conditions	Federal	Veterans Affairs Benefits Administration
Housing					
Community Care Foster Care Homes	Private homes that have 2 or less residents who receive care from live-in caretakers. Assistance with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided.	Persons 18 years and older.	Income and asset limits depending on family size. Certified as requiring nursing facility level of care. Private pays can also access without level of care certification or income/asset	State and Federal Private pay	DHS, Social Service Division/Adult and Community Care Services Branch For private pays, DHS only licenses the Case Management Agency

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
	Level of care payments (State Supplemental Payments) are made directly to the home. Services are paid by the Medicaid waiver program. ——— No Level of Care payments for private individuals not meeting income and asset limits. These individuals are considered "private pay".		limitations		that certifies the homes.
Adult Residential Care Homes	Private homes that have 5 or less residents with at least two functional deficits in ADLs who receive care from live-in caretakers. Assistance with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided. Level of care payments (State Supplemental Payments) are made directly to the home. ———	Persons 18 years and older with two functional deficits ——— Same for private pays	Income and asset limits depending on family size. Do not have caregivers or a residence. ——— Private pays can also access by meeting functional deficits. Asset and income limitations do not apply.	State and Federal-if individual is receiving Level of Care payments, funding is from individual's SSI income combined with the State Supplement Payment. ——— Private pay	Social Security Administration-SSI DOH-Licensure DHS-Social Service Division /Adult and Community Care Services Branch (administration of the Level of Care Payments) ——— For private pays, DOH only licenses the home.

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
	No Level of Care payments for private individuals not meeting income and asset limits. These individuals are considered "private pay".				
Expanded Adult Residential Care Homes	Private homes that have 5 or less residents, of which 2 may be certified at nursing facility level of care, who receive care from live-in caretakers. Assistance with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided. Level of care payments (State Supplemental Payments) are made directly to the home. No Level of Care payments for private individuals not meeting income and asset limits. These individuals are considered "private pay".	Persons 18 years or older with two or more functional deficits. Same for private pays	Income and asset limits depending on family size. Do not have caregivers or a residence. For private pays, no certification or income/asset determinations.	State and Federal Private pay	DOH-Licensure DHS-Social Service Division/Adult and Community Care Services Branch For Private pays, DOH only licenses the home.

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Residential Alternatives Community Care Program (RACCP) Foster Homes	Private homes that have 2 or less residents who receive care from live-in caretakers. Assistance with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided. Payments are made directly to contracted providers. No payments for private individuals not meeting income and asset limits. These individuals are considered "private pay".	Persons 18 years and older requiring nursing level of care.	Income and asset limits depending on family size. Certified as requiring nursing facility level of care. Private pays can also access without level of care certification or income/asset limitations	State and Federal Private pay	DHS, Social Service Division/Adult and Community Care Services Branch For private pays, DHS only licenses the Case Management Agency that certifies the homes.
Assisted Living	Apartments for persons who are not able to live on their own safely, but do not require the high level of care provided in a nursing home. Assistance varies, but may include help with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided.	Persons 18 years and older requiring nursing level of care. For private pays, requirements vary depending on the assisted living facility.	Income and asset limits depending on family size. Certified as requiring nursing facility level of care and do not have caregivers or a residence. For Private pays, no certification of income/asset limitations or nursing facility level of care.	State and Federal Private pay	DOH-Licensure DHS-Social Service Division/Adult and Community Care Services Branch For Private pays, DOH only licenses the home.

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
	Level of Care payments (State Supplemental Payments) are made directly to the home. _____ No Level of Care payments for private individuals not meeting income and asset limits. These individuals are considered "private pay".				
Domiciliary Care Homes	Licensed domiciliary care homes that have 5 or less resident who have a developmental disability. Assistance with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided. Domiciliary care payments are made directly to the home.	Persons 18 years and older certified as being Developmentally Disabled/Mentally Retarded _____ Same for private pays	Income and asset limits if requesting/receiving Domiciliary Care payments. _____ For Private pays, no certification or income/asset determinations	State and Federal _____ Private pay	DOH-Office of Health Care Assurance - Licenses home DOH-Developmental Disabilities Division - certifies home _____ For Private pays, DOH only licenses and certifies the home.

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
DOH Foster Homes (Takes up to 2 people)	Homes that have 2 or less residents who have a developmental disability. Assistance with daily living activities such as bathing, feeding, medication administration, ambulation and dressing; and independent living activities such as cooking, money management, and laundry are provided. Domiciliary payments are made directly to the home.	Persons 18 years and older certified as being Developmentally Disabled/Mentally Retarded _____ Same for private pays	Income and asset limits if receiving Domiciliary Care payments. For Private pays, no certification or income/asset determinations	State and Federal	DOH Developmental Disabilities Division – certifies the home, certifies the individual as meeting DD/MR criteria, and places the individual. DHS-Social Service Division/Adult and Community Care Services Branch – administration of domiciliary payments.
24-Hour group home, 8-16 hour group home, interim housing, semi-independent housing, specialized residential housing, supported housing	Licensed interim housing and other homes with 15 or less beds. Includes supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training.	Persons 18 years and older meeting criteria for being seriously mentally ill (mental illness diagnosis and serious functional impairment).		State and Federal	DOH Adult Mental Health Division

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Community residential services, therapeutic group homes, therapeutic foster homes	Licensed group and foster homes with usually 3 to 6 individuals, but not more than 15 beds. Includes supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training. Out-of-home treatment settings are designed to treat specific mental health challenges and only incidentally provide housing as part of the comprehensive treatment approach.	Persons 20 years old or younger meeting criteria for serious emotional and behavioral disturbance (SEBD) which include a qualifying psychiatric DSM-IV diagnosis and CAFAS above 80. Youth needing a complex array of rehabilitative services may qualify provisionally with a lower CAFAS score.	Income and asset limits if requesting QUEST/ Medicaid coverage.	State and Federal for QUEST/Medicaid	DOH Child and Adolescent Mental Health Division – SEBD determination DHS-Med-QUEST Division – QUEST/Medicaid eligibility determination
Public Housing and Rent Supplement Programs (State only) and Section 8 Housing Choice Voucher Program (State and Counties)	Rent subsidy programs	Disabled 18 years and older	Income and asset limits depending on family size.	1. Federal Public Housing (HUD) 2. Section 8 Housing Choice Voucher Program (HUD) 3. State Public Housing (State) 4. Rent Supplement Program (State)	DHS, Housing and Community Development Corporation of Hawaii (funding source 1-4) City & County of Honolulu, County of Hawaii, County of Kauai, and County of Maui (funding source 2).

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Section 8 Project-Based Programs	Rent subsidy programs	Disabled 18 years and older	Income and asset limits depending on family size.	Privately operated housing projects.	DHS, Housing and Community Development Corporation of Hawaii
Hula Mae Program (Homeownership)	This program provides eligible homebuyers with mortgage loans at lower interest rates than those available on conventional loans.	Disabled or Elderly	Income and purchase price limits. Participating lending institutions accept applications and screen applicants to determine their eligibility according to program guidelines, process loan applications, and deliver the loans to the HCDCH upon closing.	State and private financial institutions	DHS, Housing and Community Development Corporation of Hawaii
Mortgage Credit Certificates Program (Homeownership)	As an alternative method of financing for homebuyers. MCC Program provides eligible borrowers with a direct tax credit against their federal income tax liability making more income available both to qualify for a mortgage loan and make monthly payments.	Disabled or Elderly	Income and purchase price limits.	State and private financial institutions	DHS, Housing and Community Development Corporation of Hawaii
Downpayment Loan Program (Homeownership)	Provides eligible borrowers with downpayment loans. Funds made available under this Program must be applied toward the downpayment for the purchase of a home.	Disabled or Elderly	Income limits. The Program loan is to be processed simultaneously with the first mortgage and will be recorded or filed as second mortgage on the property purchased with the loan.	State and private financial institutions	DHS, Housing and Community Development Corporation of Hawaii City and County of Honolulu

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Low Income Home Energy Assistance Program (LIHEP)	Financial assistance to help with the high cost of utilities or prevent termination of utilities. Payment is made directly to utility company on an annual basis.	Low-income persons	Income and asset limits depending on family size.	Federal	DHS, Benefits, Employment and Support Services Division
Health Care					
Newborn Hearing Screening Program	Arrange follow-up audiological evaluations	Newborns who fail to pass hearing screen; children less than age 3 who develop a permanent hearing loss after birth.		State	DOH, Early Intervention Section
Children with Special Health Needs Program	Pediatric cardiology and/or neurology clinics on islands of Hawaii, Kauai, and Maui where services are not available	Children 0 to 21 years	Income and asset limits for children with no other resources	State	DOH, Children with Special Health Care Needs Branch
Public Health Nursing Services Program	Skilled Nursing	Students in public schools with need for specialized medical care (i.e., ventilator and trach care; gastrostomy feeding, catherization, etc.)	IDEA, Part B and 504 having need for specialized medical treatment by licensed nurses	State	DOH, Public Health Nursing Branch
Medicaid	Medical coverage for hospital, skilled nursing care, outpatient, physician, pharmacy, durable medical equipment, laboratory, x-ray, and other medical services. Payments are made directly to	Low-income children, pregnant women, adults, individuals with disabilities, blind and persons aged 65 and older	Income and asset limits depending on family size. Children less than age 19 and pregnant women do not have an asset limit.	State and federal	DHS, Med-QUEST Division

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Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
	providers of care or to health plans.				
Medicare	Medical coverage for hospital, skilled nursing care, outpatient, physician, some durable medical equipment, some pharmacy, laboratory, x-ray and other medical services. Payments are made directly to providers of care or to health plans.	Persons aged 65 or older, persons with disabilities, and persons with end-stage renal disease	Worked 10 years and paid Medicare taxes	Federal	Centers for Medicare and Medicaid Services
Veterans Affairs	Medical coverage for hospital, outpatient, physician, durable medical equipment, and other medical services.	Veterans	Honorably discharged, served one day of active duty before 09/07/80 or two consecutive years of active duty after 09/07/80 or was a National Guardsman or reservist brought to active duty by President. Depending on the availability of funding, VA may establish priority groups.	Federal	Veterans Affairs
Pharmaceutical Assistance	Prescription drugs	Programs vary, but typically they are designed for persons aged 65 and older	Income limits, but typically no asset limits.	Private	Various pharmaceutical manufacturers.

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

Hawaii Rx Plus	Prescription drugs	Prescription drugs at Medicaid prices from participating pharmacies	Hawaii resident, family income less than or equal to 350% of the federal poverty level.	State	DHS, Med-QUEST Division
Medicine Bank	Limited prescription drugs				
Home and Community Services					
Older Adult and Caregiver Services	Personal care, homemaker, chore, home-delivered meals, adult day care/health, case management, congregate meals, nutrition counseling, assisted transportation, transportation, legal assistance, nutrition education, information and assistance, outreach; information, training and services for family caregivers; and other services respective to individual County needs and resources	Persons aged 60 and over, caregivers of persons aged 60 and over, caregivers of children below 18 years.	Persons with 2 ADLs or IADLs and are not receiving other government assistance	State and Federal	DOH, Executive Office on Aging and Area agencies on Aging
Chore	Help with independent living such as housekeeping, money management, shopping, cooking, and laundry services. Payments to client who reimburses the provider of services or payments to contractor for specified number of hours.	Adults with disabilities	Deficit in 2 ADL, certification from physician may be required	State and Federal Social Service Block Grant	DHS, Social Service Division/Adult and Community Care Services Branch
Adult Day Care	Social and education stimulation. Payments are made directly to contracted providers.	Adults with disabilities	Deficit in 2 ADL, certification from physician	State	DHS-Social Service Division/Adult and Community Care Services Branch

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

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Senior and Respite Companion	Cash subsidies to the Senior and Respite Companions	Persons aged 65 and older	For companions, they must meet income limits in order to draw the subsidies _____ For individuals receiving the companionship, they must have functional deficits.	State and federal grant	DHS-Social Service Division/Adult and Community Care Services Branch
Foster Grandparent Program	Cash subsidies to the Foster Grandparents	Children with developmental disabilities	For companions, they must meet income limits in order to draw the subsidies _____ The children must be certified as having special needs.	State and Federal Grant	DHS-Social Service Division/Adult and Community Care Services Branch
Nursing Home Without Walls (NHWW)	Skilled nursing, personal care, meals, adult day health, personal emergency response system, transportation, respite. Payments are made directly to contracted providers or payments are made to the client who reimburses the providers of service.	Medicaid-eligible individuals living in the community.	Income and asset limits depending on family size. Certified as requiring nursing facility level of care.	State and Federal	DHS-Social Service Division/Adult and Community Care Services Branch
Developmentally Disabled/Mentally	Adult day health, habilitation, habilitation supported	Medicaid-eligible individuals with developmental	Income and asset limits depending on family size.	State and Federal	DOH-Developmental Disabilities Division

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

Retarded Home and Community-Based Services Program (DD/MR HCBS)	employment, personal assistance, respite, skilled nursing, specialized services, outreach, physical adaptations and non-medical transportation. Payments are made directly to contracted providers.	disabilities and mental retardation living in the community.	Certified as requiring ICF-MR level of care.		
Developmentally Disabilities	Person-centered adult supports	Adults with developmental disabilities/mental retardation that are NOT eligible for the DD/MR HCBS program	Adults with developmental disabilities/mental retardation eligible for services under 333F-2, HRS	State	DOH-Developmental Disabilities Division
Developmentally Disabilities	Partnerships in community living	Children and adults with developmental disabilities/mental retardation NOT eligible for DD/MR HCBS except for Kauai and Kona (RWJ exceptions)	Children and adults with developmental disabilities/mental retardation eligible for services under 333F-2, HRS	State	DOH-Developmental Disabilities Division
Developmentally Disabilities Respite	Respite reimbursement	Families of individuals with developmental disabilities or mental retardation living in the family home.	Children and adults with developmental disabilities/mental retardation eligible for services under 333F-2, HRS	State	DOH-Developmental Disabilities Division
Developmentally Disabilities Family Support	Family support to maintain individual with developmental disabilities or mental retardation living in the family home.	Families of individuals with developmental disabilities or mental retardation living in the family home.	Families of individuals with developmental disabilities/mental retardation eligible for services under 333F-2, HRS	State	DOH-Developmental Disabilities Division
HIV Community Care Program (HCCP)	Skilled nursing, personal care, meals, adult day health, personal emergency response system, transportation, respite.	Medicaid-eligible and diagnosed with HIV infection and/or AIDS living in the community.	Income and asset limits depending on family size. Certified as requiring nursing facility level of care	State and Federal Medicaid	DHS-Social Service Division/Adult and Community Care Services Branch

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

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	Payments are made directly to contracted providers or to the client who reimburses the providers of service.				
Medically Fragile Community Care (MFCC)	Skilled nursing, personal care, personal emergency response system, transportation, respite, case management, electricity for life support equipment. Payments are made directly to contracted providers.	Medicaid-eligible children and youth below age 21 living in the community.	Income and asset limits depending on family size. Certified as requiring sub-acute facility level of care.	State and Federal Medicaid	DHS-Social Service Division/Adult and Community Care Services Branch
Program of All-Inclusive Care for the Elderly (PACE)	Primary care medicine, skilled nursing facility, home health, prescription drugs, speech, occupational and physical therapies, durable medical supplies, transportation, and other medical services except acute hospital and . Capitated rate payment is made directly to Maluhia and Leahi Hospitals.	Medicaid-eligible adults aged 65 and older.	Income and asset limits depending on family size. Certified as requiring nursing facility care. Participants receive all services through a managed care program at Maluhia Hospital and satellite at Leahi Hospital.	State and Federal Medicaid	DHS-Social Service Division/Adult and Community Care Services Branch
Independent Living (IL) Services	Information & referral, IL skills training, peer counseling, advocacy	Persons with significant disabilities	In need assistance to function independently in family or community.	State and Federal	Hawaii Centers for Independent Living (HCIL)
Independent Living (IL) Services for Older Blind	Information & referral, IL skills training, peer counseling, advocacy	Persons who are blind age 55 or older	In need of IL services	State and Federal	DHS/VRSBD/Services for the Blind Branch (Hoopono)

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

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As of November 8, 2004

Independent Living (IL) Services	Information & referral, IL skills training, community based support services	Veterans with disabilities	Veterans with qualifying service connected disabilities who are unfeasible for employment	Federal	Department of Veteran Affairs/Independent Living Program
Community Adult Mental Health Services	Case management; support services such as intervention, advocacy, transportation and outreach; crisis services; psychosocial rehabilitation services; and treatment.	Adults 18 years and older requiring mental health interventions and services. Emergent and urgent services such as crisis intervention and certain treatment services may be provided as needed. Services longer than 30 days require the person to meet criteria (mental illness diagnosis and serious functional impairment).for being seriously and persistently mentally ill (SPMI)	Income and asset limits if requesting QUEST/Medicaid coverage.	State and Federal for QUEST/Medicaid Community Mental Health Services Block Grant, PATH grant for non-Medicaid services. State, Medicaid and private insurers for treatment services	DOH-Adult Mental Health Division – SPMI determination DHS-Med-QUEST Division – QUEST/Medicaid eligibility determination
Child and Adolescent Mental Health Services	Crisis telephone hotline, crisis mobile outreach teams, crisis respite, hospital residential services, and intensive in-home mental health services. Time limited intensive interventions to diffuse individuals in an active state of crisis and to stabilize the family environment to improve the capability of the individual to care for self, and family to care for the individual.	Persons 20 years old or younger meeting criteria for serious emotional and behavioral disturbance (SEBD) which include a qualifying psychiatric DSM-IV diagnosis and CAFAS above 80. Youth needing a complex array of rehabilitative services may qualify provisionally with a lower CAFAS score. For crisis services only,	Income and asset limits if requesting QUEST/Medicaid coverage.	State and Federal for QUEST/Medicaid State for non-QUEST/Medicaid children/youth	DOH-Child and Adolescent Mental Health Division – SEBD determination DHS-Med-QUEST Division – QUEST/Medicaid eligibility determination

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

		screening by ACCESS line for services. Youth in the juvenile justice system (Detention Home and at the Hawaii Youth Correctional Facility) requiring mental health services receive necessary services through the CAMHD Family Court Liaison Branch. Youth identified by the Department of Education through the IEP process under IDEA and youth identified by Department of Education modification plan under Section 504 as needing intensive mental health services are served by the CAMHD Family Guidance Centers or contract agencies by arrangement through the FGCs.			
Children with Special Health Needs Program	Information and referral, outreach, care coordination, social work and medical nutrition therapy	Children with special health care needs age 0 to 21 years.		State	DOH, Children with Special Health Care Needs Branch
Early Intervention	Care coordination, audiology, family training, counseling, home visits, health and diagnostic evaluation, nursing, nutrition, occupational, physical and speech therapy, psychological and social work services, transportation, vision.	Birth to age 3 who are developmentally delayed (delay in one of five areas of development), or at biological (physical or mental condition with a high probability of resulting in developmental delay) and/or environmental		State and Federal Federal Medicaid funds are available for Medicaid eligible children	DOH, Early Intervention Section

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

		(physical, social or economic factors that may limit development) risk.			
Inclusion Project	Assistance to families to help identify and choose appropriate childcare settings for children with developmental delays.	Families with a child with developmental delays.	Child must meet requirements for developmental delay as defined by EIS.	State	DOH, Early Intervention Section
Respite Program	Respite care	Families with responsibilities for a child with special health care needs.	Child must meet requirements for developmental delay as defined by EIS.	State	DOH, Early Intervention Section
Public Health Nursing Services Program	Care Coordination	Individuals with complex medical needs requiring linkages to medical and other community resources	No other program services available	State	DOH, Public Health Nursing Branch
Public Health Nursing Services Program	Case Management	Frail, vulnerable elderly aged 60 and older living in the community.	Nursing assessment to determine eligibility	State	DOH, Public Health Nursing Branch
Food Stamp Program	Purchase of food	Low-income individuals and families	Income and asset limits depending on family size.	Federal	DHS, Benefits, Employment and Support Services Division
Women, Infant and Children (WIC)	Purchase of food	Low-income women, infants and children	Income and asset limits depending on family size.	Federal	DOH,
Assistive Technology					
Keiki Tech	Demonstrate and recommend low and assistive technologies appropriate for a child and family.	Child with developmental delays.	Child must meet requirements for developmental delay as defined by EIS.	Federal and state	DOH, Early Intervention Section
Assistive Technology (AT) Services	Systems change advocacy, AT education & training	Persons with disabilities, service providers, educators, professionals	Persons with significant disabilities in need of AT goods and services	Federal	Assistive Technology Resource Centers of Hawaii

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

APPENDIX C

COMMUNITY-BASED LIVING OPTIONS AND SUPPORT SERVICES

As of November 8, 2004

Employment and Training					
Vocational Rehabilitation	Assessments, diagnosis and treatment of impairments, vocational rehabilitation counseling and guidance, rehabilitation technology services, supported employment, vocation and other training, job placement and follow-up.	Persons with disabilities	Person must require and can benefit from services to become employed.	Federal funding with a 20% state match.	Department of Human Services, Vocational Rehabilitation Division
Ho'opono Center for the Blind	Assessment, career planning, adjustment, training, placement & follow-up, post employment services	Blind & Visually impaired adults age 55 or older	Need assistance to become employed	State and Federal	Department of Human Services, Vocational Rehabilitation Division
Vocational Rehabilitation & Employment Services	Assessment, career planning, training, placement & follow-up	Veterans with disabilities	Have qualifying service connected disabilities seeking employment	Federal	Veteran Affairs/Vocational Rehabilitation & Employment Services
Transition Centers	School-based counseling; career information; career exploration; work experience; community service learning; job placement	Students through 12th grade	Attending one of 13 participating schools	State	Department of Education
Career & Technical Education – Secondary	Basic skills; evaluation; occupational skills; integrated instruction leading to job placement or postsecondary training	8th – 12th graders enrolled in career and Technical Education Programs, disabled; economically disadvantaged; nontraditional (gender); single parents/displaced homemakers; other barriers		State and Federal	Department of Education, Instructional Services Branch/UH-OSDCTE
Career & Technical Education –	Assessment; classroom training and tutoring; counseling and guidance; recruiting/outreach;	Career & Technical Education students, with priority given to individuals with disabilities,		Federal	UH Community Colleges/OSDCTE

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

Postsecondary	occupational skills; personal skills; support services; assistance for childcare, books, tools, supplies	economically disadvantaged, nontraditional (gender), single parents; displaced homemakers; other educational barriers; limited English			
Vocational Education-Offenders	Basic skills; occupational skills; personal skills; pre-employment counseling; employment training	Sentenced felons		State and Federal	Department of Public Safety/OSDCTE
Native Hawaiian Vocational Education Program	Business, arts and communication center; assistance into postsecondary, vocational and technical training; summer bridge programs, student development; leadership development; career development; short-term training; work site and field experience; tutorial services; entrepreneurship and business technical assistance.	Native Hawaiian vocational educational students		Federal	ALU LIKE, Inc.

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

APPENDIX C

COMMUNITY-BASED LIVING OPTIONS AND SUPPORT SERVICES

As of November 8, 2004

Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Youth Programs	Basic education; job training; counseling; support services; job placement	Low income youth age 14 – 21.		Federal	Department of Labor and Industrial Relations, WDD/LWIAs
Molokai Youth Opportunity Grant	Basic education; job training; counseling; support services; job placement; community service; pre-employment; subsidized and unsubsidized employment	Molokai youth, age 14 -21		Federal	County of Maui
Hawaii Job Corps	School-to-Work; residential component; job placement; child care for non-residential component	Low income youth age 16-24		Federal	Pacific Educational Foundation, Inc.
Summer Youth Employment and Training Program	Classroom training; on-the-job training; work experience	Native Americans (Hawaiians, Indians, Alaskans) age 14 – 21		Federal	ALU LIKE, Inc.
Youth Challenge Academy	Life skills; high school diploma	At-risk youth age 16 – 18		State and Federal	U.S. Amy Hawaii National Guard
Community-Based Youth Mentoring Program	Mentor training; Mentor matching	Youth referrals from community including high schools and Maui Police Dept.		Federal	U.S. OJJDP/Hui Malama Learning Center
Youth Service Center	Basic education; vocational training; health and fitness; case management; counseling	Youth age 13 – 19		State	Hui Malama Learning Center
Indian and Native American Program	Basic education; job training; counseling; support services; job placement	Low income American Indians and Alaskan Natives age 16 and older		Federal	ALU LIKE, Inc.
Native American Employment & Training	Classroom training; on-the-job training; work experience; job placement	Native Americans (Hawaiians, Indians, Alaskans)		Federal	ALU LIKE, Inc

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

APPENDIX C

COMMUNITY-BASED LIVING OPTIONS AND SUPPORT SERVICES

As of November 8, 2004

Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
Employment Core Services for Immigrants and Refugees	Outreach and intake; assessment and planning; employment preparation; job placement & maintenance; family stability & development	Immigrants and refugees		State and federal	Department of Labor and Industrial Relations, Office of Community Services/Subrecipients
National Farmworker Jobs Program	On-the-job training and work experience supplemented by classroom instruction and support services such as clothing, safety shoes	Low income seasonal farmworkers		Federal	U.S. Department of Labor/ETA Division of Seasonal Farmworker Programs/Maui Economic Opportunity, Inc.
Senior Community Service Employment Program	Part-time employment in community service jobs	Low income persons age 55 and older		State and federal	Department of Labor and Industrial Relations, WDD/Subrecipients
Adult Programs	Basic education; job training; counseling; support services; job placement	Low income persons age 18 and older		Federal	Department of Labor and Industrial Relations, WDD/LWIAs
Employment Related Services for Low Income Persons Statewide	Employment assessment and preparation; job preparation and maintenance	Low income persons		State	Department of Labor and Industrial Relations, Office of Community Services/Subrecipients
Employment Program	Assessment and employment readiness; job placement and maintenance	Low income persons		Federal	Department of Labor and Industrial Relations, Office of Community Services/Subrecipients
Americorps USA	National and community service	Volunteers who receive		Federal	UH-

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

APPENDIX C

COMMUNITY-BASED LIVING OPTIONS AND SUPPORT SERVICES

As of November 8, 2004

Service Category	Services	Persons Served	Eligibility*	Funding Source	Dept/Agency/ Organization
	programs in the areas of human needs, environment, education, public safety	federal stipend			Manoa/subrecipients
Self Sufficiency Programs	Job training; employment counseling; homeownership and education counseling; basic computer skills	Federal public housing residents and Section 8		Federal	Department of Human Services, Housing and Community Development Corporation of Hawaii
Dislocated Workers Program	Basic education; job training; counseling; support services; job placement	Persons who have been or will be terminated, laid-off		Federal	Department of Labor and Industrial Relations, WDD/LWIAs
Labor Exchange-Job Seeker Services	Job matching; job placement; assessment; counseling	All persons legally qualified to work in the U.S.		Federal	Department of Labor and Industrial Relations, WDD
Disabled Veterans Outreach Program and Local Veterans Employment	Job placement; counseling; employer relations; outreach	Job ready veterans		Federal	Department of Labor and Industrial Relations, WDD
Veterans Workforce Investment Program	Training; job placement	Campaign/wartime veterans; service-connected disabled veterans; recently separated veterans		Federal	Department of Labor and Industrial Relations, WDD

* In addition to meeting requirements for target population (e.g., veteran, family with children, disabled, etc.).

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
Financial (Cash) Assistance		
Social Security, SSI, SSDI	Social Security Administration	Toll-Free: 1-800-772-1213 TTY: 1-800-325-0778 Social Security website: http://www.socialsecurity.gov/retirement Supplemental Security Income website: http://www.socialsecurity.gov/notices/supplemental-security-income Social Security Disability Insurance Website: http://www.socialsecurity.gov/disability
TANF, TAONF, GA, AABD	Department of Human Services Benefit, Employment and Support Services Division (BESSD)	TANF website: http://www.acf.hhs.gov/programs/ofa
VA Compensation	Department of Veterans Affairs	Toll-Free: 1-800-827-1000 TTY: 1-800-829-4833 http://www.vba.va.gov/bln/21/ http://www.va.gov/homeless/index.cfm
Housing		
Adult Foster Care Homes, Adult Residential Care Homes, Expanded Adult Residential Care Homes, Assisted Living	Department of Human Services Social Services Division (SSD)	Oahu: 832-51115 Kauai: 241-3337 Maui, Lanai, Molokai: 243-5151 East Hawaii: 933-8820 West Hawaii: 327-6280 http://www.hawaii.gov/dhs for program information http://www.hawaii.gov/health/elder-care/health-assurance/licensing/index.html for licensing information
Domiciliary Care Homes, DOH Foster Homes	Department of Health Developmental Disabilities Division Case Management and Information Services Branch 3627 Kilauea Avenue, Room 104	Oahu: Metro Honolulu 587-7564 West Oahu 692-7485 Waipahu-Ewa Beach 692-7493 Windward Oahu 587-7270

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
	Honolulu, Hawaii 96816	East Waipahu 587-7685 Mililani-Turtle Bay 587-7685 Salt Lake-Pearl City 587-7675 Central Honolulu 587-7281 Hawaii: East 974-4280 West 322-4880 North 887-8114 Kauai 241-3406 Maui & Lanai 984-8250 Molokai 553-3200 http://www.cmisb.org
Rent subsidies, homeownership, public housing	Department of Human Services Housing and Community Development Corporation of Hawaii (HCDCH)	Contact individual offices for applications Oahu: 832-5960 TTY: 832-6083 http://www.hcdch.hawaii.gov Contact individual county offices for information: City and County of Honolulu 527-5909 County of Hawaii 961-8690 County of Kauai 241-4443 County of Maui 270-7351
Medical Assistance		
Medicaid, QUEST and Hawaii Rx Plus	Department of Human Services Med-QUEST Division (MQD) P. O. Box 700190 Kapolei, Hawaii 96709	General Information 1-808-692-8139 TTY: 692-8054 Contact individual offices on each island for assistance. Med-QUEST Division website: http://www.med-quest.us Medicaid website: http://www.cms.hhs.gov/medicaid

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
Medicare	Centers for Medicare and Medicaid (CMS)	Toll-Free 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048 Medicare website: http://www.medicare.gov http://www.cms.hhs.gov http://www.socialsecurity.gov
VA Health Care	Department of Veterans Affairs	Toll-Free: 1-800-827-1000 TTY: 1-800-829-4833 http://www.vba.va.gov/bln/21/ http://www.va.gov/homeless/index.cfm
Mental Health Services for Youth	Department of Health Child and Adolescent Mental Health Division	Administrative Offices: 1-800-294-5282 TTY: 1-808-733-9335 TTY Toll-Free: 1-800-294-5282 Crisis telephone Hotline: County of Hawaii: 1-800-753-6879 Kauai: 274-3883 Lanai: 1-800-877-7999 Maui: 1-866-433-5702 Molokai: 1-800-887-7999 Oahu: 832-3100 1-800-753-6879 For other services, contact Family Guidance Centers: Family Court Liaison Branch: 266-9922 Diamond Head: 733-9393 Kalihi-Palama: 832-3792 Leeward Oahu: 692-7700 Windward Oahu: 233-3770

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
		Kauai: 274-3883 Maui: 873-3362 Big Island: Hilo: 933-0610 Waimea: 887-8100 Kona: 322-1542
Home and Community Services		
Older Adult and Caregiver Services	Department of Health Executive Office on Aging	Oahu: 523-4545 Kauai 241-4470 Maui 270-7774 Lahaina 661-5486 Hana 248-8833 Lanai 565-7114 Molokai 553-5241 Hawaii 961-8600
Chore, adult day care, senior and respite companion, foster grandparent, Nursing Home Without Walls, HIV Community Care, Medically Fragile Community Care, PACE	Department of Human Services Social Services Division	Oahu: 832-51115 Kauai: 241-3337 Maui, Lanai, Molokai: 243-5151 East Hawaii: 933-8820 West Hawaii: 327-6280 http://www.hawaii.gov/dhs
Developmental Disabilities/Mental Retardation Home and Community Based Services (DD/MR HCBS) and other community support services	Department of Health Developmental Disabilities Division Case Management and Information Services Branch 3627 Kilauea Avenue, Room 104 Honolulu, Hawaii 96816	Oahu: Metro Honolulu 587-7564 West Oahu 692-7485 Waipahu-Ewa Beach 692-7493 Windward Oahu 587-7270 East Waipahu 587-7685 Mililani-Turtle Bay 587-7685 Salt Lake-Pearl City 587-7675 Central Honolulu 587-7281

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
		Hawaii: East 974-4280 West 322-4880 North 887-8114 Kauai 241-3406 Maui & Lanai 984-8250 Molokai 553-3200 http://www.cmisb.org
Independent Living Services for Persons with Disabilities	Hawaii Centers for Independent Living (HCIL)	Oahu: 1-808-522-5400 HCIL website: http://www.hcil.org/default.asp
Independent Living Services for Older Blind	DHS/VRSBD/Services for the Blind Branch	Oahu: 1-808-586-5268 (V/TTY)
Independent Living Services for Disabled Veterans	Veteran Affairs/Vocational Rehabilitation Services/Independent Living Program	Toll-Free: 1-800-827-1000 http://www.vba.va.gov/bln/vre/index.htm
Community Mental Health Services for adults	Department of Health Adult Mental Health Division 1250 Punchbowl Street, #256 Honolulu, Hawaii 96813	24 hours a day/7 days a week Oahu: 1-808-832-3100 Neighbor Islands: 1-800-753-6879 AMHD website: http://www.amhd.org
Early Intervention Services including Newborn Hearing Screening Program and Respite Program	Department of Health Early Intervention Services 1600 Kapiolani Boulevard, Suite 1401 Honolulu, Hawaii 96814	H-KISS (Oahu) 1-808-973-9633 Neighbor Islands: 1-800-235-5477 EIS website: http://www.hawaii.gov/doh Click on Family/Child Health Select Early Intervention
Inclusion Project	Department of Health Early Intervention Services 1600 Kapiolani Boulevard, Suite 1401 Honolulu, Hawaii 96814	1-808-973-1113

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
Public Health Nursing	Department of Health Public Health Nursing Branch 1250 Punchbowl Street Honolulu, Hawaii 96813	1-808-586-4620 Contact individual offices on each island for assistance. Public Health Nursing website: http://www.hawaii.gov/doh Click on Family/Child Health Select Public Health Nursing
Assistive Technology		
Keiki Tech	Department of Health Early Intervention Services 1600 Kapiolani Boulevard, Suite 1401 Honolulu, Hawaii 96814	1-808-973-1120
Assistive Technology Resource Centers of Hawaii	Assistive Technology Resource Centers of Hawaii 414 Kuwili Street, Ste. 104 Honolulu, Hawaii 96817	Voice and Text Oahu: 1-808-532-7110 Neighbor Islands: 1-800-645-3007 http://www.atrc.org
Employment and Training		
Vocational Rehabilitation	Department of Human Services, Vocational Rehabilitation and Services for the Blind Division	Voice and Text: 808-692-7715 VRSBD Program Information website: http://www.state.hi.us/dhs/vr.pdf
Vocational Rehabilitation and Employment Services	Department of Veterans Affairs	Toll-Free: 1-800-827-1000 http://www.vba.va.gov/bln/vre/index.htm
Employment and Training Services to the General Public	Workforce Development Council (WDC) One-Stop Centers	WDC One-Stop Center s website http://www.hawaiiworkforce.org/OneStopCenters.cfm
Adult Program and Dislocated Worker Program		Oahu Work Links 592-8620 Hawaii County: DLIR WDD 974-4126 Maui County: DLIR WDD 984-2091 Kauai County: DLIR WDD

CONTACTS

11/08/04

Type of Assistance	Responsible Agency	Contact Information
		274-3056
Youth Program		City Office of Special Projects 832-7960 Hawaii County Salvation Army Family Intervention Services 959-5855 ext. 14 Maui County 270-7710 Kauai County 241-6390

APPENDIX D

BASELINE INFORMATION

When examining and/or discussing Olmstead issues for the state of Hawaii, it is important to know that the State funds a number of services and programs that support persons with disabilities in the community. Most of these services have been in place for many years, although only the most recent three fiscal years are presented. The following services are available through various state agencies:

Department of Human Services, Benefit, Employment and Support Services Division

The Benefit, Employment and Support Services Division (BESSD) provides a number of services that support individuals with disabilities in the community. The two financial programs available for persons who are disabled are the General Assistance (GA) and Aid to the Aged, Blind and Disabled (AABD). Both programs are funded solely by general funds and dependent on legislative funding each year.

General Assistance (GA) – provides cash benefits for food, clothing, shelter, and other essentials to adults between the ages of 18 and 64, without minor dependents, who are disabled and who do not qualify for Social Security. The current monthly maximum benefit is $418 per month for an individual. However, since the GA program is a block-grant, the monthly individual amount can be reduced if the actual number of participants exceeds the projected number of participants.

The Department has a contract with Legal Aid Society of Hawaii to maximize the number of people eligible for federal cash assistance through Social Security. As a result of this contract, a number of individuals are converted each year from the GA state assistance to federal Social Security benefits.

Aid to the Aged, Blind and Disabled (AABD) – provides cash benefits for food, clothing, shelter and other essentials to adults who are elderly (65 years of age or older) or who meet the Social Security Administration (SSA) definition of disabled.

PROGRAM	FY 01*	FY 02*	FY 03*
General Assistance	5,108/$24.1 mil	4,867/$23.2 mil.	4,488/$21.4 mil
Aid to the Aged, Blind	2,982$/7.1 mil	2,806/$7.0 mil	2,614/$6.6 mil.

and Disabled			

* average number of persons served per month /total dollars expended

Department of Human Services, Social Services Division

The Social Services Division (SSD) administers home and community-based services to help prevent premature institutionalization of vulnerable dependent adults and children. The services include:

Chore Services – provides essential housekeeping services to enable eligible disabled clients to remain in the community.

Adult Day Care – assists a limited number of disabled adults with placement into and the cost for licensed adult day care services in the community.

Senior and Respite Companion Programs – provides stipends to low income older adults who provide in-home companionship and limited personal care to frail elders and provide respite and relief to caregivers.

Nursing Home without Walls (NHWW) – provides in-home services to Medicaid-eligible individuals certified as requiring nursing facility level of care.

Residential Alternatives Community Care Program (RACCP) – provides residential placements in foster homes, adult residential care homes, and assisted living facilities as alternatives to institutional care for Medicaid-eligible adults who require nursing facility level care, and who have no caregivers or residence.

Program of All-inclusive Care for the Elderly (PACE) – semi-managed care program that provides services for elders certified as requiring nursing facility care.

HIV Community Care Program – provides in-home services to persons diagnosed with HIV infection and/or AIDS who are Medicaid-eligible and certified as requiring nursing facility level of care.

Medically Fragile Community Care (MFCC) – provides in-home services in their own home or licensed child foster homes to children less than 21 years old, who are Medicaid eligible and certified at subacute facility level of care.

Developmentally Disabled/Mentally Retarded Home and Community-Based Services Program (DD/MR HCBS) – serves Medicaid-eligible individuals with developmental disabilities and mental retardation living in the community, and certified as requiring ICF-MR level of care.

Foster Grandparent Program – enables low-income seniors to assist children with special needs.

PROGRAM	FY 01*	FY 02*	FY 03*
Chore[2]	1,423/$4.67 mil	1,359/$5.35 mil	1,204/$4.95 mil
Adult Day Care[3]	92/$.33 mil	87/$.33 mil	80/$.33 mil
Senior Companion[4]	587/$.54 mil	607/$.56 mil	602/$.61 mil
Respite Companion[5]	306/$.35 mil	241/$.33 mil	234/$.62 mil
Foster Grandparent[6]	720/$.64 mil	730/$.65 mil	730/$.66 mil
Medicaid Waiver[7] Programs:			
NHWW	805/$10.4 mil.	854/$13.8 mil	845/$17.8 mil
RACCP	653/$9.2 mil.	814/$12.0 mil	684/$13.3 mil
HCCP	86/$0.5 mil	92/$0.6 mil	92/$0.5 mil
MFCC	17/$0.04 mil	23/$0.1 mil.	45/$0.6 mil
PACE	107/$2.1 mil	104/$1.3 mil	105/$1.7 mil

* total number of persons served/total dollars expended (state and federal, if available)

[2] The Chore program has two components, purchase of service (POS) contracts and cash reimbursement to clients. POS contracts are funded with only State funds while cash reimbursements are paid with state and federal funds. Federal funds come from the Social Services Block Grant – Title XX. State funding for cash reimbursements has remained the same over the years, but the federal government experienced reductions in FY 03. Program was closed to new participants in FY 03 to ensure adequate funding was available for current clients and re-opened in April 03. Drop in recipient count over three year period reflects increasing service costs due to minimum wage increases in 01/01/02 and 01/01/03, and reduction in federal funding in FY 03.

[3] State funds only. Drop in program recipient count reflects increasing service costs with no corresponding increase in state funds. Allocation has remained constant.

[4] State and federal grants. Federally funded by the Corporation for National and Community Service, Domestic Volunteer Service Act of 1973, Title II, Part C. Requires a state match.

[5] State and federal grants. Federally funded by the Senior Community Service Employment Program, Title V. This is an employment and training program which receives the federal match from DLIR through an annual grant. The state match is in the form of DHS salaries. The program experienced recruitment problems in FY 02 resulting in slightly less funds being expended for services.

[6] State and federal funds. This stipend volunteer program for low-income seniors is federally funded by the Corporation for National and Community Service (CNCS) and authorized by the Domestic Volunteer Service Act of 1973, Title II, Part C.

[7] State and federal Medicaid Title XIX funds. Medicaid annual matching funds vary depending on the federal fiscal year.

Department of Human Services, Med-QUEST Division

In addition to institutional care (hospitals, nursing homes and ICF-MR), the Medicaid program also pays for targeted case management, hospice, home health and transportation for medical care - all services that support persons in the community. Case management is provided for medically fragile children; persons who meet criteria for DD/MR and are served by the Department of Health, Developmental Disabilities Division (DDD); and persons who meet criteria for being seriously mentally ill and served by the Department of Health, Adult Mental Health Division (AMHD). Skilled

nursing and personal care are provided only to children/youth less than age 21 under EPSDT. This Medicaid option was not selected for adults under the state plan.

Adults may receive skilled nursing care through home health services which cover skilled nursing, home health aide, and physical therapy services in the home. Services may be for a few hours per day, one or more times per week. Adults who require services that are not available through the home health benefit may obtain these services from the home and community based waiver programs.

Hospice is an option provided to those who are terminally ill and who have a life expectancy of six months or less. Medicaid covers medical transportation such as ambulance and air ambulance in addition to non-medical transportation. Non-medical transportation include airfare, taxi, handicab and handivan services and is provided when necessary in order to assist a patient in accessing Medicaid covered services. Non-medical transportation is always provided using the least expensive available means. When an individual must be flown to another island or mainland for medical care, meals and lodging are also provided. Detailed information on transportation is not available, although the program expends approximately $4 million per year on non-medical transportation. Medical transportation such as ambulance and air ambulance is in addition to the $4 million annual cost.

Medicaid Service[8]	FY 01	FY 02	FY 03
Nursing Facility Care	$145.5 mil.	$156.2 mil.	$180.5 mil.
ICF-MR	$7.6 mil.	$8.5 mil.	$7.8 mil.
Hospice	$0.5 mil.	$0.6 mil.	$0.5 mil.
Home Health	$2.3 mil.	$2.3 mil.	.7 mil.

Department of Human Services, Vocational Rehabilitation and Services for the Blind Division

VRSD is an employment program for eligible individuals with disabilities. To be eligible, the individual must have a physical or mental impairment which significantly impedes that individual from obtaining, maintaining or preparing for employment. And, the individual must need and be able to benefit from VR services in terms of employment.

All services needed for the individual to become and remain employed in a job consistent with that individual's strengths, abilities, capabilities, priorities, concerns, resources and

[8] Reflects state and federal Medicaid funds for the fee-for-service program. Does not include spending by the QUEST plans for services on a short-term basis. Annual federal matching funds vary depending on the federal fiscal year. Variation in spending reflects cash reporting and changes implemented in November 2002.

Facility costs presented for comparison purposes only. Medicaid waiver services (other community-based services for persons who meet institutional level of care) are reported in the Department of Human Services, Social Services Division and Department of Health, Developmental Disabilities Division.

interests. Major services include assessment, counseling and guidance, planning, physical and mental restoration, training, rehabilitation technology, job placement and follow up. Some services require consideration of the individual's personal financial resources while others require application to and use of comparable services available in the community.

Indicators	FY 01	FY 02	FY 03
Participants Served	6,619	5,866	6,403
Referrals received	1,912	2,053	2,260
Placed into Jobs	566	517	617
Placed into Competitive Jobs	526 (92%)	482 (93%)	597 (97%)
Participants with severe disabilities	233 (41%)	213 (41%)	448 (73%)
Receiving Public Assistance	190 (33%)	165 (32%)	223 (36%)

Department of Health, Executive Office on Aging

The Executive Office on Aging (EOA) is the lead state agency for advocacy, planning, program development, and evaluation on behalf of Hawaii's adults 60 years and older, including caregivers of children under the age of 18, and family caregivers of older adults. The EOA designates County/Area Agencies on Aging to manage, develop additional resources, and coordinate the delivery of older adult and caregiver services. The four-year State and Area Plans on Aging capture older adult needs and resources committed by the State and Counties to serve older adults.

Services[9]	FY 03*	FY 04*
EOA-funded services for older adults and caregivers	97,977/$10.7 mil	90,783/$11.1 mil

* total number of persons served/total dollars expended (state and federal, if available)

Department of Health, Developmental Disabilities Division

The Development Disabilities Division (DDD) serves individuals with developmental disabilities in Hawaii. During the 1990's through the present, the Division has worked to transition individuals from the institution to the community, educating individuals with development disabilities, their families and caregivers, and providers about the concept of self-determination, and providing services in the home and community.

The DDD administers the Medicaid waiver DD/MR home and community-based program serving over 1,700 individuals statewide. For those individuals who are not

[9] Includes state and federal funds.

Medicaid-eligible, the Division offers services such as adult day, respite, family support and other community services to help sustain persons with developmental disabilities in their family homes.

Program	FY 01*	FY 02*	FY 03*
DD/MR HCBS[10]	1,335/$27.2 mil	1,560/$34.7 mil	1773/43.0 mil
Adult Day program	$0.9 mil		
Partnerships in Community Living	$1.0 mil.	670/$1.3 mil.	704/$1.3 mil.
Person Centered Adult Supports		127/$1. mil	139/$1.0 mil.
DD respite	365/$$0.2 mil.	313/$0.2 mil.	408/$02 mil.
Family Support Services	135/$58k	122/$49k	114/$61k

* total number of persons served/total dollars expended (state and federal, if available)

Department of Health, Adult Mental Health Division

The Adult Mental Health Division (AMHD) serves individuals eighteen years and older who have a severe and persistent mental illness. AMHD operates the accredited and licensed 178-bed Hawaii State Hospital for mostly court-ordered individuals, and provides crisis intervention and services to sustain individuals in the community. Since January 2003 when the U.S. District Court for Hawaii approved the Community Plan for Mental Health Services, AMHD has been actively broadening its services statewide. Services include case management, support services such as community-based intervention, consumer advocacy and supports, transportation and outreach, crisis services, psychosocial rehabilitation services, treatment, housing and forensic services.

A detailed breakdown of persons served by service type is not available. AMHD served 4,741 consumers in FY 02 and 4,476 in FY 03. The slightly lower numbers of persons served in FY 03 is the result of AMHD's budget shortfall in that year.

Expenditures[11]	FY 01	FY 02	FY 03
General Funds	$36.2 million	$40.5 million	$34.4 million
Federal Funds[12]	$1.2 million	$0.7 million	$1.2 million
Special Funds[13]	$0.5 million	$0.6 million	$4.4 milllion
Total	$37.9 million	$41.9 million	$40.0 million

[10] Includes state and federal Medicaid spending. Annual federal matching funds vary depending on the federal fiscal year.
[11] Reflects community-based services only. Does not include costs for the Hawaii State Hospital and other inpatient services provided by private hospitals.
[12] From Community Mental Health Services Block grant and PATH grant.
[13] Includes payments from all other payors such as Medicaid, Medicare, HMSA and other insurance companies.

APPENDIX E

ACTIVITIES SUPPORTING THE IMPLEMENTATION OF THE HAWAII OLMSTEAD PLAN

Only new activities or initiatives that were implemented between the development of the Olmstead Plan and the Olmstead Implementation Plan are presented here. Olmstead-related activities that had been in place prior to the development of the Hawaii Olmstead Plan are not discussed in this section. Refer to Appendices C and D for a description of the currently available living options and the baseline data.

Real Choices Systems Change Grant

Hawaii was awarded a $1.35 million Real Choices Systems Change Grant in 2001 to develop and implement www.RealChoices.org, a web-based single entry point system. The website provides information on the options available to assist persons of all ages with disabilities and long term care needs. The website now offers an individual the opportunity to complete a DHS medical and financial assistance application on-line (which can be printed and later faxed, mailed or brought to any DHS eligibility office), a database of a variety of community and long-term care living options, information on other services such as transportation, employment, housing, and provides the ability for persons with disabilities to communicate and learn from each other in chat rooms. The project will end in May 2005, but the website will be sustained by AssistGuide, Inc., the contracted developer for the site. Future website enhancements will be made through additional grants.

Community Personal Assistance Services and Support (CPASS) Grant

[1] Moseley, Charles, "Picking Up the Pieces of Our Own Mistakes:" Supporting People with Co-Occurring Conditions, for the National Association of State Directors of Developmental Disabilities Services (NASDDDS), February 2004.

Hawaii was awarded a three-year $725,000 systems change grant in 2002 to develop, support and pilot consumer directed services. The CPASS Statewide Council has selected three demonstration sites, chosen because of their diverse demographics, to explore consumer direction in Hawaii. Site Councils onMolokai, Leeward Oahu, and East Hawaii on the Big Island have been established.. Each council will explore the supports needed for consumer direction to be successful in their own community. One of the initiatives for CPASS is to establish a model(s) for the establishment of family councils in all communities in Hawaii. Another initiative is to provide sustainable supports to individuals who choose consumer direction. Individuals choosing consumer direction must learn the responsibilities of hiring and/or supervising staff providing the Personal Assistance services. All project participants must be eligible for services from the Department of Health's Developmental Disabilities Division.

The grant provides funds to train individuals and families who volunteer to participate in CPASS as well as provide support related to building sustainable community resources to support consumer direction. Supports that have been identified as necessary to ensure individual success include personal support agents/brokers, intermediaries and peer mentors. The CPASS grant is administered by the University of Hawaii Center on Disability Studies and is guided by a State CPASS Council made up of self advocates (51%), parents and representatives from state and county offices such as the Department of Health, Department of Human Services, Elderly Affairs Division of the City and County of Honolulu, DVR (Vocational Rehabilitation) and community stakeholders such as the Hawaii Centers for Independent Living, Hawaii Disability Rights Center, non profit Service Providers and SPIN-Special Parent Information Network. The findings from the CPASS grant will be used to guide system changes necessary to implement consumer directed services statewide to all DDD participants.

Hawaii 360 Youth and Family Project
Kökua I Holomua

The Hawaii Department of Labor and Industrial Relations – Office of Community Services (DLIR-OCS) was awarded a three year grant (October 2004 through September 2007) from the U.S. Department of Health and Human Services, Administration on Developmental Disabilities for the amount of $750,000. This grant is a collaborative effort to design and implement a Navigational One-Stop System for transitioning youth with developmental disabilities and their families. Fifty families in the Oahu Windward community will participate annually in this project to transform the current system into one that values consumer choice and self-determination, appears seamless to consumers, and treats consumers with respect and dignity. The strategic partners working with OCS who have committed to help develop a new certification process for non-profits serving individuals with developmental disabilities and their family members to become part of the statewide One-Stop Center system include: Hawaii State Council on Developmental Disabilities, Hawaii Disability Rights Center, Department of Health – Developmental Disabilities Division, Child and Adolescent Mental Health Division, and Family Health

Services Division, Department of Education Windward Oahu District, Oahu WorkLinks, the University of Hawaii – School of Social Work, AssistGuide, Inc., and other State, City and County, and non-profit agencies. This grant will be facilitated by the University of Hawaii - Center on Disability Studies.

Establishment of Neurotrauma Board

The 2003 Legislature passed Act 160 which established a special fund for Neurotrauma activities. A Traumatic Brain Injury Planning Grant funded by the U.S. Department of Health and Human Services was received in 1999 followed by an Implementation Grant in 2003. Currently, efforts are underway to implement the plan. Activities include 1) creating education and awareness; 2) establishing a Board; and 3) creating expertise in the area of traumatic brain injury.

Develop and Expand the Capacity to Serve Persons with Developmental Disabilities and Mental Illness

It has generally been accepted that individuals with co-occuring conditions of Mental Retardation/Development Disabilities (MR/DD) and mental health disorders are among the most challenging to serve. Typically, individuals with developmental disabilities and people with mental illness are served by different state agencies with different structures, policies and methods of service delivery. The result is separate regulations, different eligibility criteria and separate provider networks. The individual with co-occuring conditions is often not able to access the services that are needed from both systems in order to effectively remain in the community.[2]

Hawaii is no different from other states. The Department of Health, Adult Mental Health Division (AMHD) and the Developmental Disabilities Division (DDD) confirmed the realities of the two different systems when they began to discuss discharging dual-diagnosed individuals from the State Hospital. To assist in making system infrastructure changes to support the dually-diagnosed individuals, the DDD contracted with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) to review and make recommendations to expand the state's service delivery capacity to support eligible individuals in the community. The consultants began their work in March 2004 to review the existing case management services and provide recommendations on a crisis network development plan. The "Blueprint for Case Management" was provided to DDD identifying actions that should be taken to implement a comprehensive community-based system to meet the needs of the dually-diagnosed DD/MR with serious mental illness. Recommendations on a crisis network development plan are due to the State in December, 2004.

[2] Moseley, Charles, "Picking Up the Pieces of Our Own Mistakes:" Supporting People with Co-Occurring Conditions, for the National Association of State Directors of Developmental Disabilities Services (NASDDDS), February 2004.

As a first step toward implementation of the recommendations, the DDD is contemplating issuing a Request for Proposal (RFP) for a vendor to provide a crisis response team 24 hours per day/7 days per week. The service will include emergency housing for individuals whose behavior has stabilized, but who may no longer have a home to return to and the development of short-term transitional services designed to improve a person's skill and reduce the intensity of the challenging behaviors. Other recommended improvements require additional funding so they will be implemented as dollars become available.

Olmstead: Achieving The Promise: Transforming Mental Health Care in America

The Adult Mental Health Division operates the State Hospital and is responsible for developing and maintaining the infrastructure of community services directed toward persons with serious and persistent mental illness. Since the Olmstead Decision is critical to understanding the legal issues associated with institutionalization, AMHD has collaborated with and conducted educational sessions with AMHD Service Area Administrators, Hawaii State Hospital Family Intervention Group, United Self-Help Quarterly Meetings, Bridges Education Program, Oahu Service Area Board, 2003 Consumer Conference, Brigham Young University and Hawaii Disability Rights Center PAIMI (Protection & Advocacy for Individuals with Mental Illness) Advisory Council.

The Adult Mental Health Division, in collaboration with Advocates for Human Potential, Inc. also provided technical assistance to mental health consumers and service providers regarding consumer advocacy/empowerment and housing solutions. Consultants Alan Marzilli and Ann Denton provided valuable training to mental health service providers and community consumers on how the Olmstead decision and how to advocate for improved housing situations.

The Community Plan for Mental Health Services

In January 2003, the U.S. District Court for Hawaii approved the Plan for Community Mental Health Services. The Community Plan and the Hawaii State Hospital Remedial Plan of 2002 comprise the Omnibus Plan for Hawaii's integrated public adult mental health system.

Capacity Development of Jail Diversion Program

During Fall, 2002, AMHD was awarded a federal grant of approximately $300,000 per year for up to three years for capacity development of jail diversion programs. The grant focuses on persons with mental illness who have been arrested for misdemeanors and nonviolent felonies offenses. The Big Island was selected to develop and implement an island-wide post-booking diversion program using community-based mental health services including case management, assertive community treatment, medications, treatment and psychiatric rehabilitation.

Hawaii Center for Evidence-Based Practice (HI CEBP)

Established in August 2003, the Hawaii Center for Evidence-Based Practice (HI CEBP) is a collaboration of the AMHD, University of Hawaii's School of Nursing, School of Social Work, School of Medicine's Department of Psychiatry. The goals of the HI CEBP include identifying emerging evidence-based practices, professional development and training for the current and future work force, procuring grants, establishing an annual conference, serving as a resource center and information sharing for the Pacific Basin and educating, empowering and enriching the lives of consumers and their family members.

Bridges Education Classes

Building Recovery of Individual Dreams and Goals through Education and Support (Bridges) is a program that introduces mental health consumers to the definition of hope. This program is jointly operated by United Self-Help and the Adult Mental Health Division and provides mental health education classes to community members, including AMHD consumers. The classes focus on emotional stages of recovery, mental illnesses, dual diagnosis recovery, principles of support, biology of mental illnesses, medication alternatives, tools for recovery, healthy spirituality, and consumer/patient rights.

Hawaii Certified Peer Specialists Program

AMHD established in 2003 the first Peer Specialist Training and Certification Program. It includes training for consumers who are currently working as or interested in becoming certified peer specialists involved in Assertive Community Treatment Teams, Community Support Teams, and Intensive Case Management Teams. Certified Peer Specialists are guided by the principle of self-determination and have the primary responsibility to help individuals identify their own needs, wants, and goals.

The Adult Mental Health Division's Office of Consumer Affairs networked with the Georgia Department of Human Resources Team in developing the peer training and certification process. In 2004 staff of the AMHD Office of Consumer Affairs were trained to become facilitators for subsequent training and certification of Hawaii peer specialists. Persons desiring to become Certified Peer Specialists will complete an extensive 2-week training followed by an oral and written examination. Once certification is achieved, the Certified Peer Specialists are integrated into treatment teams.

Annual Consumer Conference

Through the New Freedom Initiative State Coalitions To Promote Community-Based Care Grant from the U.S. Department of Health and Human Services, Substance Abuse

and Mental Health Services Administration, Center for Mental Health Services, the Adult Mental Health Division was awarded a 3-year contract of $20,000 per year to devote efforts towards focusing on the goals of the President's Commission on Mental Health. AMHD will be promoting its efforts around Goal 2 of the commission notes which specify the significance of mental health care that is consumer and family driven. The funds will be utilized to support a Statewide Annual Consumer Conference to be held on Oahu. The one-day conference will include consumer, family member and service provider representation from statewide initiatives. The conference will include, but not be limited to, promoting the need for recovery-based services, consumer-provider significance, least restrictive settings, individually-based treatment models, the need for peer support programs, as well as continuing education workshops for certified peer specialists.

Medicaid Reimbursement for Mental Health Services in the Community

The Department of Human Services (single Medicaid agency), Med-QUEST Division and the Department of Health, Adult Mental Health Division worked together to implement the Rehab Option under the Medicaid fee-for-service program to obtain federal Medicaid matching funds. The federal funds will be used to financially support some of the community-based services for the seriously mentally ill provided by the AMHD. Since Medicaid funds are specifically not available for housing, these services will continue to be funded by general funds. The target date for implementation is December 1, 2004.

Discharging Persons from the State Hospital with Development Disabilities

The Department of Health Adult Mental Health Division operates a 178-bed licensed and accredited facility with the goals of promoting individual recovery and community reintegration. Approximately 25 individuals who are dually diagnosed with serious mental illness and development delays or mental retardation have been identified for discharge to the community. Since these patients will largely be Medicaid-eligible upon discharge, the AMHD and DDD of the Department of Health worked with the MQD of the Department of Human Services to develop a transition process for these individuals.

The DDD will continue to certify the patients as MR/DD as appropriate. With the State Hospital's and AMHD's input, the patient is assessed for community based services. Medicaid will reimburse for Rehab Option services, but AMHD also has the ability to provide different state-funded services (such as housing supports) to sustain the individual in the community. All of these services are approved by the AMHD if medically appropriate. The providers of services are invited to participate in the Individualized Service Plan (ISP) along with AMHD and DDD. At that time, it is determined which agency (AMHD or DDD) will provide case management for the client. The DD providers will receive specialized education in the care of the individual including behavioral modification techniques, administration of behavioral health

medications, and skills to effectively identify when to contact behavioral health professions and with a patient's difficult behaviors before discharge into the community.

"Going Home Project"

The Department of Human Services covered more individuals than otherwise could have been covered in the home and community based waiver programs by transferring Medicaid funding for state plan services to waiver services. This policy change allows the funds to "follow the person" when the individual is discharged from a waitlisted bed in the hospital. An individual is "waitlisted" in the hospital when the patient is at nursing facility level of care, but a nursing home or alternative community placement is not available. In the past, community placements were not available because the Medicaid waiver program, RACCP had reached its maximum limits. The Medicaid Home and Community Based Services (HCBS) waiver programs are the only Medicaid programs that can cap enrollment and limit spending and services for each waiver program participant. This is different from the traditional Medicaid program in which all individuals who qualify are eligible for all services under the full benefit package assuming they meet criteria for being medially necessary.

With the transfer of Medicaid funds to the waiver program, additional "slots" became available.

OLMSTEAD PLAN
State of Hawai‘i

October 16, 2002

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PART I: INTRODUCTION AND BACKGROUND

Olmstead Overview

In June of 1999, the United States Supreme Court rendered a decision that provides an important legal framework for the efforts of federal and state governments to integrate individuals with disabilities into the community.

In Olmstead v L.C., 119 S. Ct. 2176 (1999), the Court issues a challenge to everyone—the public sector, the private sector, advocates, individuals with disabilities and their families and caregivers—to improve opportunities for individuals with disabilities to access systems of cost-effective community-based services. Under the Court's decision, States are required to provide community-based services for people with disabilities who are institutionalized or at risk of being institutionalized and who can benefit from community placement in the most integrated setting. It is important to note that the ruling applies to individuals with disabilities of all ages and that community-based services need to address the full life cycle, from infancy through old age, to be truly responsive.

A state may be able to meet its obligation under the Americans with Disabilities Act by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities "in the most integrated setting appropriate to the needs" of such individuals and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated.

On June 18, 2001, President George W. Bush issued an Executive Order on Community Based Alternatives for Individuals with Disabilities. This Executive Order reconfirmed the Federal Government's support of the Olmstead Decision. It directed the United States Office of the Attorney General; the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development; and the Commissioner of the Social Security Administration to "work cooperatively to ensure that the Olmstead Decision is implemented in a timely manner." These departments are directed to work with the States to "help them assess their compliance with the Olmstead Decision and the ADA in providing services to qualified individuals with disabilities in community based settings, as long as such services are appropriate to the needs of those individuals."

Hawai'i's Planning Process

In response to the Olmstead ruling, the Hawai'i State Legislature passed House Concurrent Resolution 196, "requesting the Governor to develop and implement a comprehensive statewide plan for placing qualified persons with disabilities in the most integrated setting possible and to keep waiting lists that move at a reasonable pace."[1]

[1] The full text of House Concurrent Resolution 196 is included in Appendix D of this document.

Consistent with intent of this legislation, the Hawai'i State Department of Human Services initiated a planning process with its co-chair agencies of the Department of Health and the Hawai'i Centers for Independent Living for the purpose of developing a strategy to improve community-based living opportunities and services for people with disabilities. Individuals with disabilities, their family members and representatives from advocacy groups, non-profit agencies, businesses, and government agencies who assist people with disabilities met over the course of 18 months to identify the principles, goals, objectives, activities and anticipated outcomes of the Hawai'i Olmstead Plan. The group identified primary goals of the plan, broke into smaller groups to identify detailed strategies and outcomes, and worked together on successive drafts to complete the current document. Participants in this planning process are listed in Appendix A.

Guiding Principles

The principles of the Hawai'i Olmstead Plan have been adopted from federal guidance communicated to State Medicaid Directors in several technical assistance letters from the Centers for Medicare and Medicaid Services. These principles provide a framework for developing and evaluating the State's plan for improving community-based living opportunities and services. The full text of the letter is included in Appendix C. The six guiding Olmstead principles include:

Principle 1: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings.

Principle 2: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.

Principle 3: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.

Principle 4: Ensure the availability of community-integrated Services.

Principle 5: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

Principle 6: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

Hawai'i's Olmstead Plan: Key Areas

Hawai'i's Olmstead strategy is based upon five goals addressing five key areas:

- **Informing and educating** people with disabilities, their caregivers and the public about community-based living opportunities and issues.
- **Improving the assessment and planning process** by which individuals with disabilities achieve the home of their choice.
- **Strengthening financial resources and mechanisms** necessary for individuals with disabilities to live in the community, by maximizing existing public and private resources, creating more flexibility in how these resources can be used, and increasing these resources overall.
- **Building infrastructure** necessary for individuals with disabilities to live in the community, in such key areas as housing, employment, transportation and human services.
- **Effectively evaluating the state's progress** in meeting the goals of its Olmstead plan.

PART II: SUMMARY OF PLAN

Information, Education, and Self-Empowerment

Goal 1: Each individual will be informed and educated to make choices and decisions.

Objective 1a: Increase people's knowledge about choices and rights. The plan instructs the state to improve its system for informing individuals about their community-living choices and rights.

To this end, the state will develop a way to aggregate relevant information on community-living opportunities and resources, make the information more accessible, and provide a feedback mechanism so that individuals can evaluate the accuracy, accessibility and content of the information. The state will also spearhead a public education campaign to reduce ignorance and prejudice toward people with disabilities.

Objective 1b: Assist people with using the information to make effective and informed decisions. The plan instructs the state to better assist individuals with using and understanding information.

To this end, the state will encourage networking among people with disabilities, train service professionals to use information effectively to assist individuals with disabilities, and ensure that all individuals who provide services, as state employees or contracted entities, have demonstrated their commitment to relevant Olmstead principles.

Individual Equity, Assessment, and Planning

Goal 2: Each individual will be supported in finding an appropriate, affordable and accessible home of their choice in a timely and efficient manner.

Objective 2a: Undertake periodic assessments of all individuals in institutions, in a timely and efficient manner, to determine whether they choose to remain in the care facility or move to a more independent community-based living alternative. In addition, prior to their institutional placement, undertake assessments of all individuals planning to enter a care facility.

To this end, the state will develop written assurances and requirements for timely and effective assessments; develop a standardized assessment for interviewing individuals in care facilities and identifying their goals, strengths, needs, barriers, and, if the individuals wishes to move, a transition plan; use qualified service professionals to do the assessments based upon criteria established below; and provide training opportunities to train individuals to do assessments in accordance with principles of informed-choice, person-centered planning, and neutrality.

Objective 2b: Create effective ways for people with disabilities, their family members and caregivers, to evaluate and report on the assessment process for quality improvement. In developing such a system, the state will seek input from people with disabilities and advocacy groups to ensure that the system is responsive.

To this end, the state will develop a system to collect feedback from individuals with disabilities and caregivers and will ensure that an effective connection exists between this feedback system and the monitoring of state contracts.

Objective 2c: People in institutions who have had assessments that identify them as candidates for community living will transition from institutions into the homes of their choice.

To this end, the state will contract with service providers to act as "gate-openers" who will assist candidates for community-based living with transitioning into the homes of their choice.

Financial Empowerment

Goal 3: Each individual will have access to and will direct financial resources to meet their identified goals in a timely manner.

Objective 3a: Maximize the use of existing financial benefits and resources.

To this end, the state will identify all available funding streams, both public and private, for individuals with disabilities, identify the eligibility criteria governing the use of these funds, and establish a mechanism for disseminating and updating this information on an ongoing basis.

Objective 3b: Change policies for existing resources to increase flexibility in how funds are used and give authorization to people with disabilities to control how they use their own funds.

To this end, the state will work to change policies so that funding can follow the individual rather than providers, services or settings; identify and change policies that create disincentives to independent community-living (using feedback from individuals with disabilities); address funding biases that privilege placement in an institution over community-based living, by advocating for changes in federal policy and by committing to increase funds for community-living services.

Objective 3c: Increase the availability of new financial resources to pay for community-based living services.

To this end, the state will establish new revenue sources; revise the state supplemental payment policy to allow recipients to live in the homes they choose; advocate for a redefinition of the federal Medical Assistance percentage for Hawai'i and an increase of federal funds; develop a unified community-based living funding plan; and establish a feedback mechanism to allow individuals to provide regular feedback on new fund development strategies.

Infrastructure Development

Goal 4: Each individual will be able to locate housing, acquire personal support personnel, use transportation, and engage in employment to sustain community-based living.

Objective 4a: Ensure the availability of suitable housing and enable people with disabilities to acquire the homes of their choice.

To this end, the state will increase the number of appropriate homes; develop financing mechanisms that make owning or renting such homes feasible; fund housing location and placement services for people with disabilities; and ensure that at least one full-time staff person will work with all key players, public and private, in the complex housing environment to demonstrate, with real homes for real people, that developing suitable housing is feasible and advantageous for all involved parties.

Objective 4b: Develop and maintain a suitable workforce for community-based living support personnel.

To this end, the state will identify workforce requirements for community-living personal; identify existing funding streams for workforce training and education; determine whether additional appropriations are needed; develop a unified community-living workforce development plan; establish a public-private partnership to provide professional liability insurance for community-living support personnel; and encourage policy changes that create incentives for people to become community-living support personnel.

Objective 4c: Enable people with disabilities to qualify for jobs and gain employment to help sustain their community-based living.

To this end, the state will establish a unified strategy to train and place individuals with disabilities in the employment of their choice; develop a way to evaluate the progress of individuals enrolled in public and vendor training and education programs, to ensure they are progressing toward their stated goals; support innovative employment strategies, such as micro-enterprise; ensure full employment opportunities for people with disabilities for all

government positions and contracts; and ensure that vocational service personnel are appropriately trained to work effectively with individuals with disabilities.

Objective 4d: Optimize accessibility and mobility, by developing and implementing long-range, systematic plans, to enable people with disabilities to move throughout their communities, using all means of travel.

To this end, the state will establish a unified mechanism to identify transportation requirements for people with disabilities in different communities (in cooperation with county transportation agencies); develop a unified community-based living transportation plan with key players; integrate ADA requirements into contracts with transportation vendors; appropriate and utilize necessary funds to establish accessible transportation (in coordination with county agencies); and work with county agencies to ensure that transportation personnel are appropriately trained to interact with individuals with disabilities effectively.

Objective 4e: Establish and maintain support service programs to assist people with disabilities to live in the homes of their choice.

To this end, the state will increase funds for community-living support services; utilize existing funds within a reasonable timeframe; develop and implement care guidelines that balance quality, affordability, suitability, and consumer-responsibility; and incorporate principles of self-determination and consumer control into all state-funded support programs targeting individuals with disabilities.

Evaluation and Quality Assurance

Goal 5: The State of Hawai'i will coordinate an on-going, effective quality assurance program to monitor and assess the state's progress in meeting the goals and objectives of this plan.

Objective 5a: Integrate people with disabilities, their families and caregivers, in the process of evaluating plan outcomes and the quality of community-based living services.

To this end, the state will identify a quality assurance entity to assume responsibility for evaluating the implementation of the plan; establish a unified mechanism for evaluating the goals, objectives and strategies of the plan; and take corrective action whenever evaluation and advice from the quality assurance entity recommends corrective action.

PART III: HAWAI'I STATE OLMSTEAD PLAN

INFORMATION, EDUCATION, AND SELF-EMPOWERMENT

Goal 1: Each individual will be informed and educated to make choices and decisions.

OBJECTIVE 1a: Increase people's knowledge about choices and rights.

Strategy 1a: As part of its plan, the state will:

1a1. Gather information on all available community-based living options, support services, and individual rights.

1a2. Make this information accessible to individuals with disabilities, their families, their caregivers, and service professionals on a statewide basis.

1a3. Implement an education campaign targeting the public that will increase knowledge about choices and rights.

1a4. Provide a mechanism for users to give feedback on the accuracy, content, completeness, accessibility, and presentation of the information.

1a5. Prepare and make available periodic evaluations of the state's information delivery system. The evaluation must integrate community-feedback.

Background 1a: The State of Hawai'i lacks a coordinated, comprehensive system for informing people with disabilities about their community-living choices and rights. While many public and private agencies offer websites, maintain phone voice systems, publish newsletters, and conduct outreach for their particular populations, the overall system for getting information to people is fragmented; the average individual with a disability is often challenged to find needed resources without substantial research or professional assistance. In addition, groups that naturally function as conduits of information for individuals with disabilities, such as primary care doctors, churches and health and human service agencies, can be equally mystified by the inaccessibility of coherent information. Individuals with disabilities and their supporters need more effective ways to match needs with available resources.

Those who are not currently served by the State, those in remote areas, those who are new to the disability community, those without access to computer technology, and those who, because of barriers of language, culture, or economics, are less likely to access community-based living services, all challenge the State to get information out to where it most can help. An effective information-delivery system should:

- Provide information in simple, accessible language and format, to ensure access by individuals of various educational levels and cognitive disabilities.
- Provide information in a self-directed way, so that to the extent possible individuals with disabilities can navigate through the information system on their own.
- Provide information in a comprehensive, statewide manner that reaches under-served and un-served populations, using primary and natural points of contact in the community.
- Use "people first" language principles, avoiding phrases such as "the handicapped," "the disabled," or even "disabled people." Individuals with disabilities are people first; secondarily, they are people with disabilities. Some individuals also object to the term "consumers," which appears to reduce people to their market role. This plan includes a short addendum on the language principles employed in this document.
- Provide information in other languages.
- Provide information in alternative formats, such as Braille, large print, audio tape, phone voice system, American Sign Language, and CD-ROM.

Finally, ignorance and prejudice toward people with disabilities significantly affect the viability of community-based living, by depriving individuals of community support and by limiting the choices and rights communicated to individuals by those around them. A public education campaign is necessary to address such issues.

OBJECTIVE 1b: Assist people with using the information to make effective and informed decisions.

Strategy 1b: As part of its plan, the state will:

1b1. Foster individual and group discussions that share information among people with disabilities, by encouraging agencies to coordinate peer support and mentoring activities.

1b2. Develop and implement a training initiative that teaches service professionals to effectively use the statewide information system to assist people with disabilities to make informed decisions.

1b3. Ensure that all individuals and organizations that provide services, including labor, education, transportation, and health and human services, or that receive state contracts for such services to individuals with disabilities have demonstrated their commitment to Olmstead principles.

Background 1b: Making information accessible does not in itself increase its use. Many people with disabilities will need assistance to learn how available choices lead to effective goal setting and planning. Of particular challenge are those who have lived in

restrictive settings for so long that they have no meaningful reference for understanding other options. For such individuals, meaningful choice can depend upon extensive education about the possibilities of community-based living. The individual may choose to live alone in a house or apartment, with others in a group home, in an assisted living or nursing facility, or in any other setting that meets the individual's needs. The individual and his or her support system must be fully informed about what services may or may not be available in each setting and apprised of the impact that the presence or absence of such services is likely to have. Most of all, the ability of each individual to make choices, and take action to obtain choices, must be honored in all cases.

A top priority of this plan is to assist people with disabilities to understand information and make informed decisions about the use of resources and the community-living options available to them. Such an effort should consider:

- Engaging individuals with disabilities as a key resource for educating others about community-based living options. Individuals with disabilities share many common experiences. As a result, many support organizations offer peer networking activities, such as support groups, mentoring programs, internet chat rooms and other forums. These activities are usually organized by type of disability, although common interests and concerns, such as housing, employment, and recreation, can be a better foundation upon which to build mutually supportive relationships.

- Helping service professionals assist people with disabilities to understand choices and identify effective options. In the community, many people with disabilities lack computer access and often rely on service professionals for information and referral services. In institutions, the service professional is often the direct contact for those who reside there. Yet many service professionals employ the traditional approach to case management, which, derived from the medical model, attempts to "govern through treatment" rather than assist the individual with becoming self-empowered. To address this problem, service professionals need contract assurances and evaluation protocols that address Olmstead principles, so they can integrate an effective community-based living policy into their professional practices. In addition, service professionals need professional development to help them effectively use the statewide information system discussed above.

INDIVIDUAL EQUITY, ASSESSMENT AND PLANNING

Goal 2: Each individual will be supported in finding an appropriate, affordable and accessible home of their choice in a timely and efficient manner.

OBJECTIVE 2a: Undertake periodic assessments of all individuals in institutions, in a timely and efficient manner, to determine whether they choose to remain in the care facility or move to a more independent community-based living alternative. In addition, prior to their institutional placement, undertake assessments of all individuals planning to enter a care facility.

Strategies 2a: As part of its plan, the state will:

2a1. Develop assurances and requirements to periodically assess, in a timely and efficient manner, individuals in all care facilities, institutions and hospitals— and to initially assess individuals *planning* to enter such facilities— to identify their choice for community-based living. The written policy will require a neutral assessor.

2a2. Develop a standardized personal-choice assessment for interviewing care facility residents about their choice for community-based living.

2a3. Develop a standardized assessment for identifying community-based living goals, personal and environmental strengths and needs, barriers to accomplishing goals, and an individualized plan for achieving the goals when the person wants to transition from the care facility.

2a4. Use qualified service professionals and qualified peer advocates to facilitate the periodic assessments. Qualifications should be based upon knowledge and practice of informed choice, self-determination, person-centered planning principles and neutrality (i.e., lack of a conflict of interest).

2a5. Provide training opportunities for service professionals and peer advocates to learn how, while using the standardized assessment tool, to practice principles of informed choice, self-determination, person-centered planning, and neutrality.

Background 2a: According to the Robert Wood Johnson Blue Ribbon Panel on Personal Assistance, "Medicare and Medicaid legislation came to guarantee public payment for institutional services. Nursing home care in the United States is an entitlement—any person who is eligible for nursing home services cannot be denied that service if there is a nursing home bed available. . . . Personal assistance services

delivered in the community do not have such entitlement status. There is still a strong institutional bias in federal and state policies which provide funding for long-term services."

To address this bias, social policy at the federal level resulted in the Supreme Court Olmstead Decision, President Bush's Freedom Initiative and CMA Nursing Home Transition grants. These federal initiatives do not guarantee that all individuals with disabilities will soon be living in the homes of their choice. The success of the initiatives depends upon a formalized assessment process that ensures adherence—in relevant private and public sectors—to the practice of informed choice, self-determination and person-centered planning.

Individual assessments for community-based living and services must consider the person's community-living goals, personal and environmental strengths and needs, barriers to accomplishing goals, and an individualized plan for achieving goals. In addition, identifying the person who should conduct the assessment can be a key consideration, since the current and substantial revenue-bias* toward institutional care can create a conflict of interest among service professionals who do assessments, particularly if those service professionals are employed by the institution.

Finally, the assessment process as it is currently practiced creates impediments to effective community-living services due to its fragmentation and complexity. Individuals must withstand repetitive assessments and multiple referrals in their effort to finalize planning. Assessments move through different phases, addressing the individual's functional capacity, their goals, available options and resources, informed choice, their need for assistance with implementing the plan, and plan re-evaluation. These phases tend to be repeated, using different formats, whenever someone new appears to do an assessment. To address this problem, the state should work toward identifying common and key data fields and consolidating interview tools, in order to reduce the need to subject people with disabilities to hours of redundant disclosures and to improve coordination among various services and agencies.

OBJECTIVE 2b: Create effective ways for people with disabilities, their family members and caregivers, to evaluate and report on the assessment process for quality improvement.

* "Adults with Severe Disabilities: Federal and State Approaches for Personal Care and other Services" indicated that Medicaid was the principal source of public funding for long-term care, with 1998 expenditures of $59.1 billion. In 1996, Medicaid accounted for 38 percent of total long-term care spending. Between 1987 and 1998, long-term care expenditures increased from 10 percent to 25 percent of Medicaid long-term care spending.

Strategies 2b: As part of its plan, the state will:

2b1. Develop a system to collect feedback from people with disabilities, their families and caregivers, to improve, simplify, and better coordinate the assessment process. In developing such a system, the state will seek input from people with disabilities, their families and caregivers, to ensure that the system is responsive.

2b2. Maintain an effective connection between consumer feedback and the monitoring of state contracts for assessment services, so as to make competency in effective assessments a requirement of all service professionals who facilitate assessments of individuals in institutions and individuals who are planning to enter institutions.

Background 2b: Consumer direction assumes that consumers are the best judges of their needs and are in the best position to decide how those needs should be met. Consumer direction ranges from the individual independently making all decisions and managing services directly, to the individual using a representative to manage his or her affairs. Either way, the common element in consumer direction models is a belief that the individual has the primary authority to make the choices that work best for him or her, regardless of who pays for the service or the nature and extent of the individual's disability.

Consumer direction also holds that the individual is in the best position to evaluate the outcomes of community-based living and services and the implementation of this plan. The state needs to ensure that an effective feedback mechanism exists to define and to assess quality and to gage the satisfaction of consumers. Such a feedback mechanism is a prerequisite to effectively evaluating and updating assessment protocols and practices within the state system.

Consumer feedback mechanisms should address the range of resources and supports necessary for successful community-based living, including housing, transportation, case management, home care, and employment services. Effective state responses to feedback may include, for example, reducing duplicate data collection, simplifying forms, creating single points of access for multiple services, standardizing data elements across services, and making existing data more accessible across agencies within the constraints of confidentiality and consumer choice.

OBJECTIVE 2c: People in institutions who have had assessments that identify them as candidates for community living will transition from institutions into the homes of their choice.

Strategies 2c: As part of its plan, the state will:

2c1 Contract with service providers to act as gate-openers who will assist people

with disabilities with implementing their individualized plans for community-based living.

Background 2c: The number of individuals identified as candidates for community living who actually move into the homes of their choice is a key indicator of the success of this plan. The current system is so complex that, without advocates or "gate-openers" who specialize in helping the individual navigate the existing maze of assessments, services and resources, many individuals with disabilities will never reach their chosen home.

FINANCIAL EMPOWERMENT

Goal 3: Each individual will have access to and will direct financial resources to meet their identified goals in a timely manner.

OBJECTIVE 3a: Maximize the use of existing financial benefits and resources.

Strategy 3a: As part of its plan, the state will:

3a1. Identify all presently available funding streams, both public and private, for people with disabilities, including the elderly, with special emphasis on general financial assistance, housing, health care, personal assistance and chore services, assistive technology and employment training.

3a2. Identify all eligibility and other criteria governing the use of funding sources.

3a3. Establish a mechanism for disseminating information on funding sources and eligibility and continuing to update this information on an ongoing basis.

Background 3a: At least two significant barriers exist between resources and the individuals who need them. These barriers are 1) limited knowledge about resources by those needing to access them and 2) difficult procedures for obtaining benefits.

First, people must be able to find the resources necessary to meet their daily needs, as they understand them. These individuals may seek information from a variety of service providers, but service providers differ in their knowledge, so that getting information can be hit-or-miss. In addition, relevant resources and funding come through many state, federal, and county agencies and, within these agencies, funding can be spread further among myriad departments and offices. Needless to say, such a complex funding environment poses a particular challenge for information seekers.

Second, people must be able to access the resources once they find them. In attempting to do so, they often encounter barriers, including hard-to-access application documents, complicated or excessive forms, narrow eligibility requirements, or difficulty communicating with agency representatives. In some cases, agency funding allocated for resources go altogether unused due to inadequate management and other issues, despite obvious community need. When this happens, funding sources can decrease the amount of funds allocated to those agencies in subsequent years, under the mistaken perception that community need is lessening rather than increasing.

OBJECTIVE 3b: Change policies for existing resources to increase flexibility in how funds are used and give authorization to people with disabilities to control how they use their own funds.

Strategy 3b: As part of its plan, the state will:

3b1. Change policies so that public funding can be attached to, and follow, individuals rather than providers, services or settings. In cases where federal regulations prevent such changes, the state will work with federal agencies to encourage changes in federal policy and regulation and will incorporate these changes at the state level when federal obstacles have been removed.

3b2. Review state regulations so that people with disabilities, their families and caregivers, can decide how their individual benefits will be used for the home and services of their choice.

3b3. Identify policies that create disincentives to independent community living and consumer choice by establishing a mechanism for people with disabilities, their families and caregivers, to provide feedback.

3b4. Change policies that create disincentives for people with disabilities to use available benefits. In cases where federal regulations prevent such changes, the state will work with federal agencies to encourage changes in federal policy and regulation and will incorporate these changes at the state level when federal obstacles have been removed.

3b5. Address funding biases that privilege placement in an institution over community-based living, by advocating for changes in federal policy and by committing to increase funds for community-living services relative to funds traditionally allocated to institutional placement.

Background 3b: Funding policies should do a better job of acknowledging that people with disabilities, their families and caregivers do in fact have the ability to define their daily living needs, choose services and assess quality. These individuals should have more control over funding than current policies allow. Funding should follow *them* from agency to agency, and if needed, from county to county, rather being restrictively allocated to a single service or program. When funds follow the person rather than the agency, services are more inherently responsive and individualized.

State and federal governments have many policies that discourage people with disabilities from living productive, independent lives in the community. The National Council on Disability concludes that "[a]n individual who needs long-term services must pursue them through a complex, confusing and uncoordinated series of agencies and funding sources. Most frequently, the services are provided as a part of medical services. Sometimes services are provided as a part of a supported living setting. In both cases, the services may be restrictive, failing to meet the full independent living needs of the consumer."

Examples of restrictive and categorical policies include those which:

- Restrict services to a single category of disability or age range, though other individuals with disabilities may clearly benefit from the same service.
- Limit services to a few government-sponsored service professionals, though the individual may want to choose other providers.
- Favor institutions and service professionals, rather than home- and community-based support by family and community members.
- Require that services for people with disabilities be separated out from similar services to the general population, thus stigmatizing the individual. To the extent feasible, services for people with disabilities should be integrated into employment, education, housing and other services for the general population.

Getting a job can cause someone to lose his or her eligibility for medical benefits. Finding a roommate can cause someone to loose support services: "...under the Intermediate Care Facilities for People with Mental Retardation program, Medicaid may pay for a group home and the services needed for a person who lives there. The option of living with a roommate at another location must be forgone because the individual would risk losing needed support services if she or he moved." This same report by the National Council on Disability concludes: "When eligibility for support services is decoupled from eligibility for a housing subsidy, people with disabilities are not so restricted in where they might live."

OBJECTIVE 3c: Increase the availability of new financial resources to pay for community-based living services.

Strategy 3c: As part of its plan, the state will:

3c1. Establish new revenue sources through user fees, investment strategies, legislative appropriations and/or other mechanisms to fund community-based living options and services.

3c2. Revise the state supplemental payment policy to allow recipients to live in the homes they choose.

3c3. Work with Hawai'i Congressional Representatives to re-define the formula for the federal Medical Assistance percentage for Hawai'i and to increase federal funds.

3c4. Develop a unified, community-based living funding plan that maximizes and incorporates all funding streams to meet the needs of individuals with disabilities, particularly those identified as un-served or under-served.

3c5. Establish an effective mechanism for people with disabilities, their families and caregivers, to provide regular feedback to appropriate policy makers on new fund development strategies.

Background 3c: To address the anticipated demands of a growing community-based population of individuals with disabilities, it will not be enough to maximize existing resources using the strategies proposed in Objective 3a and Objective 3b. The state will need to identify new resources.

These resources will be hard to find, given the state's many competing priorities and recent economic declines. Yet future federal funding for human services may depend upon the state's ability to allocate these new resources and comply with the mandate represented by the U.S. Supreme Court's ruling on Olmstead. In the long run, not complying with Olmstead may prove more costly than building the necessary community-based infrastructure early on.

The state has already begun work on long-term care initiatives that may involve increased funds. The relationship between these initiatives and Olmstead is not clear given that Olmstead focuses principally upon self-directed community living rather than long-term institutional care. Nonetheless, the latest findings from the Joint Legislative Committee on Long-Term Care Financing are still moving through two separate actuarial studies. They include a host of recommendations but as yet no plans for funding. In addition, the state recently passed Care Plus, a long-term care insurance bill, but has not yet funded it.

INFRASTRUCTURE DEVELOPMENT

Goal 4: Each individual will be able to locate housing, acquire personal support personnel, use transportation, and engage in employment to sustain community-based living.

OBJECTIVE 4a: Ensure the availability of suitable housing and enable people with disabilities to acquire the homes of their choice.

Strategy 4a: As part of its plan, the state will:

4a1. Increase the number of available, accessible and affordable homes. The state will specifically address the needs of rural communities.

4a2. Develop financing mechanisms that make owning and renting such homes feasible for people with disabilities.

4a3. Provide housing location and placement services that help people weave through the complexities of finding, converting, renting, financing, and/or securing the home of their choice

4a4. Ensure that at least one full-time staff person will work with developers, banks, other financial institutions, housing agencies and individuals with disabilities and their caregivers, to demonstrate that developing accessible and affordable housing is feasible and advantageous for all involved parties. The individual will do this by securing actual homes for real people. The state may secure such individual(s) in the manner it finds most appropriate: Direct hire, contract, partnership with a financial institution or other private entity, or other mechanism.

Background 4a: People with disabilities face many obstacles to finding the home of their choice in the community. Low-income frequently makes them ineligible for mortgages or rental agreements and unable to afford the high cost of the physical modifications necessary to make homes accessible. Even with adequate funds, people with disabilities face a shortage of designers, contractors and rehabilitation professionals skilled in barrier-free design. Government housing assistance does not guarantee adequate homes: Both the U.S. Department of Agriculture (DOA) and Housing and Urban Development (HUD) administer rental certificate and voucher programs that enable people with disabilities to live in the community, but a shortage of affordable and accessible housing limits the effectiveness of these programs.

Considerable evidence exists demonstrating that home modifications and effective design can save human service dollars, make care giving easier and prevent

institutionalization. Yet there is no national policy or service system to guide the funding of housing that maximizes the independence of people with disabilities or that facilitates the physical modifications necessary for accessible homes.

The housing environment is complex, even for Hawai'i. Agencies that have jurisdiction over various programs and funds affecting housing for individuals with disabilities include: the Department of Housing and Urban Development (Federal), Housing and Community Development Corporation of Hawai'i (State of Hawai'i), Department of Hawaiian Home Lands (State of Hawai'i), Office of Hawaiian Affairs (OHA), Office of Housing and Community Development (County of Hawai'i), Department of Housing and Human Concerns (County of Maui), Kaua'i County Housing Agency (County of Kaua'i), and Department of Budget (City and County of Honolulu). In addition, for-profit and non-profit entities, such as financial institutions, community development corporations, and developers, also play a significant role.

Although many of these entities do cooperate for particular initiatives, no one entity currently coordinates their activities for the benefit of individuals with disabilities. As a result, overall efforts to create affordable and accessible housing are fragmented and limited, despite the good work of particular individuals and organizations. The challenge for the state exists on three fronts:

- To increase the stock of available, affordable and accessible housing.
- To develop innovative home financing mechanisms so that people with disabilities can own their homes.
- To provide housing location and placement services that help individuals access housing and financing.

OBJECTIVE 4b: Develop and maintain a suitable workforce for community-based living support personnel.

Strategy 4b: As part of its plan, the state will:

4b1. Establish a unified mechanism to identify workforce requirements for community-living personnel, using feedback from sources that include people with disabilities, their families and caregivers, service providers and public agencies.

4b2. Identify all existing funding streams for workforce training and education and determine whether further appropriations are needed to meet anticipated workforce demands. Informal opportunities, such as those offered by churches and other civic groups, will be considered in the process.

4b3. Develop a unified, community-living workforce development plan in partnership with key labor agencies, service providers and representatives from people with disabilities. The plan will specifically address the needs of rural communities.

4b4. Establish a public-private partnership that will develop and implement a cost-effective insurance plan to cover professional liability for community-living support personnel.

4b5. Encourage labor policy changes, both statutory and regulatory, that create incentives for people to become community-living support personnel and that help ensure their livelihood.

Background 4b: For many individuals with disabilities, living in the homes of their choice requires the help of trained professionals and paraprofessionals who can competently assist with chores, personal care, nursing, and other forms of support. As the number of people with disabilities grows, so too will this need for individuals trained in community-based disability services, requiring careful workforce planning on the part of the state. This need will grow particularly acute if the number of elderly with functional limitation increases at the high rate forecast by the State Executive Office on Aging in its *1998 Hawai'i Databook for Older Adults*. Currently, the local workforce shortage is already reflected in high job turnover and vacancy rates for community-living support. It is expected to worsen significantly, as the elderly population grows explosively and increasing numbers of non-elderly working-aged persons with disabilities transition into the community.

An effective state response to anticipated workforce needs would:

- Increase the availability of innovative education and training opportunities for community-based living support personnel.
- Increase recruitment of qualified paraprofessional and professional staff through financial assistance and other incentives.
- Include partnerships with vocational and educational programs, such as Welfare to
- Work, Alu Like, and high schools to improve recruitment.
- Offer reasonable liability insurance as a financial incentive.
- Improve retention by providing opportunities for continuing education, advancement, and salary increases, while balancing these retention incentives with the need for cost containment.
- Ensure that rural and neighbor island areas receive needed personnel.

The State of Hawai'i Workforce Investment Board is conducting a community audit to better identify workforce needs. Agencies key to workforce development include the U.S. Department of Labor, Hawai'i State Department of Labor and Industrial Relations, Hawai'i State Department of Education, University of Hawai'i College System, Hawai'i State Department of Human Services-Benefits and Employment Division, and the Workforce Development Council. In addition, myriad non-profit and for-profit organizations provide substantial resources for training and employing Hawai'i's workforce.

OBJECTIVE 4c: Enable people with disabilities to qualify for jobs and gain employment to help sustain their community-based living.

Strategy 4c: As part of its plan, the state will:

4c1. Establish a unified strategy to train, qualify, and facilitate the placement of people with disabilities in the employment of their choice.

4c2. Develop a mechanism to evaluate the progress of individuals enrolled in public or vendor training programs, to help ensure that they actually progress toward their stated goals and achieve their employment of choice. This evaluation mechanism should take into account the full spectrum of training, from remedial to graduate education.

4c3. Support innovative employment strategies, such as transitional employment and community-driven micro-enterprise.

4c4. Ensure full employment opportunities for people with disabilities for all government positions and enforce compliance with equal employment opportunity regulations among all private contractors.

4c5. For vocational services that choose applicants based upon a system of priority, give priority to people with disabilities who are transitioning from institutional living.

4c6. Ensure that vocational service personnel undergo the professional development necessary to interact effectively with people with disabilities and help people with disabilities achieve successful employment outcomes.

Background 4c: The majority of people with disabilities want to work. Yet historically public policies discourage them from working. In 1996, more than 95% of federal funds spent on people with disabilities supported dependency, while only a small fraction of these funds were spent on helping people train for, find and keep jobs. The agenda for national employment policy has only recently begun to include people with disabilities.

Nonetheless, polls repeatedly indicate that employers support employing people with disabilities and consider them good employees. Judging from studies conducted in the mid-1990's, the costs of accommodating such employees does not appear significant. Despite both of these facts, the percentage of companies that have hired people with disabilities has not increased much over the years. A commonly cited reason for not hiring people with disabilities is a lack of qualified applicants.

Federal, state and non-profit programs do exist to help educate, train and place individuals in jobs, though more programs with greater effectiveness are clearly needed as more individuals with disabilities move into the homes and communities of their choice. Since 1992, the federal government has required state vocational rehabilitation

agencies to 1) act on the individual's choice of services and service providers, 2) focus on careers and not just entry-level jobs and 3) presume that most individuals with disabilities are employable. Despite some successes, these employment programs have made little impact on the percentage of people with disabilities employed nationally. In addition, programs funded through the U.S. Department of Labor assist thousands of people with disabilities nationally but, as generic programs for the broader public, they often lack accessibility and appropriateness.

Other barriers to satisfying employment for people with disabilities include benefit programs that create disincentives to work, lack of personal assistance services, lack of assistive technology; inadequate education, work experience and vocational rehabilitation, inaccessible transportation, housing and work sites, lack of opportunities for career advancement, and discriminatory attitudes.

OBJECTIVE 4d: Optimize accessibility and mobility, by developing and implementing long-range, systematic plans, to enable people with disabilities to move throughout their communities, using all means of travel.

Strategy 4d: As part of its plan, the state will:

4d1. In cooperation with county transportation agencies, establish a unified mechanism to identify transportation requirements for people with disabilities in different communities, using feedback from sources that include people with disabilities, their families and caregivers, service providers and public agencies.

4d2. Develop a unified, community-based living transportation development plan with key federal, state, and county transportation agencies, service providers and representatives from people with disabilities. The plan will specifically address the needs of rural communities.

4d3. Ensure full access in all transportation projects by integrating ADA requirements into contracts with vendors.

4d4. In coordination with county agencies, appropriate and utilize the necessary funds to establish accessible transportation services for people with disabilities for rural communities on the islands of Hawai'i, Maui, Kaua'i, Lana'i, and Moloka'i.

4d5. Work with county transportation agencies to ensure that public transportation personnel are effectively trained for interactions with—and safety protocols for services to—people with disabilities.

4d6. Assign a disability access liaison from the Disability and Communication Access Board to assist with developing and implementing the unified, transportation plan.

Background 4d: Transportation is primarily an issue of public infrastructure, rather than personalized benefits, such as financial entitlements, vocational training, or housing subsidies, which accrue more directly to the individual. As such, transportation for people with disabilities depends upon placing accessibility issues at the core of public planning—the funding, design and construction of roadways, sidewalks, bike paths, public vehicles, and other appurtenances that affect transportation access.

Hence, activities for this objective focus on strengthening the disability and ADA component of transportation planning and implementation undertaken by federal, state and county agencies. Since Hawai'i gives primary responsibility for public transportation to the four counties, the state must work closely with each county to ensure effective funding, design and implementation of a comprehensive and accessible transportation system.

According to the National Council on Disability, "Transportation access for people with disabilities includes the removal of physical, structural, communication and environmental barriers." In Hawai'i, these barriers take different forms. For example, if government does not ensure that sidewalks include curb cuts, individuals using wheelchairs cannot travel independently among homes, work places, bus stops and other necessary destinations. Some government entities are now under court consent decrees to comply with the Americans with Disabilities Act.

Another significant barrier to accessible transportation is the current inequity between transportation services on O'ahu and those on the rural neighbor islands. While some communities on O'ahu struggle to develop accessible transportation, many neighbor island communities have no public transportation at all. The state should work closely with the counties to address this inequity specifically, giving priority to neighbor island needs when Federal funding is not otherwise restricted. The long-term goal is a comprehensive transportation system that provides equal access to all communities and individuals with or without disabilities.

Transportation agencies include the U.S. Department of Transportation, Hawai'i State Department of Transportation, Department of Transportation Services-- City & County of Honolulu, Department of Design and Construction--City & County of Honolulu, Department of Public Works and Waste Management--County of Maui, Office of Community Assistance Transportation Agency--County of Kaua'i, Public Works Department--County of Kaua'i, Mass Transit Agency--County of Hawai'i, Public Works--County of Hawai'i. Government planning agencies include: Department of Planning and Permitting--City & County of Honolulu, Department of Planning--County of Maui, Planning Department--County of Kaua'i, Department of Planning--County of Hawai'i.

OBJECTIVE 4e: Establish and maintain support service programs to assist people with disabilities to live in the homes of their choice.

Strategy 4e: As part of its plan, the state will:

4e1. Increase funding for community-based living support services.

4e2. Utilize funds appropriated for support programs within a reasonable timeframe.

4e3. Develop and implement guidelines that balance quality of care, affordability, appropriateness of care, and consumer responsibility.

4e4. Incorporate the principles of self-determination and consumer control into all state-funded support programs targeting individuals with disabilities.

Background 4e: The state will need to make a substantial investment in community-based living support services if all individuals in institutions and those planning to enter institutions exercise their right to live in the homes of their choice, within the parameters of Olmstead vs. L.C.

EVALUATION AND QUALITY ASSURANCE

Goal 5: The State of Hawai'i will coordinate an on-going, effective quality assurance program to monitor and assess the state's progress in meeting the goals and objectives of this plan.

OBJECTIVE 5a: Integrate people with disabilities, their families and caregivers, in the process of evaluating plan outcomes and the quality of community-based living services.

Strategy 5:

5a1. Identify a quality assurance entity to assume responsibility for monitoring and evaluating implementation of the Olmstead Plan. This entity may be a state agency or agencies, authorized private agency, a public-private partnership, or some other entity.

5a2. Establish a unified mechanism for evaluating all goals, objectives and strategies of the Olmstead Plan. This mechanism will include 1) feedback from people with disabilities, their families and caregivers, service providers, public agencies, legislators, and other entities and 2) opportunities for these stakeholders to meet and address Olmstead implementation on a regular basis.

5a3. Take corrective action whenever evaluation and advice from the quality assurance entity recommends correct action.

Background 5a: Evaluation and monitoring will become the lifeblood of this plan. No plan, no matter how well crafted and responsive, has worth apart from well-organized and committed people who can ensure its implementation. Successful implementation will depend upon performing regular progress reviews and making adjustments when particular strategies fail, as some strategies are likely to do since no one can foresee all contingencies. Hence, the Olmstead Plan is less a document than an evolving work, consisting of the cooperation and creativity of a group of people applied to concrete objectives over a fixed period of time.

The Committee sees no way of ensuring the success of the plan without assigning to some representative group the responsibility for its oversight and evaluation. For this reason, considerable effort was expended to identify existing councils or agencies that could take on this role. Groups currently addressing disability issues include for example the Developmental Disabilities Council, the Rehabilitation Advisory Council, the Statewide Independent Living Council of Hawai'i, the Executive Office on Aging, the State Department of Human Services, the State Department of Health, and the

Disability and Communication Access Board. These entities were created to address clear and urgent community needs. While some of them reflect categorical funding streams that target particular disabilities, others do not and may be good candidates for monitoring the plan. When choosing a monitoring entity, the state should bear in mind that the Olmstead Plan has a broader mission than advocacy and services to specialized groups: It addresses the community-based living needs of all persons.

SIGNATURES OF PLANNING COMMITTEE CO-CHAIRS

Susan Chandler, Co-Chair
Director
Hawaii State Department of Human Services

Date

Bruce Anderson, Co-Chair
Director
Hawaii State Department of Health

Date

Mark Obatake, Co-Chair
Executive Director
Hawaii Centers for Independent Living

Date

OMB No. 0930-0168 Approved: 06/12/2015 Expires: 06/30/2018

APPENDIX A: PARTICIPANTS IN THE OLMSTEAD PLANNING PROCESS

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Kari Jo Hawkinson	AssistGuide, Inc.
Naomi Grossman	Autism Society of Hawai'i
Lyna Burian	Brain Injury Association of Hawai'i
Stella Wong	Catholic Charities Elderly Services
Charlotte Townsend	Disability and Communication Access Board
Francine Wai	Disability and Communication Access Board
Susan Rocco	Disability and Communication Access Board
Gary Smith	Disability Rights Center
Betsy Whitney	Dolphin Press
Pattie Nishimoto	Easter Seals
Larry Casper	Full Life
Rose Anne Poyzer	Hawai'i Association for Home Care
Mark Obatake	Hawai'i Centers for Independent Living
Sharon Ogawa	Hawai'i Long-Term Care Association
Diana Tizard	Hawai'i State Council on Developmental Disabilities
Waynette K.Y. Cabral	Hawai'i State Council on Developmental Disabilities
Linda Fox	Hawai'i State Department of Health, Adult Mental Health Division
Randolph Hack	Hawai'i State Department of Health, Adult Mental Health Division
Anita Swanson	Hawai'i State Department of Health, Behavioral Health
Al Arensdorf	Hawai'i State Department of Health, Child & Adolescent Mental Health Division
Terry Joyce	Hawai'i State Department of Health, Child & Adolescent Mental Health Division
Anita Yuskauskas	Hawai'i State Department of Health, Developmental Disabilities Division
Bruce Anderson	Hawai'i State Department of Health, Director's Office
Marilyn Seely	Hawai'i State Department of Health, Executive Office on Aging
Patricia Chang	Hawai'i State Department of Health, Executive Office on Aging
Virginia Pressler	Hawai'i State Department of Health, Health Resources
Kookie Moon-Ng	Hawai'i State Department of Human Services, Adult & Community Care Services Branch
Linda Chun	Hawai'i State Department of Human Services, Adult & Community Care Services Branch
Susan Chandler	Hawai'i State Department of Human Services, Director's Office
Susan Yamamoto	Hawai'i State Department of Human Services, Director's Office
Alan Matsunami	Hawai'i State Department of Human Services, Med-Quest Division
Lorrie Cahn	Hawai'i State Department of Human Services, Med-Quest Division
Steve Kawada	Hawai'i State Department of Human Services, Med-Quest Division

OMB No. 0930-0168 Approved: 06/12/2015 Expires: 06/30/2018

Patricia Snyder	Hawai'i State Department of Human Services, Social Services Division
Joy Patterson	Hawai'i State Department of Human Services, Vocational Rehabilitation & Services for the Blind Division
Neil Shim	Hawai'i State Department of Human Services, Vocational Rehabilitation & Services for the Blind Division
Larry Lau	Hawai'i State Department of the Attorney General
Joan White	Healthcare Association of Hawai'i
Rose Ann Poyzer	Healthcare Association of Hawai'i
Al Nitta	Housing & Community Development Corporation of Hawai'i
Brian Saito	Housing & Community Development Corporation of Hawai'i
Dana Yoshimura	Housing & Community Development Corporation of Hawai'i
Scott Kami	Housing & Community Development Corporation of Hawai'i
Wes Segawa	Housing & Community Development Corporation of Hawai'i
Lynn Maunakea	Institute for Human Services
Nicole Masukawa	Mental Health Association in Hawai'i
Greg Farstrup	Mental Health Association in Hawai`i
Paula Heim	Mental Health Association in Hawai'i
Joanne Lundstrom	Mental Help Hawai'i
Les Gusman	Mental Help Hawai'i
Mariam Poirier	National Alliance for the Mentally Ill
Ron Lim	Office of the Governor
Sheryl Nelson	Open Access
Mildred Ramsey	Residential Choices
Donna Buhrman	Statewide Independent Living Council of Hawai'i
Randall Lichter	Statewide Independent Living Council of Hawai'i
Doran Porter	Statewide Independent Living Council of Hawai'i
Howard Lesser	State Mental Health Council
Oscar Balayan	United Cerebral Palsy Association of Hawai'i
Donna Fouts	United Cerebral Palsy Association of Hawai'i
Jill Hurt	United States Department of Housing and Urban Development
Lynn Lee	United States Department of Housing and Urban Development
Mike Flores	United States Department of Housing and Urban Development
Robert Stodden	University of Hawai'i, Center on Disabilities Studies
Rebecca Ozaki	University of Hawai'i, Center on Disabilities Studies
Angie Conner	
Ann Horwath	
Emmaline Ihu	
David Pfeiffer	
Helen Smalley-Bower	
Curt Tyler	

APPENDIX B: PEOPLE FIRST LANGUAGE
Think People First

This plan was developed using the following principles of language, adapted from the website of the Hawai'i State Council on Developmental Disabilities.

Language is a reflection of how people see each other. That is why the words people use can hurt. It is also why many responsible communicators are now choosing language that reflects the dignity of people with disabilities—words that put the person first, rather than the disability. Read on for a short description of language that empowers.

1. Think "people first." Say "a woman who has mental retardation" rather than "a mentally retarded woman."

2. Avoid words like "unfortunate," "afflicted" and "victim." Also, try to avoid casting a person with a disability as a superhuman model of courage. People with disabilities are just people, not tragic figures or demigods.

3. A developmental disability is not a disease. Do not mention "symptom," "patients" or "treatment," unless the person you're writing about has an illness as well as a disability.

4. Use common sense. Avoid terms with obvious negative or judgmental connotations, such as "crippled," "deaf and dumb," "lame" and "defective." If you aren't sure how to refer to a person's condition, ask. And, if the disability is not relevant to your story or conversation, why mention it at all?

5. Never refer to a person as "confined to a wheelchair." Wheelchairs enable people to escape confinement. A person with a mobility impairment "uses" a wheelchair.

6. Try to describe people without disabilities as "typical" rather than "normal."

From the website of the Hawai'i State Council on Developmental Disabilities (http://www.hawaii.edu/ddcouncil) and produced by Ohio Public Images/Public Images Network, a not-for-profit communications and advocacy organization promoting positive awareness of people with disabilities. For more information on Ohio Public Images/Public Images Network, call 513-275-0262 (Voice/TDD).

APPENDIX C: OLMSTEAD GUIDANCE LETTER TO STATES BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES AND U.S. OFFICE FOR CIVIL RIGHTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

200 Independence Avenue, SW
Washington, D.C. 20201

January 14, 2000

Dear State Medicaid Director:

The recent Supreme Court decision in Olmstead v. L. C., 119 S.Ct. 2176 (1999), provides an important legal framework for our mutual efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. The Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.

This decision confirms what this Administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.

The Department of Health and Human Services (DHHS) is committed to working with all affected parties to craft comprehensive, fiscally responsible solutions that comply with the Americans with Disabilities Act of 1990 (ADA). Although the ADA applies to all State programs, Medicaid programs play a critical role in making community services available. As a consequence, State Medicaid Directors play an important role in helping their States comply with the ADA. This letter conveys our initial approach to Olmstead and outlines a framework for us to respond to the challenge.

The Olmstead Decision

The Olmstead case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated setting appropriate. The Olmstead decision interpreted Title II of the ADA and its implementing regulation, which oblige States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 CFR 35.130(d)). In doing so, the Supreme Court answered the fundamental question of whether it is

discrimination to deny people with disabilities services in the most integrated setting appropriate. The Court stated directly that "Unjustified isolation . . . is properly regarded as discrimination based on disability." It observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA, States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." (28 CFR 35.130(b)(7)). The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors: the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the provision of services affects the ability of the State to meet the needs of others with disabilities. Significantly, the Court suggests that a State could establish compliance with title II of the ADA if it demonstrates that it has:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and
- a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

Olmstead and the Medicaid Program

Olmstead challenges States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. Medicaid can be an important resource to assist States in meeting these goals. We want to work closely with States to make effective use of Medicaid support in your planning and implementation of Olmstead. As an example of the interface between Olmstead's explanation of the State's ADA obligation and your Medicaid program we would point to the State's responsibility, under Medicaid, to periodically review the services of all residents in Medicaid-funded institutional settings. Those reviews may provide a useful component of the State's planning for a comprehensive response to Olmstead. States must also be responsive to institutionalized individuals who request that their situation be reviewed to

determine if a community setting is appropriate. In such a case the State has a duty to redress the situation, subject to the limits outlined by the Court and the ADA. As another example, States may choose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

Comprehensive, Effectively Working Plans

As we have noted, the Supreme Court in Olmstead indicated that a State may be able to meet its obligation under the ADA by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated. The Department believes that comprehensive, effectively working plans are best achieved with the active involvement of individuals with disabilities and their representatives in design, development and implementation.

The Court's Olmstead decision regarding the integration requirement applies to all individuals with disabilities protected from discrimination by title II of the ADA. Although Olmstead involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals, nor is the scope of Olmstead limited to Medicaid beneficiaries or to services financed by the Medicaid program. In addition, the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.

The enclosure to this letter offers some recommendations about key principles and practices for States to consider as they develop plans. We recognize that there is no single plan that is best suited for all States, and accordingly that there are many ways to meet the requirements of the ADA. We certainly hope States and people with disabilities will expand and improve on these ideas. Although these plans encompass more than just the Medicaid program, we realize the important role played by State Medicaid Directors in this area. As just one example, Federal financial participation will be available at the administrative rate to design and administer methods to meet these requirements, subject to the normal condition that the changes must be necessary for the proper and efficient administration of the State's Medicaid program. Because of your significant role, we have taken this opportunity to raise these issues with you.

The principles and practices contained in the accompanying technical assistance enclosure also serve as an important foundation for the DHHS Office for Civil Rights' (OCR) activities in this area. As you know, OCR has responsibility for investigating discrimination complaints involving the most integrated setting issue. OCR also has authority to conduct compliance reviews of State programs and has already contacted a number of States to discuss complaints. OCR strongly desires to resolve these complaints through collaboration and cooperation with all interested parties.

Next Steps for the Department of Health and Human Services

Consultation: We have begun consultation with States (including State Medicaid Directors and members of the long term care technical advisory group, who share responsibility for Medicaid) and with people with disabilities. We look forward to building on this start. Many States have

made great strides toward enabling individuals with disabilities to live in their communities. There is much that we can learn from these States. We are interested in your ideas regarding the methods by which we might accomplish such continuing consultation effectively and economically.

Addressing Issues and Questions Regarding Olmstead and Medicaid: As we move forward, we recognize that States may have specific issues and questions about the interaction between the ADA and the Medicaid program. In response to the issues and questions we receive, we will review relevant federal Medicaid regulations, policies and previous guidance to assure that they (a) are compatible with the requirements of the ADA and the Olmstead decision, and (b) facilitate States' efforts to comply with the law.

Technical Assistance: In response to any issues raised by the States, the DHHS working group will develop a plan to provide technical assistance and information sharing among States and stakeholders. Responses to questions and technical assistance materials will be published on a special website. We are also funding projects in a number of States to assist with nursing home transition. Finally, we seek your ideas on the additional forms of technical assistance you would find most helpful for home and community-based services and conferences for State policy makers. We will use your suggestions to facilitate the implementation of the integration requirement. We invite all States and stakeholders to submit questions and recommendations to our departmental workgroup co-chaired by the Director of HCFA's Center for Medicaid and State Operations and the Director of the DHHS Office for Civil Rights. Please send such written correspondence to:

DHHS Working Group for ADA/Olmstead
c/o Center for Medicaid and State Operations
HCFA, Room S2-14-26, DEHPG
7500 Security Blvd.
Baltimore MD 21244-1850

Conclusion

The Administration and DHHS have a commitment to expanding home and community- based services and offering consumers choices in how services are organized and delivered. Over the past few years, DHHS has focused on expanding and promoting home and community-based services, offering support and technical assistance to States, and using the flexibility of the Medicaid program. The Olmstead decision affirms that we are moving in the right direction and we intend to continue these efforts.

We recognize that this interim guidance leaves many questions unanswered; with your input, we expect to develop further guidance and technical assistance. We recommend that States do the following:

- Develop a comprehensive, effectively working plan (or plans) to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs;
- Actively involve people with disabilities, and where appropriate, their family members or representatives, in design, development and implementation;

- Use the attached technical assistance material as one of the guides in the planning process;
- Inform us of questions that need resolution and of ideas regarding technical assistance that would be helpful.

We look forward to working with you to improve the nation's community services system.

Sincerely,

/s/

Timothy M. Westmoreland
Director
Center for Medicaid and State Operations
Health Care Financing Administration

/s/

Thomas Perez
Director Office for Civil Rights

Enclosure

cc:
All HCFA Regional Administrators
All HCFA Associate Regional Administrators
Division of Medicaid and State Operations
American Public Human Services Association
National Association of State Alcohol and Drug Abuse Directors, Inc.
National Association of State Directors of Developmental Disabilities Services
National Association for State Mental Health Program Directors
National Association of State Units on Aging
National Conference of State Legislatures
National Governors' Association

Enclosure

Developing Comprehensive, Effectively Working Plans
Initial Technical Assistance Recommendations

In ruling on the case of Olmstead v L.C., the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Supreme Court indicated that a State can demonstrate compliance with its ADA obligations by showing that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

We strongly urge States to increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA. There is no single model plan appropriate for all States and situations. In developing their plans, States must take into account their particular circumstances. However, we believe there are some factors that are critically important for States that seek to develop comprehensive, effectively working plans. Our intent in this enclosure is to identify some of the

key principles, including the involvement of people with disabilities throughout the planning and implementation process. These principles also will be used by the Office for Civil Rights as it investigates complaints and conducts compliance reviews involving "most integrated setting" issues. We strongly recommend that States factor in these principles and practices as they develop plans tailored to their needs.

Comprehensive, Effectively Working Plans

Principle: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings. When effectively carrying out this principle:

- The State develops a plan or plans to ensure that people with disabilities are served in the most integrated setting appropriate. It considers the extent to which there are programs that can serve as a framework for the development of an effectively working plan. It also considers the level of awareness and agreement among stakeholders and decision-makers regarding the elements needed to create an effective system, and how this foundation can be strengthened.
- The plan ensures the transition of qualified individuals into community-based settings at a reasonable pace. The State identifies improvements that could be made.
- The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). In this process, individuals are provided the opportunity for informed choice.
- The plan evaluates the adequacy with which the State is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals, and residential service facilities for children) to determine the extent to which they can and should receive services in a more integrated setting.
- The plan establishes similar procedures to avoid unjustifiable institutionalization in the first place.

Plan Development and Implementation Process

Principle: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:

- The State involves people with disabilities (and their representatives, where appropriate) in the plan development and implementation process. It considers what methods could be employed to ensure constructive, on-going involvement and dialogue.
- The State assesses what partnerships are needed to ensure that any plan is comprehensive and works effectively.

Assessments on Behalf of Potentially Eligible Populations

Principle: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:

- The State has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community-based settings. The plan considers what information and data collection systems exist to enable the State to make this determination. Where appropriate, the State considers improvements to data collection systems to enable it to plan adequately to meet needs.
- The State evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.
- The State also evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.
- The plan ensures that the State can act in a timely and effective manner in response to the findings of any assessment process.

Availability of Community-Integrated Services

Principle: Ensure the Availability of Community-Integrated Services. When effectively carrying out this principle:

- The plan identifies what community-based services are available in the State. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA). The State identifies what improvements could be accomplished, including in information systems, to make this an even better system, and how the system might be made comprehensive.
- The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports.
- The State evaluates whether its system adequately plans for making supports and services available to assist individuals who reside in their own homes with the presence of other family members. It also considers whether its plan is adequate to address the needs of those without family members or other informal caregivers.
- The State examines how the identified supports and services integrate the individual into the community.
- The State reviews what funding sources are available (both Medicaid and other funding sources) to increase the availability of community-based services. It also considers what efforts are under way to coordinate access to these services. Planners assess the extent to which these funding sources can be organized into a coherent system of long term care which affords people with reasonable, timely access to community-based services.

- Planners also assess how well the current service system works for different groups (e.g. elderly people with disabilities, people with physical disabilities, developmental disabilities, mental illness, HIV-AIDS, etc.). The assessment includes a review of changes that might be desirable to make services a reality in the most integrated setting appropriate for all populations.

- The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

Informed Choice

Principle: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings. When effectively carrying out this principle:

- The plan ensures that individuals who may be eligible to receive services in more integrated community-based settings (and their representatives, where appropriate) are given the opportunity to make informed choices regarding whether -and how- their needs can best be met.

- Planners address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

Implications for State and Community Infrastructure

Principle: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan. When effectively carrying out this principle:

- Planners evaluate how quality assurance and quality improvement can be conducted effectively as more people with disabilities live in community settings.

- The State also examines how it can best manage the overall system of health and long term care so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management infrastructure might be necessary to achieve this result at the State and the community level.

APPENDIX D: HOUSE CONCURRENT RESOLUTION 196
TWENTIETH LEGISLATURE, 2000, STATE OF HAWAI'I

HOUSE CONCURRENT RESOLUTION

REQUESTING THE GOVERNOR TO DEVELOP AND IMPLEMENT A COMPREHENSIVE STATEWIDE PLAN FOR PLACING QUALIFIED PERSONS WITH DISABILITIES IN THE MOST INTEGRATED SETTING POSSIBLE AND TO KEEP WAITING LISTS THAT MOVE AT A REASONABLE PACE.

WHEREAS, a recent United States Supreme Court decision in Olmstead v. L.C., 119 S. Ct. 2176 (1999), provides an important legal framework to enable individuals with disabilities to live in the most integrated setting appropriate to their needs; and

WHEREAS, the Olmstead case was brought by two Georgia women whose disabilities in clued mental retardation and mental illness, and who lived in State-run institutions, despite the fact that their treatment professional had determined that they could be appropriately served in a community setting; and

WHEREAS, the plaintiffs asserted that their continued institutionalization was a violation of their right under the Americans with Disabilities Act of 1990 (ADA); and

WHEREAS, many people with physical and sensory disabilities throughout history have historically been institutionalized by state agencies throughout the country in ways similar to the plaintiffs in the Olmstead case, and these people are equally protected by the ADA and by the United States Supreme Court's findings; and

WHEREAS, the United States Supreme Court recognized that unjustified institutional isolation of persons with disabilities is a form of discrimination that reflects two evident judgments:

(1) Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons isolated in institutions are incapable or unworthy of participating in community life; and

(2) Confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment;

and

WHEREAS, Olmstead challenges states to prevent and correct inappropriate institutionalization and to review the intake and admissions processes to assure that persons with disabilities are served in the most appropriate integrated setting; and

WHEREAS, the United State Supreme Court suggests that a State could establish compliance with Title II of the ADA if it demonstrates that it has a "comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable paced not controlled by the State's endeavors to keep its institutions fully populated"; and

WHEREAS, in a letter addressed to all State Medicaid Directors, the U.S. Department of Health and Human Services suggests that Medicaid assist States in meeting these goals and comply with ADA; and

WHEREAS, in Hawai'i, people with disabilities are faced with various waiting lists for services and supports necessary to live in the community; and

WHEREAS, the State's Home and Community Based Services Waiver Program for people with Mental Retardation and Developmental Disabilities indicates that there are over 850 people currently waitlisted for waiver services in Hawai'i; and

WHEREAS, the Nursing Home Without Walls Medicaid Waiver Program for people with personal care needs has extended waiting periods ranging from a few months to over two years at certain times; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twentieth Legislature of the State of Hawai'i, Regular Session of 2000, the Senate concurring, that the Governor develop and implement a comprehensive statewide plan to address the needs of individuals with disabilities that provides for placement into less restrictive settings and waitlists that move at a reasonable place; an

BE IT FURTHER RESOLVED that in developing the plan, the following organizations should be integral participants in the development and follow-up: the Disability and Communication Access Board, State Planning Council on Developmental Disabilities, Department of Health, Department of Human Services, Housing and Community Development Corporation of Hawai'i, other State departments as appropriate, University of Hawai'i Center on Disability Studies, Hawai'i Disability Rights Center, disability rights advocates and service providers such as the Hawai'i Centers for Independent Living, the Statewide Independent Living Council, the Arc in Hawai'i, Mental Health Association of Hawai'i, Disability Rights Hawai'i, Mental Help Hawai'i, and individuals with disabilities, parents, family members, or guardians of individuals with disabilities, and other private and public agencies providing services to persons with disabilities; and

BE FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Governor and each organization named in the preceding paragraph.

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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 more than 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.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious 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?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?

Since the early 1990's, the Department of Health, Child & Adolescent Mental Health Division (CAMHD) has been committed to the Hawaii Child and Adolescent Service System Program (CASSP) principles. Nationally, the CASSP principles provide the framework for systems of care. Hawaii's CASSP values and principles emphasize the importance of making services family-centered and culturally sensitive and assuring that families are full participants in all aspects of the planning and delivery of services. Youth-guided means that youth have the right to be empowered, educated, and given a decision making role in the care of their own lives, as well as public policy governing care for all youth in the community.

Hawaii CASSP Principles:

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

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

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

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

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

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

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

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

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

The CAMHD provides services and supports through an integrated public-private partnership consisting of contracted community-based agencies and state managed, community-based Family Guidance Centers, and a centralized state office to provide administrative and performance oversight functions. Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other Dept. of Health divisions, including the Alcohol & Drug Abuse Division, Developmental Disabilities Division, and Early Intervention Services. A large percentage of the CAMHD population in QUEST Healthplan (Medicaid) services, which requires linkages to primary care providers. The CAMHD system is committed to working with all other child-serving agencies to integrate services and programs across agencies in the best interest of the youth and their families.

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. CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services.

In a system of care approach, CAMHD has developed a comprehensive array of evidence-based practices, services and supports for children and youth with the most challenging emotional and behavioral needs, and their families. The services are delivered in the least restrictive environment possible, using evidence-based practices while providing effective cross-system collaboration and integrated management of service delivery.

CAMHD's comprehensive service array is comprised of a spectrum of effective, community-based services and supports:

- Mental Health Evaluation
- Psychological Testing
- Psychosexual Assessment
- Psychiatric Evaluation
- Medication Management
- Individual Therapy
- Group Therapy
- Family Therapy
- Multi-Systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Intensive In-Home Therapy
- Intensive In-Home Paraprofessional Support
- Transitional Family Home
- Community-Based Residential, Levels I, II and III
- Partial Hospitalization
- Hospital-Based Residential
- Respite Supports
- Therapeutic Respite Home
- Intensive Independent Living Skills
- Independent Living Skills Paraprofessional Support
- Ancillary Services
- 24-Hour Crisis Telephone Stabilization
- Crisis Mobile Outreach
- Therapeutic Crisis Home

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?

Each youth's treatment is directed by a service plan 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.

Coordinated Service Plan (CSP). The Coordinated Service Plan identifies the specific strategies that will achieve broadly defined goals for the youth and family, and integrates strategies across all those involved. The CSP process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers. The CSP process will use resources available through the service system and shall include some naturally occurring resources in the youth's family and community. Its purpose is to coordinate efforts across public agencies and other supports and services. CSP planning is guided by a long-term holistic view of the youth's life.

Mental Health Treatment Plan (MHTP). CAMHD's contracted providers are responsible for the development, implementation, review, revision and adjustments to the MHTP. The MHTP should be individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth that includes the contracted provider, family, and assigned CAMHD Mental Health Care Coordinator. The MHTP will identify evidence-based treatment interventions that are the most promising options for meeting a youth's individual goals and objectives. Progress on plans shall be tracked continuously and treatment revised as necessary with youth, family/guardian and Family Guidance Center collaboration. The treatment planning process begins with the pre-admission meeting and culminates in a document that includes expected intensity of treatment and treatment timelines, crisis and discharge plans.

The above protocols are codified in CAMHD's Child and Adolescent Mental Health Performance Standards, aka "Orange Book", under "Resource Library" at:
http://health.hawaii.gov/camhd/

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.)?

Last year, 2014, marks a high-point in working relationships with the Department of Education (DOE) administration. Several high-profile cases that required coordination of mainland behavioral health placements demonstrated the need for coordination between CAMHD and the DOE. The process for these placements was remodeled and the timeframe was shortened by one half. This required coordinated planning from DOE and Department of Human Services. DOE has agreed to pay for educational charges for all placements, no matter the requesting agency. Out of this process has grown a formalized one-to-one accountability between the CAMHD Administrator and a Deputy Superintendent of the DOE. Policy problems are handled at this level. We are now finalizing a Memorandum of Agreement with DOE concerning the process for mainland placements so all parties are held to their agreements. The Deputy Superintendent will be a standing member of Hawaii Interagency State Youth Network of Care (HI-SYNC) which will assure decision making power on this multi-agency forum.

CAMHD facilitates the monthly HI-SYNC meeting, which is comprised of representatives from many child serving agencies--the Department of Education, Department of Human Services, Judiciary, and the Early Intervention Services and Developmental Disabilities Division of the Department of Health. HI-SYNC has been increasingly recognized as an appropriate forum to discuss particularly complex, multi-agency cases. Approval of a single consent form for use by HI-SYNC was a major accomplishment that took years to develop and to get approved by all agencies involved.

CAMHD spearheads multi-agency collection of data and publication of the Hawaii Youth Inter-Agency Performance Report (HYIPER). (See http://health.hawaii.gov/camhd/home/hyipr/.) The report now reports outcomes measures from CAMHD, School-Based Behavioral Health, Special

Education, Developmental Disabilities Division, Early Intervention, Office of Youth Services and Child Welfare Services. The previously semi-annual report has been increased to an annual report and the format and measures have been revised. Previously the report focused largely on compliance measures with the Court's oversight concerns. Although still a work in progress, it will focus now on outcomes for children and clinical measures with involvement of more agencies is report features several key performance indicators for youth served by these child-serving agencies in one report and is published in hard copy and posted to CAMHD's website every year.

A process, facilitated by a grant from the Pew Charitable Trust facilitated formal discussions about the juvenile justice system and need for reform. Out of this process came a major bill, HB 2490 (Hawaii State Legislature 2014) that restructures the probation system and how it handles youth. A major part of this bill deals with strengthening the mental health services to those who have encountered the Juvenile Justice (JJ) system. A second bill increasing funding for those services was passed, increasing support for juvenile justice therapeutic programming by over one million dollars. There have been a series of meetings with Family Court Judges in addition. Two Hawaii Supreme Court justices are advocating mental health treatment for adjudicated youth with pooled resources to run a secure mental health treatment facility in Hawaii for our most troubled youth, and to avoid a further increase in mainland placements. These multiple agencies plan to soon to send a joint team to the mainland to look at models for this new level of care. CAMHD will have therapeutic oversight of this facility. This model is very innovative and shows the commitment of CAMHD, the Courts and the Office of Youth Services in working together for common programming.

CAMHD's two pilot projects are beginning to show organizational progress and varying degrees of effect among the four Federally Qualified Health Centers (FQHC) sites. One project is run by the Hawaii Primary Care Association, (HPCA), with sites at Kona and Kalihi-Palama with collaboration with CAMHD's Big Island and Honolulu Family Guidance Centers. The other project with sites at Waimanalo and Maui is run by the John A. Burns School of Medicine Department of Psychiatry with collaboration from the Central Oahu and Maui Family Guidance Centers. The Kona site has seen the most eager response and clinically has touched the largest number of clients. A consultative model seems to be emerging. Referrals have gone in both directions, both to and from the primary clinic. A very successful training with expertise from the mainland was held by HPCA, attended by both the grantee groups. Our model in Hawaii seems to closely mirror successful models in other states. Reliance on modern communication technology has been helpful. For the upcoming block grant cycles, we look forward to transitioning the projects toward a second, restructured, phase of development.

CAMHD has sponsored the wraparound initiative which is a 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. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

For CAMHD's two evidence-based packaged programs, Multi-Systemic Therapy and Functional Family Therapy, the staff are required to undergo training by licensed trainers. For Functional Family Therapy, staff must complete the required FFT training program from a licensed FFT trainer prior to assignment of families/clients. Staff must also attend quarterly booster training. For Multi-System Therapy, staff must complete a five (5)-day training program designed by MST prior to assignment of families/youth. MST staff must also attend quarterly booster training.

The nascent Coordinated Specialty Care Program for First Episode Psychosis has a training plan that specifies requirements for each staff position. During its initial stages, the program made significant progress in training the clinic staff. Psychologist Dr. Cicero attended the International Early Psychosis Association Conference to hear some of the preliminary results of the RAISE model. In March 2015, the Coordinated Specialty Care staff attended the SAMHSA Pacific Jurisdictions training in Honolulu, which was provided by staff from OnTrackNY, New York City's iteration of the RAISE model. Dr. Cicero was able to present the Hawaii model to the Pacific Jurisdictions, and serve as a "local" resource. The Coordinated Specialty Care clinic is now subscribed to the Center for Practice Innovation (CPI) learning community from OnTrackNY. With the assistance of CPI, specifically-tailored training plans for each staff member were developed, with the completion of the training targeted prior to the opening of the clinic.

Most recently, CAMHD held a 2015 Summer Evidence-Based Conference. The target audience of the training included children's and adult mental health providers, health providers, health plans, child-serving agencies and academia. Included on the agenda were CAMHD's new evidence-based clinical model and workflows. The new evidence-based clinical model emphasizes the formation of Clinical Management Teams and their key roles in clinical decision-making and management. Revised workflows were rolled out to illustrate a new model of youth and family clinical care coordination. It was stressed that key features in the new workflow were first proven in the scientific literature to improve outcomes:

- Clinical feedback has been demonstrated to increase positive outcomes in randomized trials and meta-analyses. The only way to collect consistent and reliable data is by standardizing and systematizing CAMHD's workflows.

- Family engagement has been empirically demonstrated to improve retention and outcomes and the new CAMHD model is aimed towards increased family engagement.

- There is an evidence-base for interagency collaboration to increase success in transition to adulthood for emerging adults.

The afternoon track featured transitions to adult care. Psychologist Dr. Cicero provided a presentation of the new Coordinated Specialty Care program. Additional presentations by the

Adult Mental Health Division, the Department of Human Services Med-QUEST (Medicaid) program, and several health plans provided insight into various coverage and service options.

CAMHD was a co-sponsor of the IVAT Hawaii Conference on the Assessment and Treatment of Trauma in March 2011, 2012, 2013 and 2014. This conference was attended by close to 500 professionals yearly. CAMHD has participated in conference planning and assured that sessions on Evidence-Based and Evidence-Informed Trauma treatments for children and youth were featured in the program. In 2013 CAMHD/UH psychiatrists provided a symposium session on utilizing psychotropic medicine as part of trauma treatment. As a result of this conference, a large number of CAMHD providers have expanded their understanding of trauma informed care, trauma treatment and specific, Evidence-Based trauma treatment.

Prior to the economic downturn when CAMHD had a robust training team, CAMHD regularly offered statewide trainings on evidence-based treatments, sponsored evidence-based services conferences, and provided orientations to our existing packaged evidence-based programs. CAMHD brought in experts to train CAMHD and its contracted providers on evidence-based services such as wraparound. CAMHD provided training to its staff, contracted providers and community stakeholders on evidence-based and best practices on topics such as behavior management, dialectical behavior therapy, suicide intervention, motivational interviewing, Child Parent Interaction Therapy, family therapy, telemedicine, biblio-therapy, Cognitive Behavioral Therapy, first episode psychosis and the use of clinical feedback system. CAMHD has also partnered and participated in non-CAMHD sponsored (but CAMHD endorsed) trainings including Safety Permanency and Wellbeing, family finding, mental health first aide and wraparound.

With the improved state economy and CAMHD's recent reorganization, CAMHD will be able to pursue re-establishment of former training positions. Meanwhile, CAMHD's Training *Hui* (Hawaiian for "group") gathers information about service and knowledge gaps and develops strategies to address those gaps. For example, when CAMHD's Performance Management Office finds that a provider repeatedly submits incorrect information, one-on-one training and technical assistance is provided to the provider so that the source of the problems can be identified and corrected.

CAMHD sponsors and convenes the Evidence-Based Services (EBS) Committee which is comprised of representatives of many different youth-serving agencies and meets monthly to discuss the most up-to-date topics regarding services and practices available to youth with mental health needs. This group was responsible for creating the Help Your Keiki website (http://helpyourkeiki.com/) which was created to assist parents and other laypersons about important facts and resources available to assist their youth. This group also offers quarterly presentations and interactive discussions regarding evidence-based and promising practices in the field of mental health for youth encouraging questions and feedback from the audience regarding the materials and facts presented. The goal is to help create a more informed group of parents and service providers.

5. **How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, and substance use and co-occurring disorders?**

The CAMHD tracks utilization via registration into our system, billable transactions and census at various levels of care. This utilization analysis can show the costs at different levels of aggregation i.e. individual youth, levels of care, specific regions, specific service providers etc. all against various diagnosis or other assessment metrics such as the Child and Adolescent Functional Assessment Scale (CAFAS). This utilization is monitored at different levels depending upon the level of aggregation. For example at the youth level the care coordinator and clinician monitor utilization, regional utilization by the center chief and system level analysis by the Clinical Services Office (CSO) and the Health System Management Office (HSMO).

The CAMHD Factbook is produced on an annual basis and contains information on the past fiscal year (July 1 to June 30) looking at basic numbers of youth registered and served by CAMHD as well as the demographics of those youth. Also included in this yearly summary are indicators of performance that offer a look into the outcomes for youth served by CAMHD in terms of assessments administered to the youth (CAFAS), use of evidence based practices (MTPS) and discharge status. Most of the results documented in the Factbook (as well as other analyses conducted by the Research & Evaluation Team - RET) are presented to all CAMHD staff so they can become familiar with the trends and patterns in outcomes and apply these findings to their work with youth.

The CAMHD Data Party is offered to CAMHD's contracted providers every 6 months and through the Provider Feedback Reports shared with each provider, the results of the previous two years of data analysis is shared so providers can get some perspective into their use of 'evidence-based practice elements' to address treatment targets for the youth they serve. These reports detail what proportion of their treatment strategies they implemented have been evidence-based as opposed to modalities they have implemented that as of this point in time, do not have rigorous research support behind them for their use. These presentations and the discussions to follow help providers (and CAMHD staff) understand better where future efforts must be emphasized in order to ensure treatment strategies employed have a solid foundation of success behind them.

CAMHD is currently in the process of convening a new committee that is charged with analyzing the small (but significant) number of youth who are sent to the US Mainland for service provision. In the past year, there has been a rather dramatic increase in youth who cannot be served on the islands of Hawaii. For many years previous to this past year, this number of Mainland referrals was very small (n=7), but this number has rapidly increased (n=25) over the past year. Although these numbers are still relatively low, the increase is concerning because CAMHD understands that it is not good practice for youths to be so far away from their families and where they grew up and this situation is more likely to result in non-successful outcomes for these youth. The Committee will utilize data (electronic, hard copy files, interviews) to get a better picture of why the increase has occurred and whether or not Hawaii can develop and implement a new service to serve these youth without having to send them to the Mainland.

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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 residents[1]

	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%
	all other	102	15%	*all other*	603	10%	*all other*	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

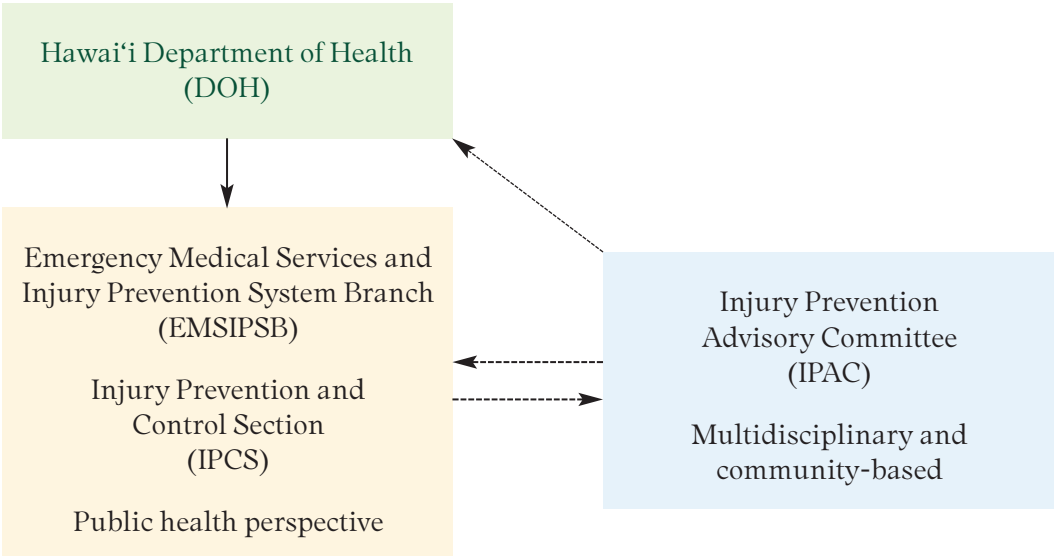
IPCS worked closely with experts and stakeholders in each area to review accomplishments, conduct needs assessments, and develop recommendations for the next five years. Additional information about the processes used to generate these recommendations are included in the individual chapters.

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



Injury Prevention Advisory Committee

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

Drowning Prevention

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

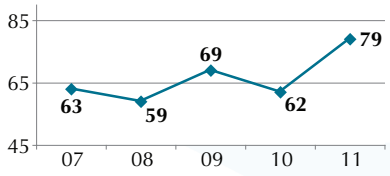
- Evaluate the Hawai'i Beach Safety website, www.hawaiibeachsafety.org, to determine effectiveness and use of the site.
- Provide data support and technical assistance to practitioners that need assistance evaluating their own drowning prevention programs.
- Evaluate effectiveness of safety efforts, 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)

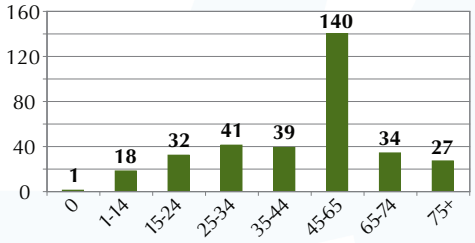
Fatal injuries

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).

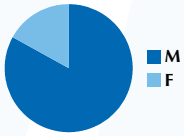
Trend: no trend
Total: 332
Ave: 66/year



Age groups:
45-64y = 42%



Gender:
83% M
17% F



County totals and 5-year rate (deaths/100,000):

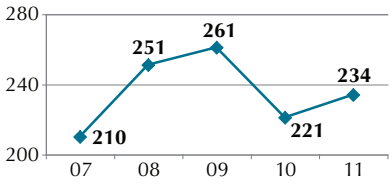
COUNTY	NUM.	RATE
Hawaii	39	19.0
Honolulu	101	10.7
Kauai	13	18.8
Maui	22	14.6

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.

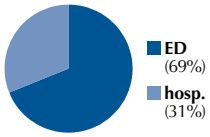
Nonfatal injuries (near drownings)

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.

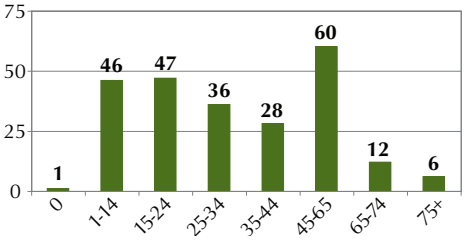
Trend: no trend
Ave: 235/year



Treatment:
163 ED
73 hosp.



Age groups:
1-24y = 39%



Hawai'i residents only:
County totals, annual number and rate (/100,000):

COUNTY	NUM.	RATE
Hawaii	23	12.5
Honolulu	88	9.6
Kauai	10	16.4
Maui	9	6.0

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.

Recommended Next Steps

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

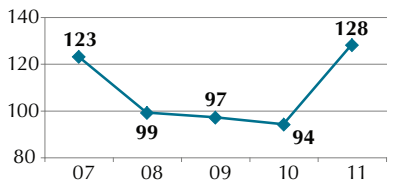
- Encourage community partners, such as fire departments and EMS providers to assist with home assessments.
- Enable more pharmacists and other qualified professionals to provide free annual medication reviews.
- Encourage medical professionals to provide fall risk assessments.
- Train care home providers 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

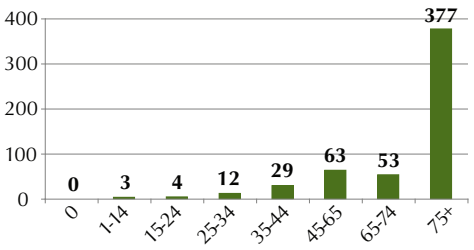
Fatal injuries

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 residentscomprised 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.

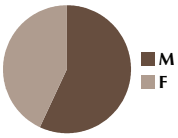
Trend: no trend
Total: 541
Ave: 108/year



Age groups:
65y or older = 79%



Gender:
57% M
43% F



County totals and 5-year rate (deaths/100,000):

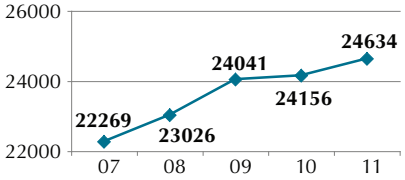
COUNTY	NUM.	RATE
Hawaii	57	29.9
Honolulu	423	35.9
Kauai	18	22.2
Maui	43	27.5

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.

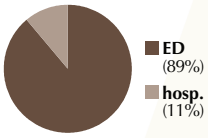
Nonfatal injuries

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.

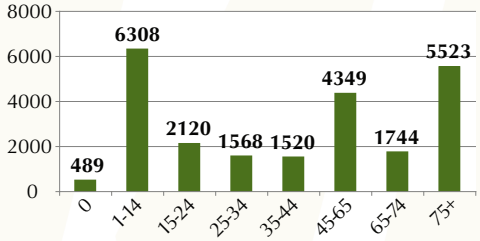
Trend: increasing trend
Ave: 23,625/year



Treatment:
20,920 ED
2,705 hosp.



Age groups:
1-14y = 27%



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

COUNTY	NUM.	RATE
Hawaii	4289	2390.8
Honolulu	15209	1584.7
Kauai	1750	2635.6
Maui	2377	1627.8

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.

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).

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- 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

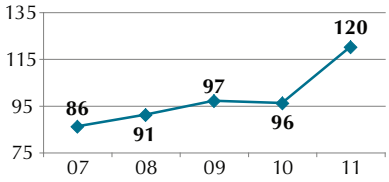
- Continue collaborating with KIPC to provide educational materials and promote the poison information hotline.
- Use data collected from the poison information hotline to identify trends and problem areas and inform prevention strategies.
- Help secure continued funding for the poison information hotline.

Injury Data for Poisonings

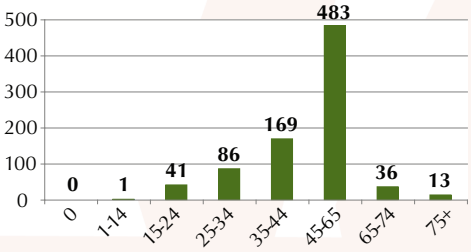
Fatal injuries

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".

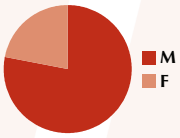
Trend: increasing trend
Total: 490
Ave: 98/year



Age groups:
45 to 64 = 58%



Gender:
78% M
22% F



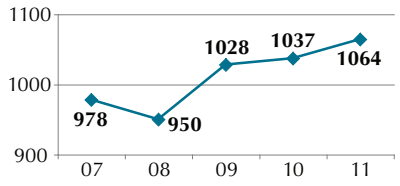
County totals and 5-year rate (deaths/100,000):

COUNTY	NUM.	RATE
Hawaii	37	21.8
Honolulu	400	43.4
Kauai	16	22.3
Maui	37	24.4

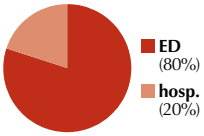
Nonfatal injuries

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.

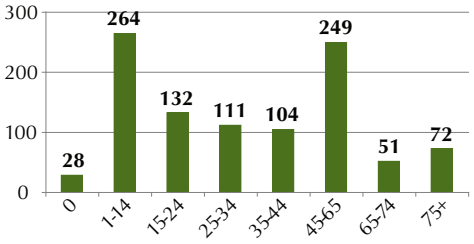
Trend: increasing trend
Ave: 1011/year



Treatment:
805 ED
207 hosp.



Age groups:
1-14y = 26%



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

COUNTY	NUM.	RATE
Hawaii	193	109.7
Honolulu	643	69.4
Kauai	72	112.6
Maui	103	69.5

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

- 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.

Recommended Next Steps

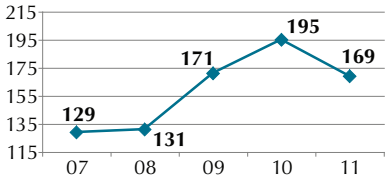
- PSHTF should provide leadership and coordination to:
  - Enhance collaboration with allied health areas to address the need for culturally sensitive prevention services.
  - Increase communication among health providers to improve the responsiveness of the system.
- Make trainings accessible to clinicians 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

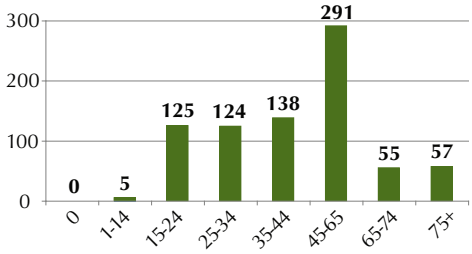
Fatal injuries

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).

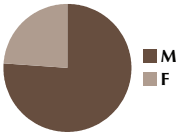
Trend: increasing
Total: 795
Ave: 159/year



Age groups:
20 to 60y = 74%



Gender:
76% M
24% F



County totals and 5-year rate (deaths/100,000):

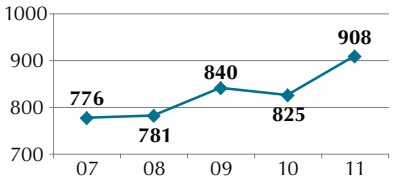
COUNTY	NUM.	RATE
Hawaii	150	98.6
Honolulu	465	57.5
Kauai	50	85.5
Maui	130	94.9

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.

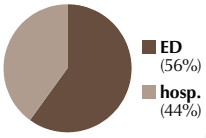
Nonfatal injuries

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.

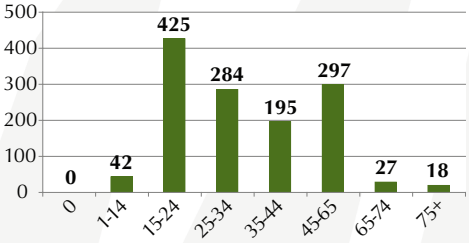
Trend: increasing trend
Ave: 826/year



Treatment:
465 ED
361 hosp.



Age groups:
15-24y = 33%



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

COUNTY	NUM.	RATE
Hawaii	166	98.8
Honolulu	525	58.1
Kauai	61	102.3
Maui	74	51.5

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

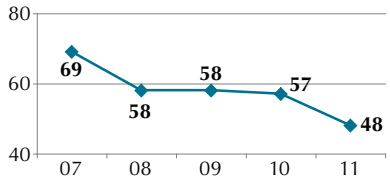
- Provide pedestrian and bicycle injury data to traffic safety partners to support implementation of complete streets policies and Safe Routes to School programs in each county.
- Support complete streets training and continuing education opportunities for engineers, planners, transportation agency heads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

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

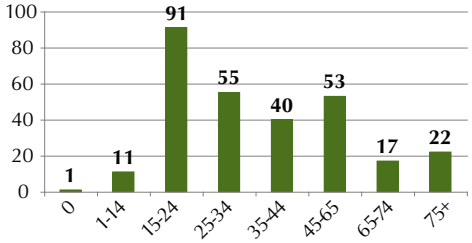
Fatal injuries

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.

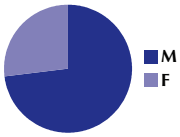
Trend: decreasing
Total: 290
Ave: 58/year



Age groups:
15-24y = 31%



Gender:
73% M
27% F



County totals and 5-year rate (deaths/100,000):

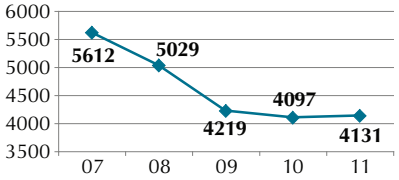
COUNTY	NUM.	RATE
Hawaii	94	55.6
Honolulu	115	12.3
Kauai	35	54.5
Maui	46	32.6

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.

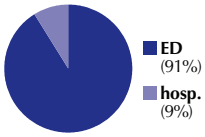
Nonfatal injuries

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.

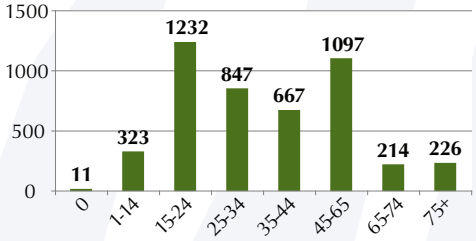
Trend: decreasing
Ave: 4618/year



Treatment
4204 ED
414 hosp.



Age groups:
15-24y = 27%



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

COUNTY	NUM.	RATE
Hawaii	1133	636
Honolulu	2606	285
Kauai	358	554
Maui	521	355

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)

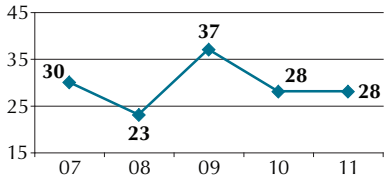
About one-third of the injured resident occupants in the Hawai'i Trauma Registry tested positive for alcohol (32%) or illicit drugs (35%). Considered together, more than half (52%, or 626) of the occupants tested positive for either alcohol or drugs. Occupants who were drinking were significantly younger 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

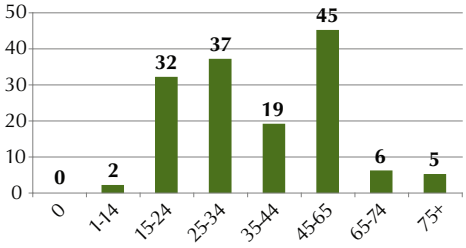
Fatal injuries

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.

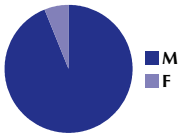
Trend: no trend
Total: 146
Ave: 29/year



Age groups:
20-34y = 41%



Gender:
94% M
6% F



County totals and 5-year rate (deaths/100,000):

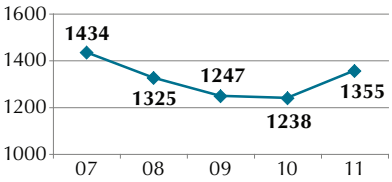
COUNTY	NUM.	RATE
Hawaii	37	19.2
Honolulu	77	8.2
Kauai	7	-
Maui	25	18.0

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%).

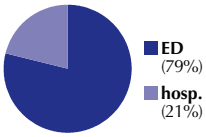
Nonfatal injuries

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.

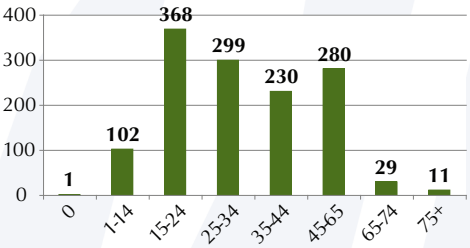
Trend: no trend
Ave: 1287/year



Treatment:
1044 ED
276 hosp.



Age groups:
15-34y = 51%



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

COUNTY	NUM.	RATE
Hawaii	265	157
Honolulu	713	78
Kauai	106	181
Maui	236	166

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 unhlemeted 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)

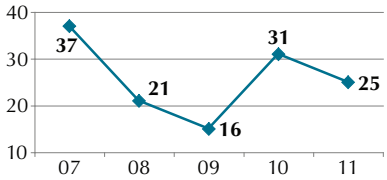
About one-fourth (26%) of the injured resident motorcycle/moped riders in the Hawai'i Trauma Registry tested positive for alcohol, including 21% (178) with BAC (blood alcohol content) levels of 0.08 or greater, and 14% (117) with BAC levels of 0.16% or greater. Moped riders were significantly more likely 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

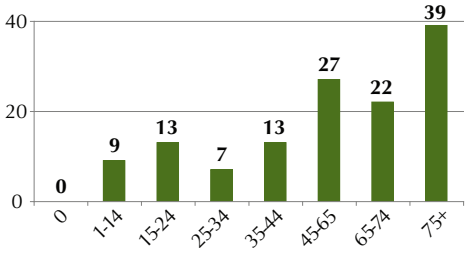
Fatal injuries

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).

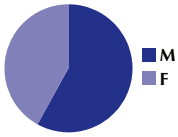
Trend: no trend
Total: 130
Ave: 26/year



Age groups:
65y and older = 47%



Gender:
58% M
42% F



County totals and 5-year rate (deaths/100,000):

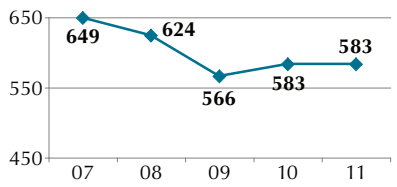
COUNTY	NUM.	RATE
Hawaii	21	11.4
Honolulu	90	8.8
Kauai	4	-
Maui	15	10.5

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%).

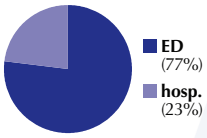
Nonfatal injuries

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.

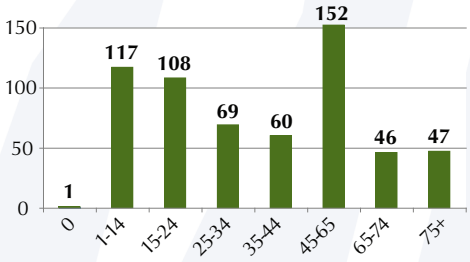
Trend: decreasing
Ave: 601/year



Treatment:
464 ED
137 hosp.



Age groups:
5-24y = 33%



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

COUNTY	NUM.	RATE
Hawaii	80	45.5
Honolulu	434	47.5
Kauai	29	46.2
Maui	58	39.6

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)

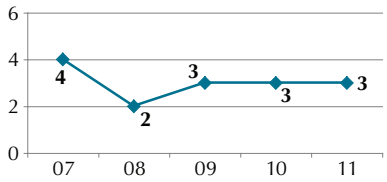
Only 16% of the injured pedestrians in the Hawai'i Trauma Registry had been drinking at the time they were hit. This percentage was significantly higher among those under 65 years of age (22%), as only 2% (3) of the 138 senior-aged pedestrians tested positive for alcohol. Illicit drug usage was documented 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

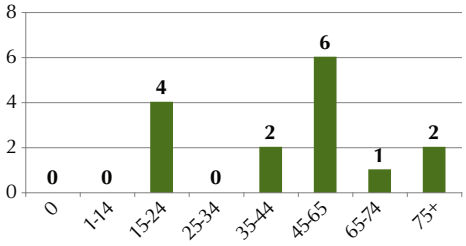
Fatal injuries

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.

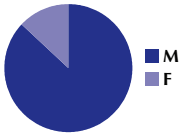
Trend: no trend
Total: 15
Ave: 3/year



Age groups:
widely distributed



Gender:
87% M
13% F



County totals and 5-year rate (deaths/100,000):

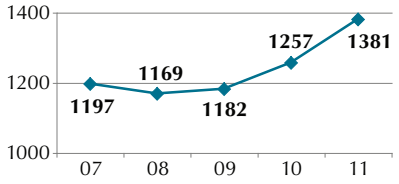
COUNTY	NUM.	RATE
Hawaii	0	-
Honolulu	12	1.3
Kauai	0	-
Maui	3	-

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).

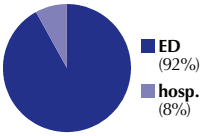
Nonfatal injuries

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).

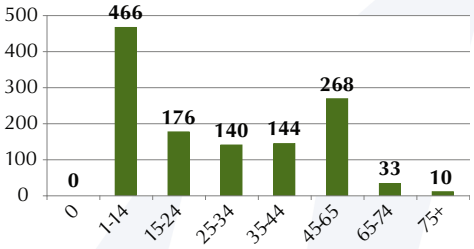
Trend: increasing trend
Ave: 1237/year



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'oikaika 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

Domestic Violence Fatality Review

Hawai‘i Children’s Trust Fund Advisory Council

Hawai‘i Coalition Against Sexual Assault

Hawai‘i Community Foundation

Hawai‘i Youth Services Network

Hawai‘i State Department of Education, School Based Behavioral Health

Hawai‘i State Department of Health, Family Health Services Division, Maternal and Child Health Branch

Hawai‘i State Department of Human Services

Hawai‘i State Department of the Attorney General

Hawai‘i State Judiciary, Children’s Justice Center and First Circuit Court

Ho‘oikaika Partnership

Injury Prevention Advisory Committee

Maui County Domestic Violence Task Force

University of Hawai‘i, John A. Burns School of Medicine, Department of Psychiatry

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

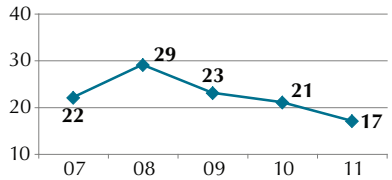
- Facilitate data and information sharing across state agencies.
- Identify and acquire new data sources to develop an annual report on child maltreatment that will enhance understanding of violence and abuse.

Injury Data for Homicides and Assaults

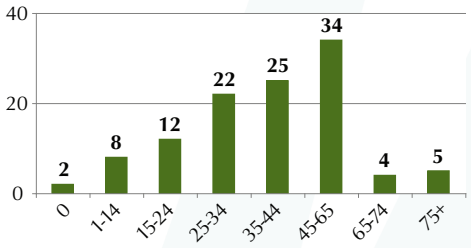
Fatal injuries

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).

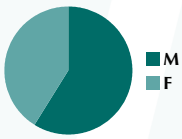
Trend: decreasing trend
Total: 112
Ave: 22/year



Age groups:
25 to 54y = 58%



Gender:
59% M
41% F



County totals and 5-year rate (deaths/100,000):

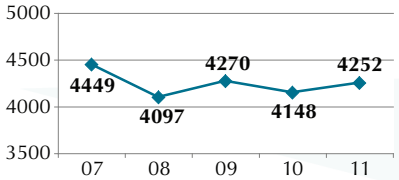
COUNTY	NUM.	RATE
Hawaii	17	-
Honolulu	81	8.8
Kauai	7	-
Maui	7	-

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%).

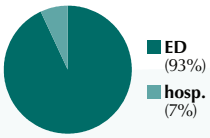
Nonfatal injuries

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.

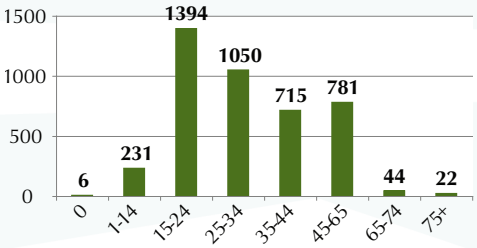
Trend: no trend
Ave: 4243/year



Treatment
3936 ED
307 hosp.



Age groups:
15-24y = 33%



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

COUNTY	NUM.	RATE
Hawaii	771	466.3
Honolulu	2735	302.4
Kauai	226	384.0
Maui	511	363.2

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.).

INFRASTRUCTURE			
RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Stabilize IPCS funding and support expansion of injury prevention services to all counties throughout the state. ▸ Stabilize funding for Core IPCS positions ▸ Establish suicide prevention coordinator position ▸ Establish Neighbor Island positions	 **Progress Made** **Objective Met** **Progress Made**	 ✓ ✓	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.
Establish standards for completeness and accuracy of external cause of injury coding (e-coding) for hospitals to achieve and maintain.	**Objective Met**		E-coding is at 90% for emergency department and hospital admission records.
Produce and disseminate annual and specialized injury reports.	**Objective Met**		*Injuries in Hawai'i 2001-2006* 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.
Incorporate injury prevention into Hawai'i's Health Education Standards for grades K through 12.	**Progress Made**		The Hawai'i Health standards-based playground safety curriculum and unintentional injury curriculum were developed for public elementary schools.
Develop a cadre of individuals and organizations who are injury literate, articulate, and active.	**Progress Made**	✓	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 conferencesand public health core competency workshops.
Cultivate awareness and advocacy among policy makers and the public in recognizing and addressing injuries as a major public health problem in Hawai'i.	**Progress Made**	✓	IPCS distributed Injuries in Hawai'i to 2008 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.
Foster partnerships with the military to address injury prevention issues in which the military can have impact.	**Progress Made**	✓	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.

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 *Tai Chi for Health* 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.

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 Hawaii.	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.

UNINTENTIONAL POISONING

RECOMMENDATIONS	STATUS*	CURRENT EFFORT**	COMMENTS
Through legislation, improve labeling on prescription drugs to include: ▸ 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.

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.

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 Oʻahu hospital began contributing ED records in November, 2008, although this hospital accounted for only 1.4% of ED records. Two other Oʻahu 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 Hawaiʻi 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 Hawaiʻi 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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August 2012

1. **Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).**

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 2012-2017 (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 (CDCI). IPCS works with the Prevent Suicide Hawai'i Taskforce (PSHTF) to implement suicide prevention recommendations found in the National Strategy for Suicide Prevention 2012 and adopted in the HIPP 2012-2017 plan.

PSHTF is a state, public and private partnership of agencies and community groups working in collaboration to provide leadership, develop strategies, coordinate activities, and monitor progress of suicide prevention efforts in Hawai'i.

There are no plans to update the "Hawai'i Injury Prevention Plan 2012-2017 at this time, however, priority activities for 2014/2015 have a stronger emphasis on integrating survivor education and support.

A copy of the plan is attached.

2. **Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.**

The HIPP suicide recommendations includes a directive that specific attention be paid to underserved populations, including youth, seniors, the homeless, those who are incarcerated, adults with mental health challenges and individuals who are lesbian, gay bi-sexual, or transgendered.

3. **Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans**

Progress of the state suicide plan – 2014-2015

The Prevent Suicide Hawai'i Task Force (PSHTF) Steering Committee held a planning retreat in 2014 to review the overall direction of the task force and to determine priority focus areas and short and long-term goals. The focus areas going forward are Training, Public Awareness, and Policy Development. All three areas are directly related to the HIPP recommendations. Subcommittees, formed in early 2015 and made up of statewide PSHTF members, will work in these three areas to develop activities, specific steps to reach goals and objectives, and timelines for completion and implementation of the activities. A draft of the Plan will be completed in September 2015.

HIPP Recommendation 1. **Enhance ongoing suicide prevention trainings for gatekeepers.**

IPCS continues to contract with the University of Hawai'i, Manoa, John A. Burns School of Medicine, Department of Psychiatry (DOP) to coordinate, promote and organize ASIST, safeTALK and CONNECT trainings and to work with IPCS and the PSHTF to identify other best practice trainings that maybe suitable to implement. A collaboration with all military branches has resulted in shared civilian and military trainings facilitated by the suicide prevention coordinator's membership on military branches and behavioral health task forces. All military branches are now represented on the PSHTF. A plan for sustaining the suicide prevention gatekeeper training network is under development to help ensure that gatekeeper trainings in all counties is accessible, refresher trainings are provided, and trainings are updated on a regular basis.

Recommendation 2. Develop and implement a public awareness campaign

As a result of the PSHTF planning retreat, a subcommittee began working to develop effective strategies and activities to promote suicide prevention with a goal of raising awareness and communication around suicide prevention among individuals and organizations. This will include informal and formal mechanisms including the development of a safe messaging training video, the development of a PSHTF website, conferences, trainings, presentations, media outreach, fundraising and other community activities. These awareness efforts will continue to build the reputation and expertise of the PSHTF to reduce suicide attempts and deaths in Hawai'i.

The IPCS in collaboration with Mental Health America Hawai'i (MHAH), produced youth suicide prevention PSA's that were aired on two local stations in October 2013. These PSAs became available for public use in 2014. They are distributed by request to IPCS and are posted on the IPCS website (http://health.Hawai'i.gov/injuryprevention/.

IPCS is currently collaborating with MHAH to develop a bullying and suicide prevention toolkit tailored to the local culture. The toolkit will include successful strategies for prevention and intervention, user-friendly data and statistics relevant to youth populations in our state, identification of model programs, protocols, and initiatives.

Recommendation 3. Develop and promote effective clinical and professional activities. The PSHTF steering committee decided that suicide prevention training at the State level should be expanded to include healthcare and related professions. An inventory of current trainings and continuing education policies in these sectors will be undertaken this year. Increasing capacity around advocacy and identifying effective clinical and professional activities will be a priority through the identification of best practice guidelines and trainings.

IPCS collaborated with MHAH, DOP and PSHTF to identify current trainings and the feasibility of requiring mental health professionals, social workers, clinical psychiatrists, clinical psychologists, school counselors, marriage and family counselors' etc. to have suicide prevention training as part of their professional education (CEUs). Upcoming activities are expected to include: training to clinical service providers on prevention of suicide and related behaviors; identifying effective clinical practices for assessing and treating at-risk clients; promoting suicide prevention as a core component of health care service; exploring requiring health professionals to receive prevention training as part of their professional training through legislative action.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs 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. Examples of partnerships may include:

- The SMA 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 any Medicaid populations;
- The state justice system authorities working 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

POLICE DEPARTMENT

CITY AND COUNTY OF HONOLULU

801 SOUTH BERETANIA STREET · HONOLULU, HAWAII 96813
TELEPHONE: (808) 529-3111 · INTERNET: www.honolulupd.org

KIRK CALDWELL
MAYOR

LOUIS M. KEALOHA
CHIEF

DAVE M. KAJIHIRO
MARIE A. McCAULEY
DEPUTY CHIEFS

OUR REFERENCE

August 13, 2015

Ms. Virginia Simmons
Grants Manager
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857

Dear Ms. Simmons:

I am writing in support of increasing or at least maintaining, the level of support that Department of Health, Adult Mental Health Division (AMHD) receives from the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) Mental Health Block Grants.

The Human Services Unit of the Honolulu Police Department has an ongoing and very productive collaborative relationship with the AMHD, in the form of our Emergency Psychological Services and Jail Diversion Program (EPSJDP). This block grant money is used to assist the sickest, most vulnerable and least powerful citizens of our community in getting the mental health services they desperately need. The loss of these funds would be catastrophic for this most deserving and underserved population.

Please feel, free to contact me if you have any questions about our collaboration.

Sincerely,

Michael Christopher Psy.D., Ph.D.
Police Psychologist
Emergency Psychological Services and Jail Diversion Program Coordinator
Human Services Unit
Honolulu Police Department
715 S. King Street, suite 408
Honolulu, HI 96814
O: 808-723-7743

Serving and Protecting With Aloha

POLICE DEPARTMENT
COUNTY OF MAUI

ALAN M. ARAKAWA
MAYOR

OUR REFERENCE

YOUR REFERENCE

55 MAHALANI STREET
WAILUKU, HAWAII 96793
(808) 244-6400
FAX (808) 244-6411

TIVOLI S. FAAUMU
CHIEF OF POLICE

DEAN M. RICKARD
DEPUTY CHIEF OF POLICE

August 13, 2015

Ms. Virginia Simmons
Grants Manager
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857

Dear Ms. Simmons:

The Department of Health, Adult Mental Health Division, is applying for the FY2016-2017 Mental Health Block Grant funds from the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS).

The Maui Police Department works collaboratively with the AMHD to design and deliver services and solutions to meet today's healthcare challenges as one of its purchase of service providers. Thus, the Maui Police Department supports the efforts of the AMHD to obtain grant funds to continue providing treatment and supports to individuals living with severe and persistent mental health illness.

The Maui Police Department will also be partnering with the AMHD in monitoring the implementation Mental Health Block Grant Plan through our continued partnership and receiving periodic reports on the plan.

If you have any questions please do not hesitate to call me at (808) 244-6300 or send correspondence to 55 Mahalani Street, Wailuku, Hawaii 96793.

Sincerely,

Tivoli S. Faaumu
Chief of Police

21. Support of State Partners – Child & Adolescent Mental Health Division

Attachments:

1. Letter of Support from the Center for Cognitive Behavior Therapy

2. Draft Memorandum of Understanding of the Hawaii Interagency State Youth Network of Care

3. Memorandum of Understanding Between Hawaii Youth Services Network and CAMHD's Project Kealahou (system of care grant)

CENTER FOR COGNITIVE BEHAVIOR THERAPY

CHARLES W. MUELLER, PH.D., CO-DIRECTOR
BRAD J. NAKAMURA, PH.D., CO-DIRECTOR
SAKAMAKI HALL C400 2530 DOLE STREET
HONOLULU, HI 96822
(808) 956-9559 (PHONE)
(808) 956-2218 (FAX)

8/14/15
Dr. Stanton Michels
Division Chief Administrator
Central Administration Offices
Child and Adolescent Mental Health Division
3627 Kilauea Avenue, Room 101
Honolulu, Hawai'i 96816

Dear Dr. Michels:

It is my sincere pleasure to write a letter of support for the Child and Adolescent Mental Health Division's (CAMHD) application for a block grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The work that you and the division you oversee have accomplished has improved the lives of children and adolescents in Hawai'i immensely. I am particularly impressed and gratified by the way you have led the Division as it transforms into an efficient, outcome-oriented, family-centered system of care. Your development of strong business practices and use of modern information technology while retaining core CASSP principles puts CAMHD at the forefront of public mental health services. The funds from the block grant have enabled you and your team to develop, deliver, and coordinate effective services. With the continuation of this grant, I have no doubt you will be able to improve the lives of many more youth and families.

As you know, I am a Professor in the Department of Psychology at the University of Hawai'i at Mānoa. I have worked with and advocated for children and adolescents in Hawai'i for over 30 years. I was on the three person team that staffed Hawai'i's first CASSP grant and I have carefully monitored progress in our system of care since. I have directly worked with CAMHD for the last ten or so years and I look forward to continuing this productive and engaging relationship. My work with CAMHD now includes research and evaluation support and training, supervision of information technology and report writing positions, clinical psychology workforce development, provision of assessment and treatment services, advancement of the use of evidence-based services throughout the system, and the development and implementation of a first episode clinic for young people with psychosis.

In the last 10 years, I have established and overseen the Research & Evaluation Team (RET). RET is a behavioral science evaluation and service collaboration between the Department of Psychology at the University of Hawai'i and CAMHD designed to provide leaders and leadership in child and adolescent mental health research and evaluation. The RET combines research and evaluation expertise from both state and UH contracted staff and supports CAMHD's Research and Evaluation Office (REO). The primary purpose of REO is to provide leadership and management regarding the division's efforts to conduct comprehensive evaluation of CAMHD's system. The office works with CAMHD's Clinical Service Office, Performance Management, Administrative Services, and Management Information System Office to develop and oversee empirically sound investigations of all aspects of the CAMHD system, while supporting the system's application of relevant research literature and evidence-based practices. REO also serves as a liaison to external researchers and evaluators and participates in the development, implementation, and monitoring of division-wide strategies and objectives.

My work with CAMHD has extended into recruitment, hiring, and administrative supervision of Research Corporation of University of Hawai'i (RCUH) personnel to support CAMHD information technology and management information services. Currently we have on board a Report Writing Specialist focused on developing and implementing programing that translates systems data into actionable information. One example

of this is the development of single case and aggregated reports of treatment progress from routine CAMHD data collection. We also hired a Telehealth Support Specialist who is embedded in CAMHD's information technology team and facilitates appropriate use of data and technologies throughout the system.

In addition, I oversee the Child Program of the Center for Cognitive Behavior Therapy (C-CBT), a research, training, and service clinic in the Department of Psychology at the University of Hawai'i at Mānoa (UHM). Co-directed by UHM Associate Professor Brad Nakamura and myself, the C-CBT contracts with both CAMHD and the State of Hawai'i's Department of Education to train Ph.D.-level psychology graduate students in evidence-based assessment and treatment strategies and to provide evidence-based consultation, assessment, and intervention services. Within this capacity, C-CBT has trained a multitude of graduate students and postdoctoral fellows, and has delivered services statewide to well over 2,000 youth over the past 18 years.

Dr. Nakamura also co-leads CAMHD's Evidence-Based Services (EBS) Committee, an interdisciplinary workgroup composed of stakeholders from numerous practice, research, educational, and service-delivery settings. First established in 1999, the mission of the EBS committee is to provide relevant, easily understood, and up-to-date knowledge to key stakeholders in order to support evidence-based decision making and the CAMHD mission of timely and effective services for youth and their families. Current noteworthy initiatives of the EBS Committee include youth and family empowerment efforts as well as broader professional stakeholder outreach on a wide variety of youth evidence-based treatment approaches.

In the past year, Dr. Nakamura, and Dr. David Cicero (an Assistant Professor in our Department), and I have adapted the Recovery after Initial Schizophrenia Episode (RAISE) Coordinated Specialty Care model to our local mental health care system in Hawai'i. We plan to implement the full model, including individual resiliency training, supported education and employment, family therapy and psychoeducation, case management, and medication management. This is a necessary program in Hawai'i because there are currently no specialty programs for young people with psychosis anywhere in the state. We have worked with CAMHD and other local organizations, including the University of Hawai'i's Department of Psychiatry, to ensure the program is sustainable over the long-term in Hawaii.

Children's mental health care in Hawai'i has dramatically advanced in the last 30 years but we still have a long way to go. I am extremely confident that CAMHD continues to push the system in positive directions and is leading our state in the development of a powerful and sustainable system of care. Thank you for all the work you and your team have done and all the accomplishments therewith. My colleagues and I are committed to doing everything we can, in partnership with CAMHD, to further your success. I look forward to continuing this productive collaboration for many years to come.

Sincerely,

Charles W. Mueller
Professor
Department of Psychology
University of Hawai'i at Manoa
2530 Dole St. Sakamaki C-400
Honolulu, Hawai'i 96822
Phone: 808/956-6727
Fax: 808/956-2218
e-mail: cmueller@hawaii.edu

Memorandum of Understanding

Hawaii Interagency State Youth Network of Care

I. Introduction

The State of Hawaii's Department of Education, Department of Health, Department of Human Services, and the Judiciary are the agencies responsible for serving the multiple needs of children, youth and families. Through this Memorandum of Understanding, these state agencies and additional child-serving organizations have formed a committee known as The Hawaii Interagency State Youth Network of Care (HI-SYNC) whose purpose is to work collaboratively to improve our child-serving system and to better serve the emotional, educational and developmental needs of children and families in the state.

The purpose of this Memorandum of Understanding is to establish working agreements among HI-SYNC members and detail how the committee will work together to provide leadership, guidance and coordination to serve children, youth and families with complex needs.

II. Mission Statement

The HI-SYNC committee, comprised of leadership from Hawaii's child-serving agencies and organizations, serves as a multi-agency forum focused on improving outcomes for children, youth and families through: (1) continuous review and analysis of data to identify areas for system improvement, (2) the recommendation of policies to address system barriers, (3) collaboration, coordination, integration of services and resources, (4) planning on joint treatment and management of specific cases, and (5) problem-solving around multi-agency challenges.

III. Guiding Principles/Values

- Individualized, strengths-based, youth-guided, family-driven, and community-based care
- An appreciation of diversity, and cultural and linguistic competency
- Promoting self-determination
- Assuring the safety and well-being of all children and youth
- Supporting the educational success and career readiness of children and youth
- A commitment to clinical excellence, evidence based practices, and community best practices for mental health and well-being
- Supporting the complex needs of children and youth
- Working collaboratively, with both shared accountability and coordinated resource management

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IV. Membership and Structure

A. Participating Agencies

This Memorandum of Understanding is entered into among:

1. Department of Education
   a. Community Children's Council Office
   b. Office of Curriculum Instruction and Student Support designee
   c. School-Based Behavioral Health
   d. Special Education

2. Department of Health
   a. Alcohol and Drug Abuse Division
   b. Child and Adolescent Mental Health Division
   c. Developmental Disabilities Division
   d. Family Health Services Division

3. Department of Human Services
   a. Child Welfare Services
   b. Office of Youth Services

4. Family Court, First Circuit
5. Family Support Organization
6. Additional stakeholders may be invited as non-voting members, on a case by case basis, in both the local and state-level committee.

B. Structure

1. State Level Team

   There will be one state-level committee, comprised of high-level leadership from the organizations listed above. The State-level team is convened by co-chairs elected every two years by the committee (see Section IX).

2. Local Team
   a. Structure
      The local level committees will be organized by district: Honolulu, Leeward, Central, Windward, Hawaii (East Hawaii, West Hawaii), Maui, and Kauai

   b. Participating Role Groups:
      The organizations that comprise the local-level committee will mirror the organizations that comprise the state-level committee, and will include: School Based Behavioral Health (SBBH) District Educational Specialists (DESs),

Complex Area Superintendents (CASs) or designee, Special Education DESs, DOE Clinical Psychologists or Clinical Supervisors, Family Guidance Center Branch Chiefs, Psychologists, a representative from the Family Health Services Division, Parent Partners from family support organization, and additional stakeholders as needed to reflect the local community and culture.

V. Function of Local and State Level Committees

A. Function of State-level HI-SYNC Committee

1. Data Review and Analysis
   a. Hawaii Youth Interagency Performance Report
   b. Review system performance issues regarding quality of services.
   c. Align strategic plans and goals

2. System Problem-Solving
   a. Recommend strategies to address multi-agency system issues affecting quality of services.
   b. Identify barriers to effective service delivery that require system changes.
   c. Monitor implementation of improvement activities.
   d. Provide resolutions to system problems the local committees are facing

3. Updates/Communication
   a. Share information through interdepartmental updates
   b. Establish mechanisms to ensure communication linkage with staff in the field and with high-level decision makers
   c. Discuss high-profile interagency cases, i.e. child-specific issues being covered by media
   d. Provide a forum for networking and interagency engagement

4. Youth-Specific Problem-Solving
   a. Address and problem-solve around complex, multi-agency cases that have not be resolved at the local-level.
   b. Identify and address gaps/duplication in services available for families and youth

5. Policy Recommendations
   a. HISYNC members will utilize information from the committee in their own policy decisions
   b. Develop joint proposals for higher-level decision-makers and for legislative initiatives
   c. HISYNC provides input on policy proposals, when requested, from a multi-agency perspective.

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B. Function of Local-level Committees

The function of the local level committee will mirror the function of the state level committee, but relating to regional interagency issues.

VI. Deliverables

A. Deliverables State-level Committee
1. HIPYR/Annual Report
2. Follow-up to local-level teams
3. Monthly minutes made available to local –level teams

B. Deliverables for Local-level Committees
1. System Review Summary (online form?)
2. Committee minutes
3. An Interagency Referral Form, as referrals are identified. Action steps taken toward resolution should be noted.

VII. Communication between Local and State Level Committees

A. Meeting Minutes
The Local-level and State-level committees shall record their meetings through minutes; minutes shall be made available to state and local level teams.
The minutes shall reflect:

1. Attendees
2. General updates
3. Data sharing
4. Trainings/events
5. The development of task groups for follow up
6. Referrals

B. Referrals

1. Any referrals from the Local-level committee to the State-level committee shall be acknowledged within two weeks. Such acknowledgement shall include a timeline for a full report back and who has been assigned as lead on the issue with contact information.
2. Responses to referrals will be agreed upon by members of the State-level team.

C. Annual Meetings

VIII. Annual meetings of State and Local–level teams? Bi-annual? ?Decision-making for State and Local-level Committees

A. Decision making for the State and Local-level committees shall be by consensus of the group whenever possible when it is within their ability to make the decision.

B. When it appears to the co-chairs that opinions are divided, voting will occur. Each member will have one (1) vote. A simple majority will prevail.

C. A quorum defined as a simple majority of all members is necessary to make decisions.

IX. Frequency of Meetings

Both local and state-level committees will meet on a monthly basis, subject to the discretion of the co-chairs. Case-specific problem-solving will take place separately from the monthly HISYNC meeting, and will involve only those agencies specifically involved in the case. Case-specific information will not be a part of any meeting minutes.

X. Election of State (and Local?) Committee Co-Chairs

Co-chairs shall be elected for a two year term and may serve two consecutive terms and shall represent two different agencies. The Department of Health (DOH) shall be designated lead based on the Cluster Statute [HAW. REV. STAT. § 19-321-D(year)].

XI. Information-Sharing and Confidentiality

A. Collaboration
The state and local-level committees shall develop working collaborations with members/departments and shall abide by existing data sharing and confidentiality agreements, as necessary.

B. Applicable Laws
All applicable state and federal laws governing the sharing of information shall be adhered to. The interagency consent form shall be utilized for all child-specific concerns. All meeting minutes shall abide by agency's confidentiality rules.

XII. Special Understanding between Signatory Agencies/Partners

Each party to this Agreement shall continue to support staff participation in any or all of the following:

a. State-level committee participation
b. Local-level committee participation
c. School-level team participation, as necessary

XIII. Term of Agreement

The term of this understanding shall be for a period of six (6) years. Before the end of the six (6) year period, the parties to the agreement shall evaluate all processes to determine if any changes are needed. Signatories to this agreement may also choose to amend this agreement, in whole or in part.
Any party to this Memorandum of Understanding may withdraw from this agreement upon service of written notice to other participating agencies at least thirty (30) days prior to withdrawal.

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This Memorandum of Understanding is agreed upon by the Department of Education, the Department of Health, the Department of Human Services, the Judiciary, the Office of the Governor and the Family Support Organization. It is the intent of all parties to fully implement all aspects of this Agreement.

Superintendent of Education	Date
Director of Health	Date
Director of Human Services	Date
Chief Court Administrator	Date
Executive Director Family Support Organization	Date

HAWAII STATUTES AND CODES

§321D-1 - Interdepartmental cluster for services to children; establishment, functions.

§321D-1 Interdepartmental cluster for services to children; establishment, functions. (a) There is established a statewide interdepartmental cluster for services to children within the department of health which shall be comprised of representatives of major child-serving agencies with statewide authority and responsibility. The cluster shall include the department of education, the department of health, the department of human services, the judiciary, the office of the governor, and the office of youth services as regular members. The department of health shall staff the cluster and provide an identified place where development and coordination of service plans and programs for the multisystem children having severe emotional and developmental problems may be done on a systematic basis.

(b) The statewide interdepartmental cluster shall:

(1) Establish interdepartmental clusters at the local level;

(2) Establish written policies and procedures for both itself and the local clusters;

(3) Review and make recommendations on individual cases referred by local clusters or by directors of child-serving departments or agencies that have documentation that various county or local agencies have jointly attempted to develop programs and funding to meet the child's need, and that existing or alternative programs and funding have been exhausted or are insufficient or inappropriate in view of the distinctive nature of the child's situation;

(4) Develop written, comprehensive, and coordinated service plans for individual multineeds children for implementation by local clusters and, where required, utilize funds appropriated to it to assist local clusters in implementing such plans;

(5) Identify a single local agency to provide case management for each case accepted by the statewide cluster;

(6) Monitor each case; and

(7) Adjust policies and procedures and develop training which will ensure appropriate services for multisystem involved children at both the state and local levels. [L 1987, c 342, §2; am L 1988, c 141, §25; am L 1993, c 38, §1; am L 1996, c 298, §4]

DRAFT

MEMORANDUM OF UNDERSTANDING BETWEEN
HAWAII YOUTH SERVICES NETWORK AND PROJECT KEALAHOU

Hawaii Youth Services Network (HYSN) is seeking funding for teen pregnancy prevention and positive youth development from the federal Office of Adolescent Health

HYSN and its partner organizations recognize that many youth at risk for unplanned pregnancy and sexually transmitted infections may have experienced trauma. Youth workers will need an understanding of trauma and the skills to work effectively with youth who have experienced trauma.

Project Kealahou provides gender-specific, culturally responsive, mental health services to girls who have experienced trauma and training for youth workers on trauma and trauma-informed care.

HYSN and Project Kealahou mutually agree that:

1. HYSN and its partner organizations in the Runaway and Homeless Youth Collaborative may refer runaway and homeless female youth to Project Kealahou for services. All services to youth will be provided free of charge if the youth meets criteria for enrollment and space is available in the program.

2. HYSN will inform staff and volunteers of agencies serving runaway and homeless youth of any training on trauma and trauma-informed care offered by Project Kealahou.

3. Depending on need, Project Kealahou may provide customized training on trauma to staff and volunteers working on teen pregnancy and STI prevention. HYSN will reimburse Project Kealahou for travel costs if training is held on a Neighbor Island.

Signed,

Judith F. Clark
Executive Director
Hawaii Youth Services Network

Tia Roberts
Director
Project Kealahou

21. Support of State Partners

AMHD works with a wide variety of public and private entities to promote recovery and in treatment initiatives to ensure success of the MHBG program. Some of its programs are:

- Hawaii State Hospital. The support received from the MHBG program is to support consumers in successful transitions to community settings, where consumers do not have the financial resources before their entitlements are received. Funds are also used to assist consumers with psychiatric medication before their entitlements start.

- The Institute of Human Services. The AMHD collaborates with the IHS in data collections for the homeless, and outreach coordination requests from the public and community stakeholders.

- The Honolulu Police Department. The intent of this letter of support the Central Receiving Division and the Jail Diversion Program activities.

- The Maui Police Department. The AMHD collaborates with MPD to provide training to police officers on Maui in the crisis intervention project.

- The National Alliance on Mental Illness – Hawaii. The AMHD has a relationship with NAMI to provide supports designed to improve the overall functioning of adults with Serious Mental Illness (SMI), improve quality of life of families, foster consumer/provider/family collaboration, and provide services to promote recovery for adults with SMI.

Child and Adolescent Mental Health Division

See Attachments

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, 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 block grant 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 SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) 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 (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. State Behavioral Health Advisory Council and Input on the Mental Health Block Grant Application

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 Council operates under the following laws: Hawaii Administrative Rules, Hawaii Revised Statutes, Sunshine Law and Federal Law.

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 kept abreast of current issues, programs, upcoming grants, and other topics in behavioral health field through presentations from AMHD, CAMHD and community partners. The Council has been involved in the development of the State Plan in the following ways:

- Members were involved in the two-year development of the AMHD Strategic Planning effort.
- At the May 12, 2015 Council meeting, the AMHD Planner apprised members of the changes in the FY2016-2017 Mental Health Block Grant Application.
- At the June 9, 2015 meeting, received the FY2016-2017 Mental Health Block Grant Application. Members selected an Ad Hoc Committee to research and develop two sections of the MHBG Application.
- At the August 11, 2015 meeting, members reviewed and approved the sections on State Parity Efforts and the Criminal Justice Section of the Environmental Factors and Plans section of the MHBG Application.

- On August 24, 2015, the Ad Hoc Committee received, provided feedback and made recommendations for improvement on the Plan.

The Hawaii Planning Council's membership is reflective of its community and is composed of individuals in recovery, family members of individuals living with mental illness, providers of mental health services and representatives from state agencies. The Council continues to struggle with recruiting parents of SEBD youth due to employment commitments when the Council meets, and with youth staying on the Council due to school commitments.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Sheila Calcagno	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Kauai Service Area Board on Mental Health and Substance Abuse	P.O. Box 370 Kilauea, HI 96754 PH: 808-821-8167	sheilainhi@yahoo.com
Louise Crum	State Employees	Criminal Justice	Mental Health Court, 777 Punchbowl Street Honolulu, HI 96813 PH: 808-593-4573	louise.k.crum@courts.hawaii.gov
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
Theresa Minami	State Employees	Department of Human Services	810 Richard Street, Ste. 400 Honolulu, HI 96813 PH: 808-429-5602	timinami@dhs.hawaii.gov
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
Marie Vorsino, Psy.D.	State Employees	Child & Adolescent Mental Health Division	FCLB, 42-477 Kalanianaole Highway Kailua, HI 96734 PH: 808-266-9922	marie.vorsino@doh.hawaii.gov
Noelani Wilcox	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1968 Paula Driive Honolulu, HI 96816 PH: 808-382-4213	noelaniwilcox@yahoo.com
Chad Koyanagi, M.D.	State Employees	Department of Human Services - Med-QUEST Division	601 Kamokila Blvd., Room 415 Kapolei, HI 96707-2021 PH: 808-692-7364	koyanagic@dop.hawaii.edu
Alfred Arensdorf, M.D.	Others (Not State employees or providers)	Maui Service Area Board on Mental Health and Substance Abuse	33 Keoneloa Street Wailuku, HI 96793 PH: 808-244-6601	ARENSDORA001@hawaii.rr.com
Benjamin Park	State Employees	Hawaii Public Housing Authority	Hawaii Public Housing Authority, 1002 N. School Street, Bldg. G Honolulu, HI 96817 PH: 808-832-4673	benjamin.h.park@hawaii.gov
Cynthia Dang	Others (Not State employees or providers)	Oahu Service Area Board on Mental Health and Substance Abuse	P.O. Box 893012 Mililani, HI 96789 PH: 808-492-5818	leanpathways@gmail.com
Frances (Elaine) Lyons	Others (Not State employees or providers)	Hawaii Service Area Board on Mental Health and Substance Abuse	16-2022 King Kamehameha Highway Blvd. Pahoa, HI 96778 PH: 617-257-1891	franelyons@gmail.com

Ridge Ryerson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Veterans Administration	1145 Third Avenue Honolulu, HI 96816 PH: 808-275-7075	akamaiokole2@hotmail.com
Iris Kaneshiro	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	OPTUM	1132 Bishop Street, Suite 400 Honolulu, HI 96813 PH: 808-741-7496	iris.kaneshiro@optum.com
Susan Foard	State Employees	Vocational Rehabilitation	1901 Bachelot Street Honolulu, HI 96817 PH: 808-586-9740	sfoard@dhs.hawaii.gov

Footnotes:

-Dr. Chad Koyanagi sits in the dual role of State Medicaid Representative (Med-QUEST) and a member of the Hawaii Advisory Commission on Drug Abuse and Controlled Substances. Several community members have applied for the Provider position once it becomes vacant.
-Dr. Steve Shiraki's terms on the Council has expired as of June 30, 2015. The Behavioral Health Administration has contacted the the Department of Education for a replacement.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

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)	6	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	13	61.9%
State Employees	6	
Providers	0	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	8	38.1%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* 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?

The Planning Council took the initiative to research, develop, and write two (2) sections of the Environmental Factor Section of the Application: Criminal and Juvenile Justice, Parity Efforts. The Planning Council reviewed and approved the FY2016-2017 Mental Health Block Grant Application before submission to SAMHSA.

Footnotes:

The State of Hawaii does not ask individuals about their sexual orientation when they apply for membership on the State Planning Council.

All members of the community are recruited based on their interest and willingness to advocate for individuals living with mental illness.

Hawaii continues to struggle with recruiting youth representatives and parents of SEBD youth on the Planning Council. Efforts are being for a membership drive and outreach to the Department of Education to recruit for these two groups.

Several individuals have applied to fill the provider segment of the Council. The Behavioral Health Administration plans to recommend an individual to fill this position through the Boards and Commissions' Office.

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Ms. Lynn Fallin
Department of Health Behavioral
Health Administration
1250 Punchbowl Street
Honolulu, HI 96813

Dear Ms. Fallin:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Judith Clarke
Sandra Pak
G. Mike Durant

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory