

## I: State Information

### State Information

#### Plan Year

Start Year:

2014

End Year:

2015

#### State DUNS Number

Number

90266185

Expiration Date

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

Agency Name

Department of Health

Organizational Unit

Alcohol and Drug Abuse Division

Mailing Address

Kakuhihewa Building, 601 Kamokila Boulevard, Room 360

City

Kapolei

Zip Code

96707

#### II. Contact Person for the Grantee of the Block Grant

First Name

Nancy

Last Name

Haag

Agency Name

Alcohol and Drug Abuse Division

Mailing Address

Kakuhihewa Building, 601 Kamokila Blvd., Rm. 360

City

Kapolei

Zip Code

96707

Telephone

808-692-7507

Fax

808-692-7521

Email Address

nancy.haag@doh.hawaii.gov

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

From

To

#### IV. Date Submitted

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

Submission Date

Revision Date

#### V. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

Footnotes:

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## Assurance - Non-Construction Programs

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

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

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

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

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

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

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Name	<input type="text" value="Loretta J. Fuddy"/>
Title	<input type="text" value="Director of Health"/>
Organization	<input type="text" value="Hawaii State Department of Health"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

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## Certifications

### 1. Certification Regarding Debarment and Suspension

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

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

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

### 3. Certifications Regarding Lobbying

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

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

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

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

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

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

### 5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

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Name	<input type="text" value="Loretta J. Fuddy"/>
Title	<input type="text" value="Director of Health"/>
Organization	<input type="text" value="Hawaii State Department of Health"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:



## I: State Information

### Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3) - Fiscal Year 2014

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant: Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

Name of Chief Executive Officer (CEO) or Designee   
 Title

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

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

Footnotes:

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### Disclosure of Lobbying Activities

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

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

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Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## II: Planning Steps

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

Narrative Question:

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

Footnotes:

## Step 1: Assess the Strength and Needs of the Service System to Address the Specific Populations—Description of Substance Abuse Service System

The Hawaii State Alcohol and Drug Abuse Division (ADAD) is the Single State Agency (SSA) that manages the Substance Abuse Prevention and Treatment (SAPT) Block Grant for Hawaii. ADAD's efforts are designed to promote a statewide culturally appropriate, comprehensive system of substance abuse services to meet the treatment and recovery needs of individuals and families and to address the prevention needs of communities.

ADAD is under the Hawaii State Department of Health (DOH), Behavioral Health Administration (BHA). BHA also includes the Adult Mental Health Division (AMHD) and Child and Adolescent Mental Health Division (CAMHD). While mental health and substance abuse services are organizationally under the DOH-BHA umbrella, ADAD's operations are not integrated with AMHD and CAMHD, and ADAD is physically sited in separate and distant locations from the mental health divisions. Also, while mental health services for adults and children are administered by separate divisions, ADAD oversees and funds substance abuse services for both adults and adolescents.

ADAD is the primary source of public substance abuse treatment funds in Hawaii. Some substance abuse treatment services are publicly funded through the Hawaii Medicaid 1115 waiver program called QUEST which is administered by the Department of Human Services. Each QUEST managed care plan determines the substance abuse treatment providers that it will contract. Treatment services are provided to QUEST clients within the limits of the benefits in the plan.

ADAD's major functions include: grants and contracts management; monitoring implementation of treatment services and prevention activities; clinical consultation; accreditation of substance abuse treatment programs; training and certification of substance abuse counselors and program administrators; policy development; planning and coordination of services; needs assessments for substance abuse services; and information systems management. Lingering effects of the recent economic recession and severe State budget deficits have resulted in significant statewide budget cuts which have required reductions in State funding for contracted services and loss of positions. Although State furloughs and paycuts have recently ended, staff turnover, attrition, and difficulties in filling positions continue to adversely affect ADAD's operations.

ADAD utilizes the State procurement process to direct available Block Grant and State funds to support the provision of services for the substance abuse continuum of care. In planning for substance abuse services, ADAD focuses on four substate planning areas that are consistent with the State's island counties. Oahu (City and County of Honolulu) is the major substate planning area that comprises 70.1 percent of the State's population of 1,392,313 as of July 1, 2012, based on estimates from the U.S. Bureau of the Census, Federal-State Cooperative Program for Population Estimates. The other three substate planning areas consist of the neighbor island counties of Hawaii, Maui (which includes the islands of Maui, Molokai and Lanai), and Kauai. Of the State's population, Hawaii County has 13.6 percent, Maui County has 11.4 percent, and Kauai County has 4.9 percent.

As required by the State procurement process, ADAD holds request for information (RFI) sessions to obtain community input on substance abuse services that ADAD intends to procure. The information that is acquired through the RFI is incorporated into requests for proposals (RFPs) that ADAD develops and issues in accordance with State procurement procedures. The RFPs also: (1) encompass SAPT Block Grant requirements for services for specified target groups; (2) reflect existing needs assessment data and other pertinent data sources; and (3) require applicants to substantiate the need for their proposed programs and services and identify their target populations for which services will be provided. ADAD reviews, evaluates and scores the proposals submitted by community-based organizations, and awards service contracts based on the evaluation criteria set forth in the RFP requirements. While procurement and contracting cycles vary depending on the type of service and funding availability, the typical service contract is approximately four years. This would generally commit the State to these services for the entire contract period. However, after the first contract year, continuation of the contract is subject to the availability of funds, satisfactory performance of the contracted services, and the determination by the State that the services are still needed.

### **Substance Abuse Treatment Services**

ADAD-contracted treatment services for adults, supported by Block Grant and/or State general funds, offer a continuum of treatment services that includes residential services (including non-medical residential detoxification), motivational enhancement services, intensive outpatient, outpatient, therapeutic living programs, opioid addiction recovery services, group recovery homes, continuing care services, clean and sober housing, transportation, child care, translation/interpretation services, cultural and recreational activities, and HIV early intervention services for persons in substance abuse treatment programs. Adult populations receiving specialized services supported by Block Grant and/or State general funds include dual diagnosed, pregnant women and women with dependent children, intravenous drug users, offenders on supervised release, furlough, probation or parole, and the homeless. ADAD-contracted treatment services for adolescents consist of school-based and community-based substance abuse treatment supported by State general funds. School-based treatment services are provided at nearly all of the public middle and high schools in each of the State's four counties. The school-based treatment allows for 1-8 hours per week of outpatient treatment. The community-based treatment allows for 1-9 hours per week of intensive outpatient and 1-8 hours per week of outpatient treatment services, cultural and recreational activities.

ADAD's Access To Recovery (ATR) Ohana Project, funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT) ATR grant, provides funding for voucher programs for substance abuse clinical treatment and recovery support services such as clean and sober housing, child care, self-help and support groups, cultural and spiritual support, and treatment for co-occurring disorders. In consideration of the ending of federal funding for the ATR Ohana Project in September 2014, selected elements of ATR recovery support services (transportation, child care, translation/interpretation) have been integrated in ADAD-contracted treatment services for adults which covers the 2014-2015 planning period of this SAPT Block Grant Application.

## **Substance Abuse Prevention Services**

Community-based public and non-profit organizations are the core strength of the prevention service system in Hawaii. ADAD-contracted substance abuse prevention programs, funded by Block Grant and/or State funds, primarily focus on the provision of evidence-based curricula, programs, practices and strategies targeting at-risk youth and their families. The goal of the service delivery is to prevent the onset, severity and disabling effects related to alcohol and other drug use by assuring an effective, accessible public and private community-based system of prevention services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. State and local government agencies and community-based organizations coordinate to leverage resources and services to expand prevention approaches, improve the quality of comprehensive community-based prevention efforts, and prevent substance use through the implementation of evidence-based prevention programs and strategies.

ADAD awards prevention contracts based on the best configuration of services to meet the needs of the State. Considerations for the allocation of funds include, but are not limited to, geographic areas and populations at risk; underserved geographic areas or populations; gaps in services within a geographic area; the community's readiness to implement evidence-based prevention services; the community-based organization's capacity for working with other community stakeholders including children, youth and Native Hawaiian organizations; and cost effectiveness as determined by estimated per participant costs. The general target populations identified for services are at-risk children, youth and their families, schools and/or communities. Additionally, providers are asked to target and include for prevention services populations identified below:

- Children and youth whose parents are substance abusers;
- Victims of physical, sexual, or psychological abuse;
- Children and youth who have experienced academic difficulties or chronic failure in school;
- Pregnant women and youth at risk of pregnancy;
- Children, youth and families who are economically disadvantaged;
- Children, youth and families who have committed or are at risk of committing a violent or delinquent act;
- Children, youth and families who have experienced mental health problems;
- Children, youth and families who are physically disabled;
- Children, youth and families who recently arrived immigrant populations;
- Youth at risk for suicide;
- Lesbian, Bisexual, Gay, Transgender, Questioning, and In transition individuals (LBGTQI);
- Homeless children, youth and families.

From 2006 to 2012, ADAD managed the Strategic Prevention Framework State Incentive Grant (SPF-SIG) funded by SAMHSA's Center for Substance Abuse Prevention (CSAP). The Hawaii SPF-SIG Project implemented the SPF process in the State and its four counties to develop a comprehensive, coordinated, and sustainable substance abuse prevention system based on data driven decision-making process. The Hawaii SPF-SIG Project focused on the reduction and prevention of underage alcohol consumption of youth 12-17 years old. Efforts to incorporate the

SPF process were made during the most recent procurement of prevention services. Organizations were required to utilize data and develop logic models, as well as submit community action plans for the implementation of selected evidence-based programs and strategies which address the needs of their identified target populations.

Based on the substantiated need for the proposed programs and services for the identified target populations for which services would be provided, contracted community-based organizations conduct ADAD-funded prevention services and programs that include parenting, mentoring, and school-based programs, alternative activities for youth that include recreational, cultural, sports and community service activities, programs designed for high-risk adolescent girls, court-involved youth and dropouts, and a program designed to prevent the misuse and mismanagement of prescription and over-the-counter medications by the elderly.

ADAD promotes the coordination of resources to further support and strengthen the prevention service system. To this effect, ADAD funds the Prevention Resource Center (PRC) (formerly referred to as the Regional Alcohol and Drug Awareness Resource (RADAR) Center) which houses the State's most comprehensive resource on prevention of alcohol, tobacco and other substance use/abuse and related issues available through its lending library, resource clearinghouse, and technical assistance services. Information about the Center is available at its website <http://www.drugfreehawaii.org/index.php/PRC>.

Programs and service activities related to reducing minors' use of and access to tobacco and alcohol are also overseen by ADAD. ADAD manages the Enforcing Underage Drinking Laws (EUDL) Block Grant, funded by the Department of Justice, Office of Juvenile Justice and Delinquency Prevention, to support activities in law enforcement, public education and policy development focusing on limiting youth access to alcohol, strictly enforcing underage drinking laws, and promoting zero tolerance for underage drinking while creating positive outlets for youth. In addition to carrying out SAPT Block Grant requirements for the Synar Program (42 USC 300x-26 and 45 CFR 96.130 (e)) to reduce youth access to tobacco products, ADAD has a contract agreement with the U.S. Food and Drug Administration (FDA) for field enforcement of FDA regulations (21 CFR 897014 (a) and (b)) prohibiting tobacco sales to minors and carrying out inspection of retail outlets throughout the State using FDA Commissioned Officers and underage volunteers in controlled, observed undercover buy operations.

Ongoing challenges in developing and sustaining an effective prevention service system exist. There is a continued commitment to incorporate cultural values and traditions without compromising the integrity of selected evidence-based programs. The lack of evidenced-based culturally appropriate prevention programs and curricula challenge the effective service delivery to specific at-risk populations such as homeless and/or Native Hawaiian populations. Additionally, the limited capacity and financial resources of community-based organizations to implement certain State and federal requirements of contract agreements creates challenges for the substance abuse prevention system. Certain prevention services might be delivered more effectively by local, smaller agencies in particular communities or for specific populations; however, the smaller organizations may not be able to front the funds necessary for billing and cost reimbursement processes or even be able to afford the staff required to conduct the fiscal aspects of government contracts.

## **Certifications for Substance Abuse Professionals**

ADAD certifies substance abuse counselors and program administrators pursuant to State law (HRS §321-193(10) and regulations (Hawaii Administrative Rules, Title 11, Dept. of Health, Chapter 177.1). In efforts towards advancing the workforce development of substance abuse professionals, ADAD expanded its certification services. In July 2011, ADAD began offering certification services for the Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate. Information on the certification process and requirements is available at ADAD's certification website <http://health.hawaii.gov/substance-abuse/counselor-certification/>. ADAD collaborates with community professionals to provide trainings which have been approved for contact hours that may be applied toward meeting the educational requirements for certification. To help address the substance abuse treatment needs of sexual gender minorities, ADAD has provided an annual training for substance abuse professionals to enhance familiarity with the issues and barriers faced by lesbian, gay, bisexual and transgender/transsexual persons in need of substance abuse treatment.

## II: Planning Steps

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

### Narrative Question:

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

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

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

### Footnotes:

## Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System—Data Sources

ADAD seeks data from various information resources in planning for the provision of substance abuse services, identifying service needs and critical gaps, and developing priorities and goals. These information resources include surveys, groups and agencies engaged in data collection, alcohol and drug service providers, community forums, and officially appointed advisory bodies in operation.

There are data limitations in utilizing national surveys such as the National Survey on Drug Use and Health (NSDUH) and Monitoring the Future survey to obtain information on Hawaii's population. The number of Hawaii residents sampled in national surveys is often too small to yield meaningful data, particularly at the substate or community level, or Hawaii may be totally excluded from a survey due to its relatively small population size, distance from the mainland U.S., and the high cost of survey implementation in a multi-island state.

As initially described under Step 1 in this application, ADAD utilizes the State procurement process to direct available Block Grant and State funds to support the provision of services for the substance abuse continuum of care as well as to seek information on service needs in Hawaii's four counties. As required by the State procurement process, ADAD holds RFI sessions to obtain community input on services that ADAD intends to procure. It is an opportunity especially for service providers to express what they perceive the gap areas to be in the current system. The information that is acquired through the RFI is then incorporated into RFPs that ADAD develops and issues in accordance with State procurement procedures and to ensure compliance with SAPT Block Grant requirements for services for specified target groups. The RFPs also reflect existing needs assessment data and other pertinent data sources, as well as require applicants to substantiate the need for their proposed programs and services and identify their target populations for which services will be provided. Proposals from community-based organizations are reviewed and scored by ADAD based on evaluation criteria set forth in the RFP requirements, and service contracts are then executed. While procurement and contracting cycles vary depending on the type of service and funding availability, the typical service contract is approximately four years. This would generally commit the State to these services for the entire contract period. However, after the first contract year, continuation of a contract is subject to the availability of funds, satisfactory performance of the contracted services, and the determination by the State that the services are still needed.

### **Substance Abuse Treatment and Recovery Support Services**

The application planning period of July 1, 2013 to June 30, 2015, covers the first and second year of ADAD's new four-year contract period for treatment and recovery support services from July 1, 2013 to June 30, 2017. The Federal fiscal year (FFY) 2013 SAPT Block Grant is being allocated for services primarily during the first contract year, i.e., State fiscal year (SFY) 2014 (July 1, 2013-June 30, 2014). Then the FFY 2014 SAPT Block Grant will be allocated to help maintain services for the second contract year, i.e., SFY 2015 (July 1, 2014-June 30, 2015).

During the planning process for the four-year contract period, ADAD utilized information from (1) RFI sessions and (2) various data sources to identify unmet needs and critical gaps within the Hawaii treatment infrastructure. Planning activities for ADAD's new four-year contract period included conducting RFI meetings in each of the State's four counties throughout the month of August 2011. RFI meetings were conducted on the islands of Oahu, Hawaii (in Hilo and Kona), Maui, Molokai, Lanai, and Kauai.

The following is a description of other data sources used in planning for substance abuse treatment and recovery services by types of service populations funded by the SAPT Block Grant and/or State funds.

**Adult Population:** In planning for substance abuse treatment and recovery support services, ADAD reviewed 2008-2009 NSDUH data on Hawaii's population. For the population 12 years of age and older, dependence on or abuse of illicit drugs or alcohol in the past year was estimated at 8.99%; illicit drug dependence or abuse in the past year was estimated at 2.9%. For persons in the 18-25-year age group, dependence on or abuse of illicit drugs or alcohol in the past year was estimated at 19.76%; illicit drug dependence or abuse in the past year was estimated at 7.49%. For the population 12 years of age and older, NSDUH reported 7.32% needing but not receiving treatment for alcohol use in the past year, and 2.62% needing but not receiving treatment for illicit drug use in the past year. For persons in the 18-25-year age group, 16.35% needed but did not receive treatment for alcohol use in the past year, and 6.62% needed but did not receive treatment for illicit drug use in the past year.

ADAD's 2004 Treatment Needs Assessment also provided data on Hawaii's adult population. The 2004 survey of adults was a household telephone survey of the population 18-65 years of age with an unweighted sample size of 5,067. The sample was adjusted to reflect the State's population distribution among the State's four counties as well as for ethnicity, age and gender. Treatment need was measured when participants' responses to certain questions met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV criteria for substance abuse or dependence. The substances on which substance abuse or dependence was determined included alcohol, marijuana, cocaine, methamphetamine, heroin, and synthetic opiates. Due to difficulties encountered in the use of telephone surveys and the increasing costs of conducting such surveys, ADAD plans to explore the utilization of other data sources (e.g., archival data and client services data) to obtain data on the treatment needs of the adult population.

**Pregnant Women and Women with Dependent Children:** In planning for specialized substance abuse treatment and recovery support services for pregnant women and women with dependent children, ADAD reviewed NSDUH data, 2004 statistical data provided by the Child Welfare Services (CWS) of the Hawaii State Department of Human Services, ADAD's Alcohol and Drug Treatment Services Report (ADTSR), 2006-2010, and the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) Trend Report, 2000-2008 from the Department of Health, Family Health Services Division. NSDUH national data focused on substance use treatment among women of childbearing age for whom substance use may pose particular risks to vulnerable offspring. According to NSDUH 2009-2010 data for the U.S., the rate of illicit drug use among pregnant women was 16.2% for those 15-17 years of age, 7.4% for those 18-25 years of age, and 1.9% for those 26-44 years of age. CWS data clearly illustrated the

methamphetamine epidemic that Hawaii had been experiencing since the mid-1980s. The data indicated that methamphetamine use was involved in over 80% of its active cases. Likewise, ADTSR data indicates the primary substance used at admission among women ages 18-48 as methamphetamine, followed by alcohol and then marijuana. Methamphetamine use among females decreased from 2006 (60%) to 2008 (55%), but increased from 2008 (55%) to 2010 (58%). According to the PRAMS Trend Report, 19.5% of mothers reported binge drinking in the three months prior to pregnancy in 2008; an estimated 8.5% report cigarette smoking at least one cigarette per day in the last three months of pregnancy; and an estimated 2.3% reported drug use during pregnancy. Of reported drug use by race, Black and Hawaiian mothers reported the highest use (6.8% and 3.9%, respectively), followed by White (2.7%) and Korean (2.3%). Regarding violence between intimate partners (defined as being physically hurt or pushed, hit, slapped, kicked, choked in any way by a husband, ex-husband, partner or ex-partner in the 12 months prior to getting pregnant or during the most recent pregnancy), 7.2% of the mothers reported experiencing intimate partner violence.

**Opioid Addiction (encompasses services for intravenous drug users):** In planning for opioid addiction treatment and recovery services, ADAD reviewed the 2008-2009 NSDUH, 2011 Treatment Episode Data Set (TEDS), and ADAD's Web Infrastructure for Treatment Services (WITS) data. For a description of WITS, please see Sec. Q-Data and Information Technology in this application. NSDUH data on past year nonmedical use of pain relievers indicated an estimated average of 5.06% for persons age twelve and older and 11.33% for adults age 18-25 in Hawaii. Likewise, data from TEDS indicated, by primary substance of abuse, that heroin accounted for 1.6% of treatment admissions; other opiates accounted for 4.4%, for individuals age 12 and older. In 2011, TEDS data indicated that Asian, Native Hawaiian and Other Pacific Islanders accounted for 21.7% of admissions for heroin use and 28.8% for other opiates. Based on WITS data for SFY 2012 (July 1, 2011 to June 30, 2012), ADAD's contracted providers reported total admissions of 4,650 ADAD-funded clients of which 7.1% had a primary, secondary or tertiary substance use of heroin, non-prescription methadone or other opiate/synthetic drug. For SFY 2012, ADAD-contracted providers admitted 7,892 ADAD and non-ADAD funded clients of which 10.76% had a primary, secondary or tertiary substance use of heroin, non-prescription methadone or other opiate/synthetic drug.

**Dual Diagnosed:** In planning for substance abuse treatment and recovery services for the dual diagnosed (those with co-occurring disorders), WITS provided data for SFY 2012. ADAD's contracted providers admitted 7,932 ADAD- and non-ADAD-funded clients. Of these clients, 16.8% were identified as having a psychiatric problem at intake/admission, and 23.7% were identified as unknown as to whether they had a psychiatric problem at intake/admission. Please note that ADAD's RFP for this population excluded clients with serious persistent mental illness as well as other DOH Adult Mental Health Division (AMHD) eligible clients who should be referred to AMHD for services.

**Treatment Services/Groups Supported by State Funds Only:** The services described above will be supported by both SAPT Block Grant and State funds. ADAD's new four-year contract period will also cover services supported only by State funds for certain populations. These State-funded services include school-based and community-based substance abuse treatment services for adolescents, integrated case management and substance abuse treatment services for

offenders on supervised release, furlough, probation or parole, substance abuse treatment and recovery support services for the homeless, and HIV early intervention services for persons in substance abuse treatment programs. In planning for services for these populations, data sources utilized (in addition to those described above) included ADAD's 2007-2008 Hawaii Student Alcohol, Tobacco, and other Drug Use Study, 2010 Recidivism Update by the Hawaii Interagency Council on Intermediate Sanctions, information from the Hawaii State Judiciary, Hawaii State Department of Public Safety, and Hawaii Paroling Authority, and the 2011 Statewide Homeless Point-in-Time Count.

According to CSAT's list of "designated states" for the FFY 2014 SAPT Block Grant, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SAPT Block Grant funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

### **Substance Abuse Prevention Services**

During this application planning period of July 1, 2013 to June 30, 2015, ADAD is using the FFY 2013 SAPT Block Grant and State funds to fund the second year of prevention contracts during SFY 2014 (July 1, 2013 to June 30, 2014). Then the FFY 2014 SAPT Block Grant will be used to help maintain services for third-year contract extensions during SFY 2015. Prevention contracts are either Block Grant funded or State funded, i.e., Block Grant and State funds are not combined in any one contract. The two-year contracts for prevention services may be extended for up to two additional twelve-month periods, ending on June 30, 2016. The funding of awards focused on supporting community efforts to prevent and reduce the use of alcohol, tobacco, and other drugs among children, youth, families, the elderly, and other at-risk populations and leveraging community resources and services to expand prevention approaches, improve the quality of community-based prevention efforts, and prevent substance use through the implementation of evidence-based prevention programs and strategies.

To enhance the planning for the purchase of services and develop the request for proposals (RFP) for the prevention services currently funded by ADAD, a request for information (RFI) was conducted on the island of Oahu on October 14, 2011 to gather input related to the needed services. Topics of discussion centered on target populations, target services, ability to submit multiple proposals, and multiple agencies collaborating to submit proposals and provide the services. There was broad based agreement among those involved in the drug prevention effort in Hawaii that families, schools, and communities can be safe and drug free, and the preferred strategy to achieve that goal is to increase protective factors and decrease risk factors.

In addition to the RFI to support the RFP, ADAD used the 2009 State Level Data on Alcohol, Tobacco, and Illegal Drug Use from the Substance Abuse and Mental Health Statistics found on the website for Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies (OAS) <http://www.oas.samhsa.gov/Data.cfm>. Additional local data sources were used to support the data driven process to identify service needs and develop priorities and

goals for the RFP. Information was obtained from the “Hawaii Epidemiological Profile for Substance Abuse Prevention” Spring 2007, March 2008 (revised), and “Hawaii Strategic Prevention Framework State Incentive Grant (SPF-SIG) Project Infrastructure and Capacity Assessments –Results Final Analysis,” May 2009. “Epidemiological Profile of Alcohol Related Behaviors among Youth,” Spring 2007, March 2010 (revised), for each of Hawaii’s four counties provided information on the strengths and challenges of the prevention infrastructure in each of the counties. These reports are available at <http://health.hawaii.gov/substance-abuse/survey/>.

ADAD has periodically contracted consultants to conduct statewide student surveys to obtain ongoing data to assess the nature and extent of substance use among Hawaii’s youth, assess prevention and treatment needs, and measure risk and protective factors. “The Hawaii Student Alcohol, Tobacco, and Other Drug Use Study: 2007/2008 Comprehensive Report” is the latest report from ADAD’s series of student surveys. Due to the Hawaii State Department of Education’s (DOE) requirements for the Youth Risk Behavioral Survey (YRBS), Youth Tobacco Survey (YTS), and the Student Alcohol, Tobacco, and Other Drug Use Survey (SATOD) to be administered jointly, and the need to obtain parental consent for middle and high school students to participate in such surveys, ADAD has been collaborating with other Department of Health programs, the DOE, and consultants from the University of Hawaii to develop an integrated survey which combines items from each of the three former surveys. The Diagnostic Statistical Manual (DSM) criteria used in the past to measure treatment need has been replaced with questions from CRAFFT, a research documented adolescent screening instrument. Epidemiological analyses and profiles were developed through the SPF-SIG project. The reports are available at <http://health.hawaii.gov/substance-abuse/survey/>.

ADAD has been utilizing the Center for Substance Abuse Prevention (CSAP’s) Minimum Data Set (MDS) 4 System software to obtain data from Block Grant funded prevention programs on types of services and activities conducted and information on service populations. In an effort to improve ADAD’s prevention data collection and management system, ADAD contracted with the University of Hawaii, Center on the Family (UHCOF) to provide technical assistance for customizing Knowledge-Based Information Technology (KIT) Solutions based management information system to replace the MDS 4. ADAD has named this system the Hawaii Information System for Substance Abuse Prevention (HISSAP). ADAD’s contracted prevention providers piloted HISSAP in July 2010 and began utilizing a second, refined version of the HISSAP in July 2013. For a description of the HISSAP, please see Sec. Q-Data and Information Technology in this application.

Presently, ADAD does not have staff with expertise in the area of prevention data collection systems and technology, so it is uncertain how the HISSAP will be maintained and sustained should the UHCOF determine it is no longer able to provide technical assistance. The same lack of staff and expertise issue creates the situation for ADAD to rely on the available secondary data sources and contracted service providers to identify needs and gaps. Without trained epidemiologists and evaluators, the local information gathered and presented may be flawed or biased relative to the service providers’ depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation.

## **State Epidemiological Workgroup**

In March 2006, ADAD was awarded a one-year \$200,000 CSAP-funded subcontract through Synectics for Management Decisions, Inc., for the establishment of a State Epidemiological Outcomes Workgroup (SEOW) for the purposes of substance abuse prevention data collection and reporting. The SEOW merged with the Honolulu Community Epidemiological Work Group (which began in 1989 and is sponsored by the National Institute on Drug Abuse) to become the Hawaii Drug Information Network (HDIN). In September 2006, CSAP awarded the Strategic Prevention Framework-State Incentive Grant (SPF SIG) to Hawaii. In accordance with CSAP requirements, Hawaii's SEOW, i.e., HDIN, was maintained with SPF SIG funds. In 2007, HDIN was reorganized to form the State Epidemiological Workgroup (SEW). The SEW contributed to needs assessment, planning and evaluation processes through its role as an advisory body to the State Advisory Council (SAC) for the SPF SIG. The primary function of the SEW was to confirm the science of the methods used in data collection as well as to review and assess outcome measures related to substance abuse. The SEW was comprised of voluntary members, primarily directors, epidemiologists or data managers, from government, educational and community agencies involved in research or data collection. The SEW was not used for treatment planning since its role was advisory to the SAC which was prevention-based and specific to the SPF SIG.

Due to staff transitions and limited resources and expertise, ADAD has found it challenging to sustain the SEW/SEOW and the accomplishments of the SPF-SIG project. Fortunately, in November 2012, ADAD was awarded a ten-month CSAP funded subcontract through Synectics for Management Decisions, Inc., to revive the SEOW for the purposes of applying the lessons learned in substance abuse prevention data collection and reporting to broader behavioral health issues. To this end, ADAD contracted with the University of Hawaii, Office of Public Health Studies to revive and enhance the work of the Hawaii SEOW. It is anticipated that the revitalization of the SEOW will provide additional support to sustain SPF efforts, fill knowledge gaps, develop a platform for data sharing, and develop a data sharing protocol that enables timely and efficient sharing of epidemiological data relating to substance abuse and its consequences.

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

Priority #:	1
Priority Area:	Services for Pregnant Women and Women with Dependent Children
Priority Type:	SAT
Population (s):	PWWDC
Goal of the priority area:	
	To expand services for children of pregnant women and women with dependent children (PWWDC) with substance abuse treatment needs up to twelve (12) years of age.
Strategies to attain the goal:	
	Scope of services for PWWDC contracts for the next four-year contract period (July 1, 2013-June 31, 2017) to include treatment and supportive services for children up to twelve (12) years of age with substance abuse treatment needs.
<b>Annual Performance Indicators to measure goal success</b>	
Indicator #:	1
Indicator:	Execution of PWWDC service contracts (retroactive to July 1, 2013) with a scope of service to include a provision for treatment and supportive services for children, up to the age of twelve. Note: A contract is not considered executed until signed by the Director of Health. In a "retroactive" contract situation, the provider may agree to continue providing services in anticipation of an executed contract; a break in service is avoided.
Baseline Measurement:	There were no (0) PWWDC contracts providing treatment and supportive services for children up to 12 years of age with substance abuse treatment needs during the previous four-year contract period (July 1, 2009-June 30, 2013).
First-year target/outcome measurement:	At least one (1) executed contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai and Hawaii) to provide treatment and supportive services for PPWDC children up to 12 years of age with substance abuse treatment needs in SFY 2014.
Second-year target/outcome	Maintain at least one (1) PWWDC contract in each of Hawaii's four counties to provide

measurement: treatment and supportive services for children up to 12 years of age in SFY 2015.

Data Source:

Executed contract.

Description of Data:

In accordance with Hawaii Revised Statutes (HRS) Chapter 103F (procurement of health and human services), all documents listed below are required for contracts. Documents must be complete and meet State compliance standards:

- 1) Contract Checklist for 103F Health and Human Services
- 2) Vendor Confirmation in Financial Accounting and Management Information System (FAMIS)
- 3) Hawaii Compliance Express Certificate
- 4) Request for Taxpayer Identification Number and Certification
- 5) Contract Recitals – AG Form 103F1 (10/08)
- 6) Provider’s Acknowledgement – AG Form 103F7 (10/08)
- 7) Scope of Services
- 8) Time of Performance – AG Form 103F11 (10/08)
- 9) Compensation and Payment Schedule – AG Form 103F12 (10/08)
- 10) Certificate of Exemption from Civil Service – AG Form 103F8 (9/08)
- 11) Provider’s Standards of Conduct Declaration – AG Form 103F9 (10/08)
- 12) General Conditions for Health & Human Services Contracts – AG Form 103F (10/08)
- 13) Special Conditions
- 14) Allocation Schedule
- 15) Rate Schedule and/or Budget
- 16) Certification of Insurance
- 17) Proof of other related documents:
  - a. Attestation of Internet Posting
  - b. Printout of Solicitation
  - c. Retroactive Contract Approval (if applicable)

Data issues/caveats that affect outcome measures::

Any unanticipated delay may affect the timely execution of contracts.

Priority #: 2

Priority Area: Services for Injection Drug Users (includes intravenous drug users)

Priority Type: SAT

Population IVDUs  
(s):

Goal of the priority area:

To enhance services for injection/intravenous drug users (IDUs) by broadening the spectrum of treatment options for opioid addiction..

Strategies to attain the goal:

Scope of services for opioid service contracts for the next four-year contract period (July 1, 2013-June 30, 2017) to include motivational enhancement, transportation, translation, and cultural activities.

#### Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Execution of opioid service contracts (retroactive to July 1, 2013) with a scope of services to include motivational enhancement, transportation, translation and cultural activities. Note: a contract is not executed until signed by the Director of Health. In a "retroactive" contract situation, the provider may agree to continue providing services in anticipation of an executed contract; a break in service is avoided.
Baseline Measurement:	There were no (0) opioid service contracts providing motivational enhancement, transportation, translation and cultural activities during the previous four-year contract period (July 1, 2009 - June 30, 2013).
First-year target/outcome measurement:	At least one (1) executed opioid service contract with enhanced services in SFY 2014.
Second-year target/outcome measurement:	Maintain at least one (1) opioid service contract with enhanced services in SFY 2015.
Data Source:	

Executed contract.

Description of Data:

In accordance with Hawaii Revised Statutes (HRS) Chapter 103F (procurement of health and human services), all documents listed below are required for contracts. Documents must be complete and meet State compliance standards:

- 1) Contract Checklist for 103F Health and Human Services
- 2) Vendor Confirmation in Financial Accounting and Management Information System (FAMIS)

- 3) Hawaii Compliance Express Certificate
- 4) Request for Taxpayer Identification Number and Certification
- 5) Contract Recitals – AG Form 103F1 (10/08)
- 6) Provider’s Acknowledgement – AG Form 103F7 (10/08)
- 7) Scope of Services
- 8) Time of Performance – AG Form 103F11 (10/08)
- 9) Compensation and Payment Schedule – AG Form 103F12 (10/08)
- 10) Certificate of Exemption from Civil Service – AG Form 103F8 (9/08)
- 11) Provider’s Standards of Conduct Declaration – AG Form 103F9 (10/08)
- 12) General Conditions for Health & Human Services Contracts – AG Form 103F (10/08)
- 13) Special Conditions
- 14) Allocation Schedule
- 15) Rate Schedule and/or Budget
- 16) Certification of Insurance
- 17) Proof of other related documents:
  - a. Attestation of Internet Posting
  - b. Printout of Solicitation
  - c. Retroactive Contract Approval (if applicable)

Data issues/caveats that affect outcome measures::

Any unanticipated delay may affect the timely execution of contracts.

Priority #: 3

Priority Area: Recovery Support Services

Priority Type: SAT

Population PWWDC, IVDUs, Other (Adults)

(s):

Goal of the priority area:

To enhance recovery support services to include transportation and translation services for adults, pregnant women and women with dependent children, and IDUs with substance abuse treatment needs.

Strategies to attain the goal:

Scope of services for adult, pregnant women and women with dependent children, and IDU service contracts for the next four-year contract

period (July 1, 2013-June 31, 2017) for recovery support services to include transportation and translation services.

### Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of adult, pregnant women and women with dependent children, and IDU service contracts (retroactive to July 1, 2013) with a scope of services for recovery support services to include transportation and translation services. Note: a contract is not executed until signed by the Director of Health. In a "retroactive" contract situation, the provider may agree to continue providing services in anticipation of an executed contract; a break in service is avoided.

Baseline Measurement: There were no (0) adult, pregnant women and women with dependent children, and IDU service contracts providing recovery support services that included transportation and translation services during the previous four-year contract period (July 1, 2009- June 30, 2013).

First-year target/outcome measurement: Minimum of: two (2) executed contracts per county (four counties in the State) with recovery support services that include transportation, and translation services for adults; one (1) executed contract per county with recovery support services that include transportation and translation services for pregnant women and women with dependent children; and one (1) executed contract statewide with recovery support services that include transportation and translation services for IDUs in SFY 2014.

Second-year target/outcome measurement: Maintain a minimum of: two (2) executed contracts per county (four counties in the State) with recovery support services that include transportation and translation services for adults; one (1) executed contract per county with recovery support services that include transportation and translation services for pregnant women and women with dependent children; and one (1) executed contract statewide with recovery support services that include transportation and translation services for IDUs in SFY 2015.

Data Source:

Executed contract.

Description of Data:

In accordance with Hawaii Revised Statutes (HRS) Chapter 103F (procurement of health and human services), all documents listed below are required for contracts. Documents must be complete and meet State compliance standards:  
1) Contract Checklist for 103F Health and Human Services

- 2) Vendor Confirmation in Financial Accounting and Management Information System (FAMIS)
- 3) Hawaii Compliance Express Certificate
- 4) Request for Taxpayer Identification Number and Certification
- 5) Contract Recitals – AG Form 103F1 (10/08)
- 6) Provider’s Acknowledgement – AG Form 103F7 (10/08)
- 7) Scope of Services
- 8) Time of Performance – AG Form 103F11 (10/08)
- 9) Compensation and Payment Schedule – AG Form 103F12 (10/08)
- 10) Certificate of Exemption from Civil Service – AG Form 103F8 (9/08)
- 11) Provider’s Standards of Conduct Declaration – AG Form 103F9 (10/08)
- 12) General Conditions for Health & Human Services Contracts – AG Form 103F (10/08)
- 13) Special Conditions
- 14) Allocation Schedule
- 15) Rate Schedule and/or Budget
- 16) Certification of Insurance
- 17) Proof of other related documents:
  - a. Attestation of Internet Posting
  - b. Printout of Solicitation
  - c. Retroactive Contract Approval (if applicable)

Data issues/caveats that affect outcome measures::

Any unanticipated delay may affect the timely execution of contracts

Priority #: 4

Priority Area: Quality Substance Abuse Prevention Services

Priority Type: SAP

Population (s): Other (Rural, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, At-risk children, youth and their families, schools and/or communities; adults ages 65 years and older)

Goal of the priority area:

Improve and sustain the quality of community-based prevention efforts to prevent substance use through the implementation of evidence-based prevention programs and strategies.

Strategies to attain the goal:

1. Obtain data from ADAD-funded prevention programs on types of services and activities conducted and information on service populations.
2. Support the implementation of evidence-based programs and strategies that are culturally appropriate and cost effective models to prevent substance use by youth in a variety of community settings.
3. Develop and sustain state- and community-level monitoring systems to inform and guide decision making and planning as ADAD procures future prevention services.
4. Increase competencies of the prevention workforce by promoting the Prevention Specialist Certification and providing opportunities for professional development.
5. Provide communities and organizations with resources and technical assistance to foster implementation of the Strategic Prevention Framework (SPF) and to sustain their prevention efforts.

#### Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of evidence-based programs and strategies implemented by contracted community-based agencies to address issues related to alcohol, tobacco and other drug use.
Baseline Measurement:	79% of funded prevention interventions were evidence-based in SFY 2013.
First-year target/outcome measurement:	82% of funded prevention interventions will be evidence-based by end of SFY 2014.
Second-year target/outcome measurement:	82% of funded prevention interventions will continue to be evidence-based by end of SFY 2015.

Data Source:

1. Hawaii Information System for Substance Abuse Prevention (HISSAP)
2. Community Action Plan (CAP) submitted by contracted agency

Description of Data:

1. The number of times (cycles) evidence-based curricula and strategies were implemented and NOMs data as collected on HISSAP
2. Review of plan and notes written by contracted provider on the CAP form which captures information related to community partnerships, problems, priorities, resources, readiness and implementation status of identified evidence-based program.

Data issues/caveats that affect outcome measures::

Errors or misunderstanding on the part of provider staff during data input may distort the actual outcome measure retrieved from HISSAP.

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Indicator #: 2

Indicator: Increased capacity of prevention organizations to measure and evaluate the effectiveness of program implementation.

Baseline Measurement: 7% of ADAD-funded prevention programs utilized an evaluator in SFY 2013.

First-year target/outcome measurement: 15% of ADAD-funded prevention programs will report piloting an evaluation tool.

Second-year target/outcome measurement: 38% of ADAD-funded prevention programs will report utilizing an evaluation tool.

Data Source:

- 1. HISSAP
- 2. Program Annual Report
- 3. Program Monitoring Report

Description of Data:

HISSAP is being enhanced to support providers' evaluation efforts; information on evaluation activities from program reports.

Data issues/caveats that affect outcome measures::

Delayed development of a consistent evaluation tool for prevention organizations; delayed enhancements to HISSAP; the information from providers may be flawed or biased relative to depth of experience and knowledge and understanding of needs assessment, evaluation, and data collection and interpretation.

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Indicator #: 3

Indicator: Increased number of technical assistance (TA) and training opportunities for prevention specialists and communities related to identifying, implementing and/or evaluating evidence-based prevention programs and strategies and/or sustaining the Strategic Prevention Framework (SPF) efforts provided by ADAD.

Baseline Measurement: Twenty (20) TA and training opportunities for prevention were provided during SFY 2013.

First-year target/outcome measurement: Twenty-three (23) TA and training opportunities for prevention will be provided by end of SFY 2014.

Second-year target/outcome measurement: Twenty-six (26) TA and training opportunities for prevention will be provided by end of SFY

measurement: 2015.

Data Source:

Registration flyers, agendas, sign-in sheets, handouts and materials distributed and participant evaluation/comment forms from TA and training opportunities

Description of Data:

Details of content delivered and participant information from TA and training opportunities

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Footnotes:

1. Although substance abusers with tuberculosis (TB) are not identified as a specific priority for Table 1, all ADAD-funded treatment programs will continue to be contractually required to comply with Sec. 1924(a) of P.L. 102-321, to routinely make available TB services to all clients either directly or through arrangements with public or nonprofit agencies. The Department of Health's Communicable Disease Division, Tuberculosis Control Branch will continue to provide needed TB services to ADAD clients in treatment for substance abuse. ADAD's contract compliance monitoring protocol for treatment programs will continue to include the review of a program's policy and procedures and documentation on TB screening and testing of clients.

2. Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse are not identified as a priority for Table 1 because Hawaii is not a "designated State" according to CSAT's list of "designated states" for the FFY 2014 SAPT Block Grant. Since 2002, SAMHSA has prohibited non-designated States from expending any Block Grant funds for HIV early intervention services. But in September 2011, SAMHSA made a program policy change to allow States that were "designated" within the last three years the option to continue to set aside 5% of their SAPT Block Grant award for HIV early intervention services. This option does not apply to Hawaii since Hawaii was not "designated" within the last three years. However, ADAD will continue to allocate State general funds to provide HIV early intervention services at substance abuse treatment programs.

3. Although Native Hawaiians are not identified as a specific priority for Table 1, ADAD makes available a proportion of the SAPT Block funds for substance abuse programs for Native Hawaiians, pursuant to Sec. 1953 of P.L. 102-321. The description of Block Grant expenditures and services for Native Hawaiians will be included in Hawaii's SAPT Reports submitted annually to SAMHSA by December 1.

Table 2 State Agency Planned Expenditures

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

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment*	\$5,332,117		\$	\$	\$14,740,401	\$	\$
a. Pregnant Women and Women with Dependent Children*	\$4,618,619		\$	\$	\$2,062,821	\$	\$
b. All Other	\$713,498		\$	\$	\$12,677,580	\$	\$
2. Substance Abuse Primary Prevention	\$1,777,372		\$	\$	\$1,923,000	\$	\$
3. Tuberculosis Services	\$		\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$378,829	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$374,184		\$	\$	\$1,963,132	\$	\$
11. Total	\$7,483,673	\$	\$	\$	\$19,005,362	\$	\$

\* Prevention other than primary prevention

Footnotes:

1. Amounts in Column A are based on the Federal Fiscal Year (FFY) 2014 SAPT Block Grant estimated allotment for Hawaii which is planned to be spent during State Fiscal Year (SFY) 2015 (July 1, 2014 to June 30, 2015). Amounts for SFY 2014 (July 1, 2013 to June 30, 2014) were reported in the required update for Table 7-Projected State Agency Expenditure Report in Hawaii's 2013 SAPT Block Grant Application Plan based on the final FFY 2013 SAPT Block Grant allocation.

2. Estimates for other columns are based on the same period as Column A. This provides a consistent basis on which to compare planned expenditures of Block Grant funds with funds that may be available from other sources during the same period.

3. Although no estimates of Other Federal Funds are shown in Column D, ADAD had applied for cooperative agreements from CSAT and CSAP and was awaiting notifications of awards during the preparation of this 2014-2015 SAPT Block Grant Application Plan.

4. Although no separate funds are shown for tuberculosis (TB) services, all ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of P.L. 102-321, regarding availability of TB services.

5. According to CSAT's list of "designated states" for the FFY 2014 SAPT Block Grant, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SAPT Block Grant funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

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

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$
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 Dissemination			\$
Prevention (Including Promotion)			\$
Screening, Brief Intervention and Referral to Treatment			\$

Brief Motivational Interviews			\$
Screening and Brief Intervention for Tobacco Cessation			\$
Parent Training			\$
Facilitated Referrals			\$
Relapse Prevention/Wellness Recovery Support			\$
Warm Line			\$
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				\$
Assessment				\$
Specialized Evaluations (Psychological and Neurological)				\$
Service Planning (including crisis planning)				\$
Consumer/Family Education				\$
Outreach				\$
Outpatient Services				\$
Evidenced-based Therapies				\$
Group Therapy				\$
Family Therapy				\$
Multi-family Therapy				\$
Consultation to Caregivers				\$
Medication Services				\$

Medication Management			\$
Pharmacotherapy (including MAT)			\$
Laboratory services			\$
Community Support (Rehabilitative)			\$
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			\$
Peer Support			\$
Recovery Support Coaching			\$

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$
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				\$
Children's Mental Health Residential Services				\$
Crisis Residential/Stabilization				\$
Clinically Managed 24 Hour Care (SA)				\$
Clinically Managed Medium Intensity Care (SA)				\$
Adult Mental Health Residential				\$
Youth Substance Abuse Residential Services				\$
Therapeutic Foster Care				\$
Acute Intensive Services				\$
Mobile Crisis				\$
Peer-based Crisis Services				\$

Urgent Care				\$
23-hour Observation Bed				\$
Medically Monitored Intensive Inpatient (SA)				\$
24/7 Crisis Hotline Services				\$
Other (please list)				\$

**Footnotes:**

1. Table 2 is not a required table. Instructions and service definitions to complete this table are not available. SAMHSA has not provided information regarding the purpose or practical utility of collecting projections on numbers of unduplicated individuals, units and expenditures at such detailed levels of service. ADAD's data systems are not designed to generate such detailed projections.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$5,332,117	
2 . Substance Abuse Primary Prevention	\$1,777,372	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$374,184	
6. Total	\$7,483,673	

\* Prevention other than primary prevention

\*\* HIV Early Intervention Services

**Footnotes:**

1. Although no separate funds are shown for tuberculosis (TB) services, all ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of P.L. 102-321, regarding availability of TB services.

2. According to CSAT's list of "designated states" for the FFY 2014 SAPT Block Grant, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SAPT Block Grant funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention

services at substance abuse treatment programs.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Education	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		

	Total		
Community-Based Process	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Environmental	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Section 1926 Tobacco	Universal	\$96,566	
	Selective		
	Indicated		
	Unspecified		
	Total	\$96,566	
Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Total Prevention Expenditures		\$96,566	
Total SABG Award*		\$7,483,673	
Planned Primary Prevention Percentage		1.29 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

1. Table 5a reflects only the portion of primary prevention planned expenditures related to Sec. 1926 of the Public Health Service Act (USC §300x-26) regarding the Synar program. The rest and most of the primary prevention planned expenditures are reported in Table 5b which is based on the Institute of Medicine prevention categories. According to CSAP's 2014-2015 SABG Application Webinar held August 7, 2013, on the primary prevention sections of the application, States have the option of completing either Table 5a or 5b. If the State completes Table 5b, then planned expenditures for the Synar program must be reported separately in Table 5a, Sec. 1926 Tobacco.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$575,072	
Universal Indirect	\$885,800	
Selective	\$99,900	
Indicated	\$120,034	
Column Total	\$1,680,806	
Total SABG Award*	\$7,483,673	
Planned Primary Prevention Percentage	22.46 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**

1. Table 5b does not include primary prevention planned expenditures related to Sec. 1926 of the Public Health Service Act (USC §300x-26) regarding the Synar program. Planned expenditures for the Synar program are reported in Table 5a, Sec. 1926 Tobacco. According to CSAP's 2014-2015 SABG Application Webinar held August 7, 2013, on the primary prevention sections of the application, States have the option of completing either Table 5a or 5b. If the State completes Table 5b, then planned expenditures for the Synar program must be reported separately in Table 5a, Sec. 1926 Tobacco.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	b
Heroin	b
Inhalants	b
Methamphetamine	b
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	e
Military Families	e
LGBTQ	e
American Indians/Alaska Natives	e
African American	e
Hispanic	e
Homeless	e
Native Hawaiian/Other Pacific Islanders	b
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

**Footnotes:**

1. The State's geography creates diverse communities, ranging from the highly urbanized and populous city of Honolulu on the island of Oahu to small, rural communities on the "neighbor islands." The State's population is comprised of diverse racial and ethnic backgrounds. According to the U.S. Census Bureau's 2011 American Community Survey, 24 percent of the State's population were multi-racial (two or more races).

### III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	83210.00			\$83,210				
2. Quality Assurance	85258.00	152494.00		\$237,752				
3. Training (Post-Employment)	10000.00	12850.00		\$22,850				
4. Education (Pre-Employment)								
5. Program Development	2180.00	10770.00		\$12,950				
6. Research and Evaluation								
7. Information Systems	199656.00	407500.00		\$607,156				
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	\$380,304	\$583,614		\$963,918				

#### Footnotes:

1. No amounts are reported for Enrollment and Provider Business Practices since Congress has not approved SAMHSA's proposal to require States to set aside a minimum of 3% of their Block Grant allotment to assist providers in improving their enrollment, billing, and business practices. If/when Congress approves SAMHSA's proposal, ADAD will allocate funds accordingly. Please note, however, Block Grant funds to assist providers billing systems are included in the amount for Information Systems for Treatment. Block Grant funds will be used for the continued development and enhancement of ADAD's Web Infrastructure for Treatment Services (WITS), an electronic health record and contract billing system. Information is not available to provide a specific breakout of funds from Information Systems for Treatment to report under Enrollment and Provider Business Practices. For further information on WITS, please see narrative plan Sec. Q-Data and Information Technology and Sec. X-Improving Enrollment Processes and Provider Business Practices Including Billing Systems.

## IV: Narrative Plan

### C. Coverage M/SUD Services

#### Narrative Question:

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

Please answer the following questions:

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

Footnotes:

### C. Coverage of SUD Services

1. Which substance abuse services in Plan Table 3 of the Application will be covered by Medicaid or QHPs on January 1, 2014?

As of yet it remains unclear what level or intensity of substance abuse services will be provided under various Medicaid plans. Equally unclear is the extent of substance abuse services to be provided under QHPs. Hawaii's benchmark plan has been identified, yet the extent and duration of substance abuse services to be provided remains unclear at this time.

2. Do you have a plan for monitoring whether individuals and families have access to SUD services offered through QHPs and Medicaid?

Yes, ADAD meets quarterly with ADAD-contracted substance abuse treatment providers. Providers will be asked to identify barriers clients may experience accessing substance abuse services through their QHP or Medicaid provider. Information will then be provided to the Hawaii Health Connector Board.

3. Who in your state is responsible for monitoring access to SUD services by the QHPs? Briefly describe their monitoring process.

The State Insurance Commissioner will retain full regulatory jurisdiction over plans. The Hawaii State Department of Commerce and Consumer Affairs (DCCA) will also play a role, albeit undefined to date. As of this writing, no detailed monitoring process has been identified.

4. Will the SSA be involved in reviewing any complaints or possible violation of MHPAEA?

No, complaints will be heard by the DCCA and its Regulated Industries Complaints Office.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

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

## IV: Narrative Plan

### D. Health Insurance Marketplaces

#### Narrative Question:

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

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

Please answer the following questions:

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

Footnotes:

## D. Health Insurance Marketplace

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

The answer remains to be determined. Both the State Director of Health and the State Director of Human Services (DHS) sit on the Board of Directors of the Hawaii Health Connector, the State-run exchange. The Director of Health is also a member of the Board's Outreach Committee.

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

The Hawaii Health Connector initiated an outreach effort to build relationships with community members, contact hard to reach populations, and identify where additional resources will be needed. In December 2012, the Connector procured subcontractor assistance with market research, development of a communication strategy (including public outreach and educational materials), and public relations.

The Connector plans a call center focusing on the exchange and transfer questions related to Medicaid and the Children's Health Insurance Program (CHIP) and have left open the possibility of expanding the call center to respond to requests from individuals, employers, employees, Navigators, and brokers.

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

A portal is planned between the Connector and DHS Med-QUEST programs which should make access to eligibility information and enrollment easier. It is the goal for ADAD-contracted providers to screen individuals for eligibility and/or assist with enrollment to third party resources prior to invoicing ADAD for services. ADAD will be enhancing its WITS system to provide third party billing capability for ADAD-contracted treatment service providers.

Additionally, many community-based service organizations work with at-risk clients (homeless, at risk of homelessness, chronic substance abuse, mental health disorders, medically fragile, recently incarcerated, etc. ) to increase enrollment and gain access to entitlement services such as SSI, SSDI, VA, medical benefits.

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs and how will the state assist its providers in enrolling in the networks?

The Hawaii Health Connector Board represents a diversity of interests across the State. Included on the board are State directors, non-profit services providers, medical providers, and union representation. This diversity is intended to assure broad participation in the networks of QHPs providers, inclusive of substance abuse providers and mental health providers.

Additionally, ADAD has been working with its contracted treatment service providers through the WITS system to build third party billing capacity, interoperability, and meet Meaningful Use standards in an attempt to assuring greater network access and resource development for community-based substance abuse providers.

5. Please provide an estimate of the number of individuals served under the SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

The estimate is 681.

Methodology:

1. Using WITS data, derived unduplicated count of admissions and unduplicated count of uninsured adult clients at admission for calendar years 2009, 2010, 2011, 2012 and 2013 (6 months data available).
2. Calculated percentage of uninsured adult clients to admission (uninsured count/admission count) for each calendar year: 2009, 37%; 2010, 33%; 2011, 35%; 2012, 32%; and 2013, 30% (6 months data available).
3. Using claims data, derived the number of adult clients (unduplicated) that were paid by SABG funds for each calendar year: 2009, 1,629 clients; 2010, 1,678; 2011, 1,980; 2012, 2,026; and 2013, 1,135 (6 months data available). Note: Adolescent client services were paid by State general funds.
4. Doubled the number of clients that were paid with SABG funds for 6 months of calendar year 2013:  $1,135 \times 2 = 2,270$ .
5. Multiplied CY 2013 (30%) calculated uninsured rate to the projected number of clients paid by SABG to get estimated number of uninsured clients to be paid by SABG:  
 $2,270 \times 30\% = 681$ .

Assumptions:

1. Amount of SABG funding remains the same.
  2. Rate of uninsured remains constant over the 2013 calendar year.
  3. Impact of Affordable Care Act will not be fully felt until succeeding years, so minimum impact on trends.
6. Please provide an estimate of the number of individuals served under the SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

For CY 2014 the estimate is 695. For CY 2015 the estimate is 757.

Methodology:

1. For CY 2014, used CY 2013 projected number of clients to be paid by the SABG (2,270), multiplied by estimated 2% increase of clients to be paid by the SABG in CY 2014:  
 $2,270 \times 102\% = 2,315$ .
2. For CY 2015, used the projected CY 2014 number of clients to be paid by the SABG (2,315) multiplied by estimated 9% increase in the number of clients to be paid by the SABG in CY 2015:  $2,315 \times 109\% = 2,523$ .
3. The pattern of increases of clients paid by SABG funds over the 2009 through 2012 period followed a pattern of, on the average, 2% in one year followed by a 9% increase the next year.
4. Multiplied 30% of uninsured rate for CY 2013 (calculated from methodology for CY 2013 above) to the projected number of clients to be paid by the SABG in CY 2014 and CY 2015. This yielded a projected 695 clients in CY2014 and 757 clients in CY2015.

Assumptions:

1. Amount of SABG funding remains the same.
  2. Rate of uninsured remains constant over the 2014 and 2015 calendar years.
  3. Number of clients whose services are paid by SABG funds will increase as indicated by the 5-year trend due to non-coverage of long-term residential services for substance abuse by other insurance plans, continuation of substance abuse services after maximum insurance coverage is exceeded; use of SABG funds spread over more contracts/providers, thereby serving more clients.
  4. Insurance service capitation may run out and additional services may be paid by SABG funds.
7. For the providers identified in Table 8 “Statewide Entity Inventory” of the FY 2013 SABG Report, please provide an estimate of the number of these providers that are currently enrolled in your state’s Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

For the providers identified in Table 8 “Statewide Entity Inventory” of the FY 2013 SABG Report, it was estimated that 12 of these providers (excluding providers listed more than once in Table 8) are currently enrolled in the State’s Medicaid program. This estimate is based on a February 2013 3<sup>rd</sup> Party Billing Survey conducted by ADAD which requested that each contracted treatment provider identify all payers which included Medicaid, Medicare, commercial health plans, and government contracts. The survey was sent to all 21 substance abuse treatment contracted providers. There were 16 respondents, 10 of which were SABG funded and enrolled in the State Medicaid program. Of the 5 non-respondents, 2 are SABG funded and enrolled in the State Medicaid program.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a

separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

It is estimated that of the number of providers estimated in Question 7, 14 providers for FY 2014 and for FY 2015 will be enrolled in Medicaid or participating in a QHP. The assumption is that the FY 2013 providers will continue to receive SABG funds and continue to be enrolled in the State Medicaid program, and two of the providers currently receiving SABG who were not enrolled in the State Medicaid program in FY 2013, will be enrolled in the State Medicaid program in FY 2014 and FY 2015. The assumption is also that the number of providers will remain unchanged.

## IV: Narrative Plan

### E. Program Integrity

#### Narrative Question:

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

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

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

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

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

#### Footnotes:

## E. Program Integrity

1. Does the state have a program integrity plan regarding the SABG?

In planning and contracting for services to be funded by SAPT Block Grant and State funds, ADAD follows requirements established in the Hawaii Revised Statutes (HRS), Chapter 103F and the Hawaii Administrative Rules (HARs) implementing regulations that regulate for fairness and quality, the basic planning, procuring, and contracting of health and human services by executive branch departments and agencies. The objective of HRS, Chapter 103F and related HAR is to ensure the fair and equitable treatment of and opportunity for all service providers delivering health and human services on behalf of the State and Federal government by using a standardized procurement process and by optimizing information sharing and coordinating, planning and service delivery efforts. The Department of Accounting and General Services (DAGS), State Procurement Office (SPO), serves as the central authority on State procurement requirements, policies and procedures.

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

ADAD does not have one specific staff person responsible for program integrity activities. Instead, ADAD's program integrity activities are carried out by various staff responsible for fiscal and contract management and oversight.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

- a. Budget review;

Yes. Providers are required to submit a budget with each proposal or contract. All budgets are reviewed by ADAD's fiscal staff to ensure that they are reasonable, appropriate, feasible, and in compliance with State and Federal requirements and guidelines.

- b. Claims/payment adjudication;

Yes. Electronically submitted claims to ADAD are adjudicated and reviewed for completeness, accuracy, and meeting required payment criteria for the contracted service. Hard invoices are reviewed for completeness, accuracy, and appropriateness before processing for payment.

- c. Expenditure report analysis;

Yes. Expenditure reports to ADAD are submitted with hard invoices summarizing the expenditures by budgeted line items. Before and after each payment is made, ADAD's fiscal staff reviews and updates expenditure report information to ensure expenditures are appropriate, reasonable, and stay within the approved budget.

d. Compliance reviews;

Yes. Program compliance reviews are conducted through desktop and onsite monitoring of contracts. The annual close-out process for every ADAD contract requires contracted agencies to submit compliance documents such as an inventory report with invoices of purchases, Hawaii State and Federal tax clearances, and single audit report. If there are findings in the single audit report, the provider is required to submit a corrective action plan for approval. The corrective action plan is reviewed the following year for compliance.

e. Encounter/utilization/performance analysis; and

Yes. ADAD reviews encounter and utilization data and does performance analysis for contracts. Program and fiscal staff have meetings together to review data and make appropriate decisions based on utilization and performance reviews for provider contracts. Contract modifications are executed to address utilization and performance issues, meet providers' needs within the requirements and guidelines of the contract, and maintain proper usage of Block Grant and State funds for the provision of contracted services.

f. Audits.

Yes. ADAD's fiscal audits include a close-out report, subsidiary ledger of expenditures for the year, sampling of transactions for allowability, appropriateness and allocability. Indirect cost rate, allocation policies and procedures, and lease rent agreements are also reviewed. ADAD also complies with the OMB Circular A-133, Single Audit Report.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

ADAD follows requirements established in the Hawaii Revised Statutes (HRS), Chapter 103F and the Hawaii Administrative Rules (HAR) implementing regulations that regulate for fairness and quality, the basic planning, procuring, and contracting of health and human services by executive branch departments and agencies. The Cost Principles for HRS, Chapter 103F are available at <http://hawaii.gov/spo/health-human-svcs/cost-principles-for-procurement-of-health-and-human-services>.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

ADAD assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards in a variety of ways. Desktop and onsite monitoring of compliance with program requirements identified in contract agreements is conducted. ADAD provides training and technical assistance opportunities for in-service and professional development for service providers. Quality and safety standards are also addressed by ADAD's accreditation process of substance abuse treatment programs. For further information, please see Sec. R-Quality Improvement Plan in this application.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

ADAD ensures Block Grant funds and State dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid by establishing financial eligibility requirements. The financial eligibility requirements of ADAD-funded clients eligible for treatment cannot exceed three hundred percent (300%) of the poverty level for Hawaii as defined by current Federal Poverty Level Standards.

In addition, administrative requirements for ADAD-contracted treatment providers include the following:

1. Providers shall not use the Department of Health's (ADAD) funding to make payment for any service which has been, or can reasonably be expected to be, made under another State compensation program, or under any insurance policy, or under any Federal or State health benefits program (including the program established in Title XVIII of the Social Security Act and the program established in Title XIX of such Act), or by any entity that provides health services on a prepaid basis. ADAD funds may be used to supplement QUEST (Hawaii's Medicaid Program) Insurance coverage, and other applicable medical programs' substance abuse services, after the benefits have been exhausted and up to the limit of the ADAD substance abuse benefits.
2. Motivational Enhancement and Recovery Support Services may be used to supplement the insurance benefits described above to clients who would otherwise qualify for ADAD services.
3. The Provider shall maximize reimbursement of benefits through any QUEST Insurance and other applicable medical programs.
4. The Provider shall comply with the Department of Human Service's QUEST Insurance program and other applicable medical program policies.
5. The Provider shall refund to the ADAD any funds unexpended or expended inappropriately.

## IV: Narrative Plan

### F. Use of Evidence in Purchasing Decisions

Narrative Question:

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

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

Footnotes:

## F. Use of Evidence in Purchasing Decisions

1. Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices?

No. ADAD has no specific staff person responsible to track and disseminate information regarding evidence-based or promising practices; however, the contracted and Block Grant-funded Prevention Resource Center makes available such information.

2. Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

Yes.

- a) What information did you use?

For substance abuse treatment services, information was included in ADAD's RFP for treatment services. The following is an excerpt from RFP 440-12-1:

“The APPLICANT shall incorporate best practices, evidence-based practices and promising practices in any substance abuse service. Best practices and evidence-based practices are defined as a body of contemporaneous empirical research findings that produce the most efficacious outcomes for persons with substance abuse problems, has literature to support the practices, is supported by national consensus, has a system for implementing and maintaining program integrity, and conformance to professional standards. Promising practices are those practices that have some research, literature and national consensus to support clinical effectiveness as well as a system for implementing and maintaining program integrity and conformance to professional standards. For best practices, evidence-based practices and promising practices in specific areas of substance abuse, the APPLICANT may consult the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol Series (TIPS), the National Institute on Drug Abuse's (NIDA) Principles of Drug Addiction Treatment, and/or access website resources listed in Attachment E-7, Important Website Addresses.” For cultural-based treatment activities, ADAD's RFP required applicants to indicate what level of evidence (client-based, practice-based or research-based), the proposed activities are based on in accordance with the Indigenous Evidence Based Effective Practice Model from the Cook Inlet Tribal Council, Inc., International Initiative for Mental Health Leadership Forum, Alaska, May 2007.

For substance abuse prevention services, ADAD's RFP requested that proposed services include the implementation of evidence-based programs and strategies that effectively address service needs identified in the proposals. The RFP listed 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 (NREPP) at <http://www.nrepp.samhsa.gov/>, as well as national registry lists from the Departments of

Justice and Education as information and guidance for selecting the strategies and programs to best address the intervening variables and populations to be impacted by the proposed services.

b) What information was most useful?

The most useful information was the information on best practices, evidence-based practices and promising practices from SAMHSA and NIDA, the HHS Publication No. (SMA) 09-4205, *Identifying and Selecting Evidenced-Based Interventions, Revised Guidance Document for the SPF-SIG Program*, SAMHSA, (January 2009), and SAMHSA's NREPP.

3. How have you used information regarding evidence-based practices?

As described above, contracts for substance abuse services were awarded based in part on the proposed inclusion of plans for the implementation of evidence-based practices. To further awareness, implementation and promotion of evidence-based practices, ADAD sponsors trainings and workshops relating to evidence-based practices and programs. During SFY 2014, ADAD intends to revive the Evidence-Based Practices Workgroup that was first initiated during the Hawaii SPF-SIG that ended September 2012.

## IV: Narrative Plan

### G. Quality

#### Narrative Question:

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

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

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

#### Footnotes:

During the preparation of this application, ADAD had not received from SAMHSA the Behavioral Health Barometer and state-specific outcome data for indicators needed to provide information requested for this Section G.

## IV: Narrative Plan

### H. Trauma

#### Narrative Question:

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

Please answer the following questions:

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

Footnotes:

## H. Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

ADAD does not have a specific policy directing providers to screen clients for a personal history of trauma; however, ADAD-contracted treatment providers are required to complete American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC) for clients in any level of treatment, as well as the Addiction Severity Index (ASI) for adults and the Adolescent Drug Abuse Diagnosis (ADAD) for adolescents. Both the ASI and ADAD have sections that address Family and Social Relationships as well as Psychiatric or Psychological Status.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

ADAD does not have specific policies in place at this time.

3. Does your state have any policies that promote the provision of trauma-informed care?

ADAD does not have specific policies in place at this time.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

There are a couple of ADAD-contracted treatment programs that use an evidence-based trauma-specific intervention as part of the treatment curriculum in providing services for pregnant women and women with dependent children.

5. What types of training do you provide to increase capacity of providers to deliver trauma-specific interventions?

ADAD schedules and sponsors training for treatment providers specific to trauma-related issues and affected groups. Training topics include the following: issues and barriers faced by gay, lesbian, bisexual and transgender/transsexual clients; cultural impacts and issues in treatment; becoming an exceptional counselor by recognizing trauma; compassion fatigue for trauma-impacted providers; and Applied Suicide Intervention Skills Training. In addition, ADAD co-sponsors trainings and conferences with organizations in the military, the Pacific Southwest Addictions Technology Transfer Centers, and the DOH Adult Mental Health Division. ADAD also certifies substance abuse counselors and program administrators pursuant to State law (HRS §321-193(10) and regulations (Hawaii Administrative Rules, Title 11, Dept. of Health, Chapter 177.1). For persons attending certain substance abuse trainings, workshops, and conferences, ADAD approves continuing education units that may be applied toward meeting the educational requirements for the Certified Substance Abuse Counselor, Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate.

## IV: Narrative Plan

### I. Justice

#### Narrative Question:

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

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

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

Please answer the following questions:

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

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

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

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

#### Footnotes:

## I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

At this time, there are no special provisions for individuals involved in the criminal and juvenile justice systems to access Medicaid coverage.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

ADAD uses only State funds to provide contracted integrated case management (ICM) and substance abuse treatment services for offenders on supervised release, furlough, probation or parole. The Supervised Release program, which is administered by the Hawaii State Department of Public Safety's Intake Service Center, is for pretrial offenders who have been assessed not to be a flight risk or a public safety risk and are released into the community pending adjudication.

To receive ICM services, offenders must be referred by the Department of Public Safety's Intake Services Center or Correction Division, the State Judiciary's Adult Client Services Branch, or the Hawaii Paroling Authority. Such referrals must have been assessed as being at medium-to-high risk for recidivism on the Level of Service Inventory Revised (LSI-R) combined with the Adult Substance Use Survey (ASUS) or the risk assessment instrument being utilized. Self-referred clients and/or clients identified by treatment providers, that might meet the criteria for ICM services, must be referred to ADAD's contracted ICM agency for assessment and approval for ICM services. ICM services include: screening/clinical assessment; individual case management service planning; court/supervising criminal justice agency technical assistance and support; service referrals and placement into substance abuse treatment; monitoring of offenders in treatment; alcohol and drug testing; HIV/AIDS education including pre- and post-test counseling; arrangements for clean and sober housing; and case management discharge. Substance abuse treatment services for eligible offenders include: motivational enhancement; residential treatment; intensive outpatient; outpatient; therapeutic living program; clean and sober housing; continuing care; transportation; translation; and cultural activities.

ADAD also uses State funds to contract with the State Judiciary Family Court of the First Circuit to provide Family Drug Court services for pregnant women and women with dependent children whose children are placed at risk by their parent's involvement in substance abuse and who also have open cases with the Child Welfare Services of the Department of Human Services. The Family Drug Court program provides intensive family case management services through substance abuse treatment matching and coordination of the entire system of care between treatment and the Family Court.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral

health services provided in correctional facilities, and the reentry process for those individuals?

As described above, coordination of services with the criminal justice systems is an integral component of ADAD's contracted ICM and substance abuse treatment services for offenders on supervised release, furlough, probation or parole. Coordination is also integral to the Family Drug Court program.

ADAD's contracted ICM services for eligible adult offenders are intended to aid interagency collaboration in the treatment of substance abuse, promote diversion from incarceration, increase supervision of offenders with substance dependence problems, control costs by assignment of clients to clinically appropriate services, and serve as the point for coordination of clinical and administrative/legal accountability. ICM services entail coordinating the entire system of care for the offender, including an intensive level of outreach beyond what treatment providers and probation and parole officers are able to provide in coordinating treatment, relapse prevention, and social services pre- and post-release. ADAD's contracted treatment programs for eligible adult offenders, in cooperation with the ICM services agency, are required to assist in linking the offender to education and vocational training to increase marketability of the offender in the work force, which shall include assessment of individual needs and services, pre-employment training classes, group and individual employment-related counseling, resume preparation, and career exploration and job search. ADAD's contracted treatment programs for eligible adult offenders are also required to develop and implement, in coordination with the ICM services agency and supervising criminal justice agency, an appropriate transition plan for each client in the final phase of treatment prior to discharge. The plan shall address recovery issues and relapse prevention.

Please note that in accordance with 42 USC §300x-31(3), ADAD is prohibited from expending SAPT Block Grant funds for the purpose of providing treatment services in penal or correctional institutions of the State.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

ADAD recognizes that offender needs, such as transportation, psychiatric needs, child care, and other physical and mental health special needs should be taken into account. ADAD's contracted ICM services are intended to provide each client with a single point of contact for linkage to multiple health and human services systems, advocate for the client, be community-based and client oriented, and assist the client with needs beyond substance abuse treatment or criminal justice systems. ICM services are required to assist in transporting and accompanying offenders to medical and dental appointments, entitlement enrollment, and other appointments. For a client who is dually diagnosed with mental illness and substance abuse dependence, and for whom services are not available in a dual diagnosis-specific treatment program, the ICM primary case manager is required to coordinate treatment services between substance abuse and the mental health system.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

ADAD provides a Hawaii State Certification in Criminal Justice Addictions Professional. This certification requires an initial 270 education hours in criminal justice studies and substance abuse related topics. For re-certification, there is a requirement of 40 continuing education units every two years. ADAD sponsors criminal justice training as well as co-sponsors with local and national organizations for trainings that have been approved for continuing education units. ADAD specifically provides criminal justice training and co-sponsorship of training and conferences with assistance from the Pacific Southwest Addictions Technology Transfer Center. Emphasis of trainings center around cognitive behavioral therapy and trauma-based curriculum utilizing the University of Cincinnati, Center for Criminal Justice Research curriculum and training staff.

## IV: Narrative Plan

### J. Parity Education

#### Narrative Question:

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

Please answer the following questions:

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

#### Footnotes:

## J. Parity Education

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

Hawaii has received a significant amount of federal funding to support a Hawaii Health Connector Call Center which includes active outreach and marketing across all sectors throughout the Hawaiian Islands. The intent is to provide accurate information regarding health care reform, assistance in navigating the system and ease of access to choosing a health care plan that works for both an individual and a business. Perhaps the Connector could be approached to include parity issues in their outreach messages as well as the Call Center. Additionally, a clearly defined process for redress if parity issues are not being met needs to be developed and shared with consumer and consumer advocacy groups.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?

The Hawaii Health Connector is positioned to coordinate such efforts as a result of the Level 2 federal funds received. Funds are being used to implement a call center as well as vigorous outreach and marketing strategies designed to target a broad range of consumers. Funding continues through 2017.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

A plan should be initiated to work with the marketing staff from the Hawaii Health Connector to develop outreach plans to minority populations, homeless populations, inmate populations, as well as mental health and substance abuse providers, homeless care services providers, community based health care centers, and advocacy groups.

## IV: Narrative Plan

### K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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

Please answer the following questions:

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

Footnotes:

## K. Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing.

Hawaii's Department of Health (DOH) is represented on the Hawaii Health Connector and on the Governor's Health Care Reform Team. The Adult Mental Health Division (AMHD), the Child and Adolescent Mental Health Division (CAMHD), and the Alcohol and Drug Abuse Division (ADAD) are part of the DOH Behavioral Health Administration. Clients with serious mental illness (SMI) or serious and persistent mental illness (SPMI) are having their care coordinated through state primary health/mental health initiatives. Many clients in ADAD-funded programs do not meet the eligibility requirements of AMHD.

ADAD is working with AMHD to improve services for clients with co-occurring mental health and substance use disorders. The divisions may create a bi-lateral memorandum of understanding (MOU) to assure client service needs are met. Currently, if a client's primary diagnosis is SMI or SPMI, the client is served via AMHD. If the primary diagnosis is a substance abuse disorder, the client is served via ADAD. The MOU will help clarify protocol leaving less opportunity for clients to fall between the cracks.

Additionally, ADAD is in the planning stages of developing targeted services to homeless persons (or persons at risk for homelessness) impacted by a substance use disorder and mental health issues but not SMI or SPMI. It is envisioned that services will be comprehensive with wrap around services such as primary care, employment, and recovery supports.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

Please see description for question 1 above.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

ADAD is contracting with two FQHCs, the Waianae Coast Community Mental Health Center and the Waikiki Health Center. ADAD is contracting with the Waianae Coast Community Mental Health Center to provide substance abuse outpatient culturally based treatment services. The Waianae Coast Community Mental Health Center sits on the campus of the Waianae Coast Primary Care Center. ADAD's contract with the Waikiki Health Center is to provide HIV early intervention services to substance abusers at treatment programs. This contract is funded by State general funds since ADAD is prohibited from using Block Grant funds for such services because ADAD is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000 (see 42 USC §300x-24(b) and CFR §96.128).

ADAD schedules quarterly meetings with its contracted substance abuse treatment providers to discuss issues, contracts, trends, capacity, etc. At a meeting in August 2013, providers discussed building closer relationship with community health centers. Providers felt some CHCs were more inclusive and willing to work with area substance abuse providers than others. ADAD provided all in attendance with a copy of the report, “Innovations in Addictions Treatment: Addiction Treatment Providers Working with Integrated Primary Care Services” (Center for Integrated Solutions, Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration, May 2013).

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

ADAD’s contracted substance abuse treatment providers are required to spend in each contract year one percent (1%) of their total contracted amount for tobacco cessation activities. Most providers also conduct nicotine cessation education as part of the treatment curriculum. In addition, providers must comply with the requirements of the Pro-Children Act of 1994 by signing the “Certification Regarding Environmental Tobacco Smoke,” attachment as part of their contract with ADAD.

One of ADAD’s providers, The Salvation Army Family Treatment Services (FTS), which provides specialized substance abuse treatment services for pregnant women and women with dependent children, has been deemed a tobacco-free facility. Smoking cessation support is provided in collaboration with the Waikiki Health Center’s Path Clinic which is located on the FTS campus. The Path Clinic also offers women’s health services, pediatrics and primary care, and assists FTS with an opiate withdrawal protocol as needed.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

Upon admission to treatment, all clients are required to be assessed, the adults using the Addiction Severity Index (ASI) and the adolescents using the Adolescent Drug Abuse Diagnosis. The Adolescent Drug Abuse Diagnosis asks about tobacco use.

ADAD’s Web Infrastructure for Treatment Services (WITS) system includes fields for providers to enter responses to the following questions upon admission and discharge of all clients. These questions are optional, but most providers address them since smoking is viewed as a gateway to other drug use especially with the adolescent population.

Have you ever used tobacco/nicotine products? At what age did you first use tobacco/nicotine products? In the past 30 days, what tobacco/nicotine product did you use most frequently? Other: Please describe. In the past 30 days, how many cigarettes did you smoke per week?

6. Describe how your behavioral health providers are screening and referring for:
  - a. heart disease,
  - b. hypertension,
  - c. high cholesterol, and/or

d. diabetes.

As described above, upon admission to treatment, adults are required to be assessed using the ASI and adolescents are assessed using the Adolescent Drug Abuse Diagnosis. Both the ASI and Adolescent Drug Abuse Diagnosis contain a Medical Status section with questions pertaining to chronic medical problems. The ASI includes a question on whether the client is taking any prescribed medication on a regular basis for a physical problem. The Adolescent Drug Abuse Diagnosis includes a list of 20 different health concerns that go into more detail, such as overweight, eating problem, pounding heart, etc. If these areas pose a concern, they should be addressed as a part of the individual's treatment plan.

## IV: Narrative Plan

### L. Health Disparities

#### Narrative Question:

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

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

In the space below please answer the following questions:

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

Footnotes:

## L. Health Disparities

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

ADAD's substance abuse treatment providers are contractually required to utilize the Web-Based Infrastructure for Treatment Service (WITS) system, an electronic health record and billing system to report to ADAD client data and types of services provided in order to receive payment for services. WITS is also used to collect treatment episode data set (TEDS) information required by SAMHSA. WITS can generate information on race, ethnicity, gender and age of clients, as well as admissions, program enrollments and disenrollments, discharges, follow-up and waitlist information. WITS does not currently collect data on sexual orientation.

ADAD recently published the "Alcohol and Drug Treatment Services Report: Hawai'i, 10-Year Trends (2003-2012)." The report focuses on substance abuse treatment services provided by agencies that were funded by ADAD during State fiscal years 2003 to 2012. The report presents information on the socio-demographic characteristics of the adolescents (17 and younger) and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes.

Enrollment in substance abuse prevention services is tracked through the Hawaii Information System for Substance Abuse Prevention (HISSAP), ADAD's prevention data collection and monitoring system which is used to collect data from ADAD-funded prevention programs on types of prevention services provided and clients served. Though race, ethnicity, gender, and age of program participants are collected in HISSAP, ADAD does not track outcomes by those characteristics.

2. How will you identify, address, and track the language needs of disparity-vulnerable subpopulations?

For ADAD's new four-year contract period, effective July 1, 2013, for substance abuse treatment and recovery services, ADAD gave providers the opportunity to have translation or interpreter services as a reimbursable recovery support service. The majority of contracted providers chose this option and, as a result, this service has been included as part of their contracts' scope of service. Services for language needs will be tracked through the WITS system. Many treatment providers try to employ a multi-ethnic, multi-cultural staff to help meet the service needs of their clients.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

ADAD-funded substance abuse treatment providers are required to submit quarterly reports that include information on treatment units provided, number of clients served, number of individuals followed up on, client participation in self-help groups, staffing information, as

well as accomplishments and challenges. Also, providers are required to report annually on various outcome measures. Regarding substance abuse prevention services, ADAD will work with community-based agencies, the State Epidemiological Outcomes Workgroup (SEOW), and service providers to assess the existence of disparities and develop plans to address and eventually reduce disparities in access, service use, and outcomes for the disparity-vulnerable subpopulations in the individual communities.

4. How will you use Block Grant funds to measure, track, and respond to these disparities?

Block Grant funds are used to support the development, maintenance, and enhancement of WITS and HISSAP which are used to measure and track ADAD-funded substance abuse services and client data. ADAD utilizes the State procurement process to direct available Block Grant and State funds to support the provision of substance abuse services as well as to seek information on service needs. As required by the State procurement process, ADAD holds request for information (RFI) sessions to obtain community input on substance abuse services that ADAD intends to procure. The information that is acquired through the RFI is incorporated into requests for proposals (RFPs) that ADAD develops and issues in accordance with State procurement procedures. The RFPs also: (1) encompass SAPT Block Grant requirements for services for specified target groups; (2) reflect existing needs assessment data and other pertinent data sources; and (3) require applicants to substantiate the need for their proposed programs and services and identify their target populations for which services will be provided. ADAD reviews, evaluates and scores the proposals submitted by community-based organizations, and awards service contracts based on the evaluation criteria set forth in the RFP requirements.

## IV: Narrative Plan

### M. Recovery

#### Narrative Question:

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

### Indicators/Measures

Please answer yes or no to the following questions:

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

### Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

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

### Housing

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

supportive community?

Footnotes:

## M. Recovery

### Indicators/Measures

1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes. ADAD, through lessons learned via the Access To Recovery Project, is in the process of developing a definition of recovery and set of recovery values.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

No. The State hiring process does not collect information on hiring people in recovery in leadership roles within the State behavioral health system. Due to the nature of the information, the State personnel office has determined a question of this nature is considered illegal based on State privacy rules. However, it is a common practice among treatment providers to hire people in recovery in various roles, including leadership roles.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes. ADAD operationalizes self-directed services through its Access to Recovery (ATR) Ohana Project which provides vouchers to people with drug and alcohol problems to pay for needed treatment and recovery support services among a network of eligible providers. The ATR Ohana Project is being funded by SAMHSA's ATR III for \$11.4 million dollars over four years from 2010-2014. This is the second ATR grant awarded to Hawaii. The ATR Ohana Project is designed to provide clients with their choice of substance abuse treatment and recovery support service providers; expand access to a comprehensive array of services including faith-based and culturally-based program options; and increase the capacity of the recovery-oriented system of care. The ATR Ohana Project encourages clients to make self-directed decisions about types, levels, and contents of substance abuse treatment and recovery support services by completing independent assessments of treatment needs and through assessment of their recovery support needs with credentialed substance abuse treatment professionals.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible?

Yes. All clients enrolled in ATR Ohana receive no-cost wellness facilitation services focused on identifying, coordinating among, and linking the client with a variety of recovery-oriented system services. ATR Ohana provides funding for "wrap-around" recovery services such as housing, child care, self-help and support groups, and cultural and spiritual support for clients requiring substance abuse treatment. Information regarding provider and service options are posted on the Hawaii Department of Health, Alcohol and Drug Abuse Division's, Access To Recovery Project at <http://health.hawaii.gov/substance->

[abuse/files/2013/05/servicescrosswalk.pdf](http://abuse/files/2013/05/servicescrosswalk.pdf) and <http://health.hawaii.gov/substance-abuse/files/2013/05/providerdirectory.pdf>.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Yes. The ATR Ohana Project currently includes peer-delivered services designed to meet the need of the following populations: veterans and military families, people with a history of trauma, and members of ethnic groups (cultural services).

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes. ADAD provides training for the workforce on recovery principles, practices and systems through a variety of training modalities. ADAD provides training programs and services and through co-sponsorship with individuals, local organization and national conferences. The training implementation occurs from training courses in treatment planning, relapse prevention techniques, and in discharge planning. In addition, providers have the capability to request from ADAD technical assistance regarding recovering systems. ADAD, through its trainings and technical assistance, promotes recovery as an ongoing system of care that can be augmented through the use of aftercare programs, self help organizations and to affiliate with peer support, mentoring or coaching services.

7. Does the state have an accreditation program, certification programs, or standards for peer-run services?

No. ADAD does not have an accreditation program, certification programs, or standards for peer-run services.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

The ATR Ohana Project provides unique cultural and spiritual support services that reflect a mixture of Hawaiian and eastern cultures. Lapa` au (Hawaiian medicine), la`au (medicinal plants), and ho`oponopono (Hawaiian practice of reconciliation and forgiveness) classes are provided. The emphasis in Hawaiian healing and Hawaiian culture is on developing a strong sense of spirituality in each individual. Aikido (a Japanese martial art) classes are also provided that incorporate light stretching and different types of low impact exercises to improve physical fitness and posture, various breathing exercises for relaxation and calmness, and meditation exercises to strengthen the mind.

## Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

As described above, the ATR Ohana Project encourages clients to make self-directed decisions about types, levels, and contents of substance abuse treatment and recovery support services by completing independent assessments of treatment needs and through assessment of their recovery support needs with credentialed substance abuse treatment professionals.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

ADAD does not; however, ADAD supports and encourages treatment and recovery providers to provide self-directed/client-choice options which may include family members.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

ADAD encourages its network of Block Grant and State-funded providers to engage and encourage clients and family members to actively participate in the development of treatment and recovery plans. For the ATR Ohana Project, providers assist clients in making decisions about types, levels, and contents of substance abuse treatment and recovery support services by completing independent assessments of treatment needs through assessment of their recovery support needs with credentialed substance abuse treatment professionals.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

ADAD's contracted recovery support services, funded by Block Grant and/or State funds, include cultural based recovery services, continuing care, child care, translation, transportation, and clean and sober housing options. ADAD continues to provide funding to maintain a network of peer-assisted group recovery homes. As described above, the ATR Ohana Project is designed to provide clients with their choice of substance abuse treatment and recovery support service providers; expand access to a comprehensive array of services including faith-based and culturally-based program options; and increase the capacity of the recovery-oriented system of care.

## Housing

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

As noted above, ADAD's contracted treatment and recovery support services, funded by Block Grant and/or State funds, include clean and sober housing. Clean and sober housing provides housing to unrelated adults who are without appropriate living alternatives and who are participating in an ADAD-contracted substance abuse treatment agency's continuum of

care or have been discharged within the past 12 months from an ADAD-contracted treatment program. The focus of this service is to provide the necessary support and encouragement for the client to adjust to a chemically abstinent lifestyle and manage activities of daily living in order to move toward independent housing and life management. Clean and sober housing differs from a therapeutic living program in that residents do not require 24-hour supervision, rehabilitation, therapeutic services or home care. Rather, it provides adults in recovery an environment that is free from alcohol and non-medically prescribed medications and illegal substances. Adults share household expenses.

ADAD is also continuing the operation of a revolving loan fund, in accordance with 42 USC 300x-25, to support peer-run group homes for recovering substance abusers in an alcohol- and drug-free environment. ADAD contracts with Oxford House, Inc. to maintain and support the start-up of new group homes and to manage the revolving loan fund in accordance with Block Grant provisions. The contract is both Block Grant and State funded.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

ADAD plans to strengthen the network of clean and sober homes and adult substance abuse recovery homes by participating in the Clean and Sober Homes and Halfway Houses Task Force. The Task Force is developing a plan to ensure homes are properly monitored and accountable for meeting occupancy, zoning and permitting requirements.

## IV: Narrative Plan

### N. Evidence Based Prevention and Treatment Approaches for the SABG

#### Narrative Question:

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As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data 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?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

#### Footnotes:

## N. Evidence Based Prevention Approaches for the SABG

1. How did 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?

To support the data driven process to identify service needs and develop priorities and goals for ADAD's request for proposals (RFP) for primary prevention services, ADAD used the 2009 State Level Data on Alcohol, Tobacco, and Illegal Drug Use from SAMHSA's Office of Applied Studies (OAS) <http://www.oas.samhsa.gov/Data.cfm>. Data from the National Survey on Drug Use and Health (NSDUH) provided 2010 state-level estimates on the use of tobacco products, alcohol, illicit drugs and mental health <http://www.samhsa.gov/data/NSDUH/2k10ResultsTables/NSDUHTables2010R/HTM/TOC.htm>.

Information was also obtained from local data sources including the "Hawaii Strategic Prevention Framework State Incentive Grant (SPF-SIG) Project Infrastructure and Capacity Assessments –Results Final Analysis," May 2009, and the "Epidemiological Profile of Alcohol Related Behaviors among Youth," Spring 2007, March 2010 (revised), which provided information on the strengths and challenges of the prevention infrastructure in each of the counties. Additionally, ADAD has periodically contracted consultants to conduct statewide student surveys to obtain ongoing data to assess the nature and extent of substance use among Hawaii's youth, assess prevention and treatment needs, and measure risk and protective factors. "The Hawaii Student Alcohol, Tobacco, and Other Drug Use Study: 2007/2008 Comprehensive Report" is the latest report from ADAD's series of student surveys. These reports are available at <http://health.hawaii.gov/substance-abuse/survey/>.

Secondary data sources were also used to support decisions regarding priorities and goals of planned services. The Hawaii Health Data Warehouse (HHDW) is a project created through the partnership between the Hawaii State Department of Health (DOH) and the University of Hawaii's John A. Burns School of Medicine (JABSOM) to address and monitor the Healthy People 2010 goals. This data resource, <http://www.hhdw.org/>, houses available data regarding health for the state of Hawaii in five interrelated components: schools, communities, public and professional education, research and evaluation, and Nutrition Education Network. Data reports from primary data sources are listed on this website by category, data source, ethnicity, county and Healthy People 2020 objectives.

2. What specific primary prevention programs, practices, and strategies does the state fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

SABG primary prevention set-aside funds are used to fund programs, practices, and strategies that have a positive impact on the promotion of health and wellness and the prevention of substance use and abuse. In particular, services are selected that support the implementation of evidence-based programs and strategies identified on a national registry.

Funded prevention strategies also include the six prevention strategies promoted by CSAP: information dissemination, education, alternative activities, problem identification and referral, community-based processes, and environmental strategies. Additionally, funds are used to support cultural adaptations and data collection. The chart below shows the programs currently funded with SABG prevention set-aside dollars.

<b>Evidence-Based</b>	<b>Other</b>
Project Venture	Synar Activities
Positive Action	E Ola Pono
Too Good for Drugs	Medication Management
Strengthening Hawaii Families	Prevention Resource Center (RADAR)
Girls Circle	
Second Step	Training
Project Alert	Student Health Survey
STARS for Families	Data Collection and Systems Development
Project Northland	
Too Good for Drugs and Violence	

To ensure that SABG dollars are used to purchase primary substance abuse prevention services that are not funded through other means, applicant agencies are required to provide information regarding all sources of funds for proposed prevention services prior to awards. In addition, as the Single State Agency (SSA) for Substance Abuse, ADAD is informed of proposed grant applications submitted by community-based, non-governmental organizations within our jurisdiction.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

By issuing the RFP and conducting informational meetings for community-based organizations and interested applicants, ADAD provided awareness and education related to the SPF process, evidence-based practices and strategies, and prevention workforce capacity. Agencies are encouraged to support workforce development and increase the number of Certified Prevention Specialists at their respective agencies to comply with ADAD's RFP and contract requirements. Additionally, ADAD has sponsored Substance Abuse Prevention Skills Training (SAPST) and Training of Trainers to advance the State's capacity to increase and enhance the prevention workforce. Follow up SAPST to be conducted statewide is scheduled for SFY 2014. ADAD is also striving to continue support and enhancement for SPF efforts by utilizing special State funds to disseminate Hawaii SPF-SIG evaluation results and assist communities to determine next steps. These funds will also assist in the revitalization of the Evidence-Based Workgroup (EBW) that was created during the implementation of the SPF-SIG project. ADAD continues to support the Prevention Resource Center (PRC) and to sponsor and organize training opportunities to disseminate information and improve skills related to evaluation, environmental strategies, evidence-based programs, capacity building, coalition building, assessment, and data collection. Further development of a website for prevention efforts and improvements to make the data

collected via the Hawaii Information System for Substance Abuse Prevention (HISSAP) more useful for providers as well as the State are also planned.

4. What outcome data 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?

ADAD collects data from program services on a regular basis through the HISSAP. The reporting fields for service data include service delivered, descriptions, Institute of Medicine (IOM) prevention categories, six CSAP strategies, service date, service location, service type (single or recurring), session length, responsible staff, staff hour(s), service population, demographic breakdown, and attendance. Currently, HISSAP provides unique client level data in the following areas: budget and spending reports; service details and number of people served; and Community Action Plan (CAP) goals. Further outcomes and impact of funded services will be determined by the State Epidemiological Outcomes Workgroup (SEOW), SPF evaluator, and the analysis and comparison of the Hawaii Youth Risk Behavior Survey results from 2011, 2013, and 2015.

5. How is the state’s budget supportive of implementing the Strategic Prevention Framework?

ADAD utilizes both Block Grant and State funds to support the Strategic Prevention Framework (SPF) and implementation of substance abuse prevention services. ADAD requires its contracted prevention providers to complete a Community Action Plan (CAP) describing evidence-based programs and strategies selected based on assessed needs and desired outcomes. The CAP is reassessed periodically by the providers and ADAD staff.

6. How much of the SABG prevention set aside goes to the state, versus community organizations?

Currently, approximately \$340,635 or 20% of the SABG prevention set aside is contracted to other State agencies to assist with data collection and reporting (HISSAP), SPF-SIG follow up, evaluation, administrative aspects of Synar requirements (e.g., sample design and conducting Synar inspections), and administration, analysis, and reporting of the Hawaii Student Health Survey (Youth Risk Behavior Survey). The rest of the set aside goes to community organizations.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Currently, approximately \$1,094,233, or 64% of the prevention set-aside goes to evidence-based practices and environmental strategies as indicated by the list of programs below:

<b>PROVIDER AGENCY</b>	<b>EBP/Environmental Strategy</b>
Aloha House	Project Venture
Alu Like, Inc.	Positive Action
Coalition for a Drug-Free Hawaii	Girls Circle, Second Step, & Strengthening Hawaii’s Families

Hina Mauka	Project Alert
Maui Youth and Family Services	All Stars, Project Venture
UH-Hilo Lanakila Learning Center	Too Good for Drugs and Violence, Life Skills
Waimanalo Health Center	Too Good for Drugs
University of Hawaii – Office of Public Health Studies	Synar Activities

## IV: Narrative Plan

### O. Children and Adolescents Behavioral Health Services

#### Narrative Question:

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

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

Please answer the following questions:

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

Footnotes:

## O. 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 mental and substance use disorders?

ADAD provides a continuum of care for eligible youth with substance use disorders through contracted providers. Services for children ages 0-12 are provided through contracted services for pregnant women and women with dependent children. Services for youth and adolescents ages 13-18 are provided through school-based and community-based services. Treatment services may include: intensive outpatient and outpatient services (including cultural, educational and recreational groups, individual and family counseling, and case management); transportation; and translation/interpreter services. Program compliance reviews are conducted through desktop and onsite monitoring of contracts.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

ADAD has established standards for individualized care planning that are reviewed and revised every contract cycle. For ADAD's contract period from July 1, 2013 to June 30, 2017, clinical performance and reporting requirements were included in the contracts for school-based and community-based substance abuse treatment services for middle-school and high-school age adolescents. Clients must meet either the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association criteria for substance abuse or dependence or the current American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC). All clients in any level of treatment shall meet the most current version of the ASAM PPC for admission, continuance, and discharge from Level 0.5 (Early Intervention), Level I (Outpatient Treatment), and Level II (Intensive Outpatient Treatment). Providers must administer the Adolescent Drug Abuse Diagnosis as part of the initial assessment and upon discharge to all clients admitted for treatment.

Providers must also submit to ADAD the following information as part of each client's health record: (1) HIV Risk Assessment; (2) Alcohol and Drug Abuse Diagnosis; (3) Master Problem List; (4) Diagnosis/Diagnoses and complete multiaxial assessment (assessment for all five axes) according to the most current version of the DSM; (5) Severity ratings for all six dimensions according to the most current version of the ASAM PPC; (6) Clinical Summary which includes relevant data and analysis of data which supports the diagnosis/diagnoses, client placement and service recommendations; (7) Treatment/Recovery Plans; (8) Treatment/Recovery Plan Updates; (9) Progress Notes; and (10) Incident Reports.

For substance abuse treatment services for pregnant women and women with dependent children, ADAD-contracted providers are also required to develop and implement individualized family service plans and therapeutic nursery child plans for children admitted to treatment along with their mothers who have been admitted to residential or therapeutic living programs.

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.)?

Through participation in various networks, committees, coalitions, and events, ADAD has established working relationships and collaboration with other child- and youth-serving agencies in the State to address behavioral health needs. These agencies include, but are not limited to, Department of Education, Department of Human Services, Coalition for a Drug-Free Hawaii, Hawaii Keiki Caucus, Hawaii School Health Survey Committee, Hawaii Family Drug Court, and the Treatment Directors Coalition. Several contracted providers are welcomed by the Department of Education and school administrators to conduct substance abuse prevention programs in the schools. Organizationally, ADAD is part of the Department of Health's Behavioral Health Administration which includes the Child and Adolescent Mental Health Division.

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?

ADAD intends to provide training for State staff, service providers, and/or community members in evidence-based substance abuse prevention services for children, adolescents and their families. Training will be delivered by subject matter experts, service providers or contracted consultants utilizing State and federal funds. Additionally, ADAD will enter into collaborative partnerships with other divisions within the Department of Health, State agencies such as the Departments of Human Services, Attorney General, Public Safety, and Education, the University of Hawaii, and non-profit and /or community-based agencies to sponsor and promote training sessions in evidence-based practices and related service areas which include but are not limited to suicide prevention, fetal alcohol spectrum disorders, and substance abuse prevention.

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?

ADAD will monitor and track service utilization and costs by conducting joint staff utilization review meetings with fiscal and program staff that monitor ADAD's service contracts. These meetings focus on review of fiscal and service utilization data provided via WITS and ADAD's fiscal staff.

ADAD's contracted providers for substance abuse treatment services for both adults and adolescents are required to submit quarterly program reports summarizing client output data and year-end program reports summarizing and analyzing required performance data. Providers are required to set a threshold percentage of achievement for each of the following measures: (1) Number of clients completing treatment; (2) Employment status at follow-up; (3) Living arrangements at follow-up; (4) Number of clients receiving substance abuse treatment since discharge; (5) Number of clients currently in substance abuse treatment; (6) In the past 30 days, number of clients experiencing significant periods of psychological distress; (7) In the past 30 days, number of days of work/school missed because of

drinking/drug use; (8) Number of arrests since discharge; (9) Number of emergency room visits since discharge; (10) Number of times client has been hospitalized for medical problems since discharge; (11) Frequency of use 30 days prior to follow-up, and (12) Usual route of administration. For the measures above (except #1), providers are required to collect data for all clients admitted to their programs six months after termination, regardless of the reason for discharge, and submit their reports to ADAD.

## IV: Narrative Plan

### P. Consultation with Tribes

#### Narrative Question:

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

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

#### Footnotes:

No federally recognized tribes or tribal lands exist within Hawaii's borders.

## IV: Narrative Plan

### Q. Data and Information Technology

Narrative Question:

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

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

Please provide an update of your progress since that time.

Footnotes:

## Q. Data and Information Technology

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data.

ADAD currently uses an algorithm based on the client's name, date of birth and gender to create a "unique" client ID. This has proven to be 97% effective with the 3% error when names or birthdates have been entered incorrectly. All client-level data is associated with one-and-only-one client (the unique client ID) since before any data can be entered, a client must be selected.

ADAD recognizes that it is not prudent to have protected health information (PHI) as part of its unique client ID. Thus, ADAD is initiating a project to implement a Master Patient Index (MPI) which assigns random numbers to clients, then assigns the same random number to all clients that have the same client ID among all providers. It is important to note that in the Web Infrastructure for Treatment Services (WITS) system, all providers have separate data areas and can only see client data in their own data area. The MPI and its randomly assigned ID will link a client that receives services from multiple providers. A manual process for assigning the MPI has been created to correct any error that may occur in the automatic MPI assignment. Depending on the availability of funding and staff resources, conversion to the MPI is expected to take about a year.

- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency.

For substance abuse treatment and recovery services, ADAD uses the WITS system which consists of an electronic health record (EHR) and a contract/billing system. The EHR is used by all ADAD-contracted substance abuse treatment providers to collect and maintain information that includes client demographics, enrollment (responsible party), assessment, admission, services, and discharge information. The WITS contract/billing system allows providers to assign State contracts as the responsible party and submit claims for payment of services rendered. Claims are adjudicated by ADAD (using the WITS contracting system). An invoice is generated which is used as the source document for payment through the State's central paying (check writing) system. A project to utilize WITS for third-party billing, primarily Medicaid, is underway and scheduled for implementation in 2014.

System and ad hoc reports are available to both providers and ADAD. The Treatment Episode Data Set (TEDS) is extracted directly from providers' data and submitted to SAMHSA. Planning is underway to implement an initiative intended to automatically send TEDS data on the first of each month. Draft specifications have been developed to collect prescription drug utilization information in WITS, but lack of funding has prevented the implementation of this function. Another enhancement being explored by ADAD is the collection of more, as yet not fully defined, detailed information on veterans and their dependents. ADAD is a member of the WITS Collaborative Partnership comprised of over 20 states and local governments to facilitate cost sharing and enhancements.

ADAD's Access to Recovery (ATR) Project also uses the WITS system for data collection, reporting and processing payment.

- Provide information regarding its current efforts to assist providers with developing and using EHRs.

WITS is already an electronic health record (EHR) system. Functionality is constantly being added to WITS. As these functions are added, providers are and will be taught more about EHR systems, e.g., electronic third party billing involving claims submission, re-submission of claims (denied, over/under payment adjustment claims), and remittance advise processing. In addition, e-signature, where clients will sign online documents, will be introduced to all contracted providers.

Education in EHR functionality occurs through the WITS Work Groups where issues and enhancements are discussed with providers. Also, onsite training and web-based training are provided.

- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment.

ADAD is already using an encounter/claims based approach to payment in WITS. However, cost reimbursement contracts or certain costs or services that are not directly chargeable to a client or for which a rate schedule is not applicable, currently preclude an encounter/claims based approach.

- Identify the specific technical assistance needs the state may have regarding data and information technology.

Regarding WITS, technical assistance needs include implementation of a H837i (institutional) format for 5010 HIPAA transaction and enhancements to support Meaningful Use.

### Hawaii Information System for Substance Abuse Prevention (HISSAP)

The Hawaii Information System for Substance Abuse Prevention (HISSAP) is ADAD's substance abuse prevention data collection and monitoring system to track the programs and activities that are implemented by ADAD's contracted prevention providers. ADAD contracted with the University of Hawaii, Center on the Family (COF) to customize Knowledge-Based Information Technology (KIT) Solutions system for the development of HISSAP. COF has a subcontract with KIT Solutions, LLC to implement this customization. COF has managed the design and overall maintenance of HISSAP which is hosted by KIT Solutions. All communication and direct contact with KIT Solutions regarding HISSAP is conducted by COF.

HISSAP includes three major modules: Assess & Plan, Manage, and Track; and five supporting sub-modules: Data Tools, Knowledge-Base, Communications, Administration, and Help. The Assess & Plan module is used to identify and define programs and services that providers plan to implement according to ADAD's Request for Proposal (RFP) for prevention services. This

module also allows providers to propose new evidence-based programs for review and approval. The Manage module stores participants' information and manages groups. Participants are either recorded as individuals or as a group. Information collected on an individual basis includes name, age, race, ethnicity, gender, languages spoken, and primary and emergency contact information. When it is not possible for the provider to collect information from each individual at a prevention activity, then the provider must estimate the demographics of the group. The Track module is used for recording the actual service data. Providers can also report ad hoc services if they perform any unplanned services. The reporting fields for service data include service delivered, descriptions, Institute of Medicine (IOM) prevention categories, six CSAP strategies, service date, service location, service type (single or recurring), session length, responsible staff, staff hour(s), service population, demographic breakdown, and attendance.

Currently, HISSAP provides data in the following areas:

- Provider organizational information
- Staff and their contact information
- Staff hours spent on prevention services
- Budget and spending reports
- Service details and number of people served
- Community Action Plan goals

Certain objectives related to the data collection system are not yet fulfilled. The process of customizing HISSAP is ongoing, thus, not all of the support modules are fully functional. The Data Tools are intended to enable providers and ADAD to pull out predefined reports. The Knowledge-Base is intended to provide supporting material such as a glossary and data dictionary. The Administration module collects provider specific information as well as manages data access. The Communication module is intended to be used to announce events and post messages. The Help module is intended to provide the system user manual and to enable users to communicate with KITS Solution regarding any system questions.

Critical examination of HISSAP and its users was conducted through a short-term subcontract with the University of Hawaii. Users related their challenges in concrete ways during the meetings/interviews, and efforts will be made to address those identified issues. Results indicated that HISSAP is experiencing not only functional problems, but also structural challenges that, in particular, prevent ADAD from directly contacting KIT Solutions. This affects responsiveness to end-users and creates obstacles to resolving functional problems.

ADAD needs technical assistance in the following areas regarding HISSAP:

- Maintaining and hosting of the system
- Providing trainings and workshops to State and provider staff to use the system
- Updating and upgrading system features to accommodate the changing needs for data and changing nature of services
- Analysis of the data collected for future planning, including funding and community needs

## IV: Narrative Plan

### R. Quality Improvement Plan

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

## R. Quality Improvement Plan

### **Substance Abuse Treatment Services**

ADAD's Continuous Quality Improvement (CQI) process for substance abuse treatment services is not contained in a specific CQI "plan." Rather, ADAD's CQI process requires ADAD's contracted treatment providers to:

1. Participate in annual program and/or clinical monitoring activities.
2. Develop a quality assurance plan that identifies the mission of the organization, the services that are provided, how the services are delivered, who is qualified to deliver them, who is eligible to receive the services, and what standards are used to assess or evaluate the quality and utilization of services.
3. Develop a grievance policy and procedure and a consumer satisfaction survey by which individuals in recovery and their families are able to give input to programmatic improvements.
4. Submit a Year-End-Program Report to summarize and analyze performance measures on a yearly basis. Providers are able to extract data from the WITS Follow-Up Report Form. Performance outcome measures are required to be administered to all ADAD admitted clients after six months from discharge. The excerpt below from RFP No. HTH. 440-12-1 outlines the quality assurance and evaluation specifications.

RFP No. HTH 440-12-1:

#### B. Management Requirements

##### 3. Quality assurance and evaluation specifications

- a. The APPLICANT shall have a quality assurance plan which identifies the mission of the organization, what services will be provided, how they are delivered, who is qualified to deliver them, who is eligible to receive the services, and what standards are used to assess or evaluate the quality and utilization of services.
- b. The quality assurance plan shall serve as procedural guidelines for staff, and will confer designated individuals and committees with the authority to fulfill their responsibilities in the areas of quality assurance.
- c. The quality assurance process shall serve as a source of information for parties interested in knowing how the program monitors and improves the quality of its services. Findings shall be integrated and reviewed by the quality assurance committee, and information shall be conveyed to the program administrator and the organization's executive officer and governing body at least semi-annually.

- d. The quality assurance system shall identify strengths and deficiencies, indicate corrective actions to be taken, validate corrections, and recognize and implement innovative, efficient, or effective methods for the purpose of overall program improvement.
  - e. Program evaluation should reflect the documentation of the achievement of the stated goals of the program using tools and measures consistent with the professional standards of the disciplines involved in the delivery of services.
4. Output and performance/outcome measurements
- a. Performance measures shall be summarized and analyzed on a yearly basis as specified in ADAD's Year-End Program Report and shall be based on the data specified below, which is, with the exception of #1, taken from the Web-Based Infrastructure for Treatment System (WITS) Follow-Up Report form. The WITS Follow-Up data is required to be administered to all ADAD clients. The APPLICANT shall set a threshold percentage of achievement for each of the following WITS data items:
    - 1) Number of clients completing treatment.
    - 2) Employment status at follow-up.
    - 3) Living arrangements at follow-up.
    - 4) Number of clients receiving substance abuse treatment since discharge.
    - 5) Number of clients currently in substance abuse treatment.
    - 6) In the past thirty (30) days, number of clients experiencing significant periods of psychological distress.
    - 7) In the past thirty (30) days, number of days of work/school missed because of drinking/drug use.
    - 8) Number of arrests since discharge.
    - 9) Number of emergency room visits since discharge.
    - 10) Number of times client has been hospitalized for medical problems since discharge.
    - 11) Frequency of use thirty (30) days prior to follow-up.
    - 12) Usual route of administration.
  - b. The APPLICANT shall collect WITS Follow-Up Data for all ADAD clients admitted to the program six (6) months after termination, regardless of the reason for discharge. Sufficient staff time shall be allocated for follow-up to ensure at least three (3) attempts to contact clients using at least two (2) different methods (e.g., mail out, telephone, face-to-face) are made, and to assure that unless the client has died or left no forwarding address they will be contacted.
  - c. APPLICANTS who contracted with ADAD during the contracting period immediately preceding this RFP are expected to report performance data on a continuous basis, e.g., follow-up data from clients served during the previous contract period should be included in the following contract year, as applicable.

## Responding to Critical Incidents, Complaints and Grievances

ADAD's Quality Assurance Improvement Office conducts investigations as described below:

When a complaint is received in writing against a counselor, investigative procedures are conducted based on the Hawaii Administrative Rules Chapter 11-177.1, Subchapter 3. The complainant may request that their identity be kept anonymous. The complaint must include the who, what, where, when, how and identify anyone else who can corroborate what has occurred. Within 15 days of receipt of the complaint, a letter must go to the respondent outlining the allegations. The respondent has 30 days from receipt to respond. Also within fifteen 15 days of receipt, a letter is sent to anyone else who has knowledge of the allegation. If further questions arise based on any of the responses, additional letters are sent from ADAD, requesting additional comment. Once all of the information is gathered, ADAD may convene a 5-person ethics advisory board to consider the information gathered and make a recommendation to the ADAD Chief about possible sanctions (from no action, to a letter of advisement, to a suspension or revocation of a counselor's certification or application for certification). The recommended action may be reviewed by a Deputy Attorney General before being issued. The notice of decision must be sent to the respondent within 30 days of the decision. Any appeal must be made to the Director or Director's designee within 45 days of receipt of the letter. If no appeal is received within 45 days, the decision becomes final.

When a complaint is received regarding an ADAD accredited agency, an investigation is conducted by performing an onsite visit to the agency, reviewing relevant documentation, and interviewing appropriate personnel. A written report, which includes an analysis and recommendations, is completed. The report is then forwarded to the ADAD Chief, with a copy to the Department of Health, Office of Health Care Assurance which is the State agency responsible for licensing treatment facilities. According to Hawaii Revised Statutes §321-16.5 and §321-16.6, the Department of Health can provide penalties for failure to comply with any rule. Depending on the outcome of the findings, recommendations may be made to change the accreditation status of the agency from full to provisional accreditation and include steps required for remediation.

## **Substance Abuse Prevention Services**

ADAD's Quality Improvement Plan (QIP) for substance abuse prevention services is stipulated in ADAD's request for proposals (RFP) and the contract awards. All contracted programs complete a Community Action Plan (CAP) describing evidence-based programs and strategies selected based on assessed needs and desired outcomes. The providers report monthly on the action plan goals and the CAP is reassessed periodically by contracted programs and ADAD staff. Providers record online the prevention services delivered and document the activities related to the chosen evidence-based programs and strategies and the unduplicated count of individuals served by each program or strategy. The reporting fields for service data include service delivered, descriptions, Institute of Medicine (IOM) prevention categories, six CSAP strategies, service date, service location, service type (single or recurring), session length, responsible staff, staff hour(s), service population, demographic breakdown, and attendance.

The monthly data report is due on the 15<sup>th</sup> of the following month. The programs also submit narrative Monthly and Year-End Reports summarizing and analyzing outcome data, accomplishments and challenges. The required program reports are accompanied by fiscal reports detailing expenditures incurred during the specific month. Monthly reports are due within 30 calendar days after the end of each month. Year-End Reports are due within 45 calendar days after the end of each state fiscal year.

## IV: Narrative Plan

### S. Suicide Prevention

#### Narrative Question:

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

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

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

#### Footnotes:

The State's suicide prevention plan is part of the "Hawai'i Injury Prevention Plan 2012-2017" produced by the Injury Prevention and Control Section of the Emergency Medical Services and Injury Prevention System Branch of the Hawaii State Department of Health, Health Resources Administration. A copy of the plan is available at <http://health.hawaii.gov/>. Click on Hawaii Injury Prevention Plan 2012-2017.

## IV: Narrative Plan

### T. Use of Technology

Narrative Question:

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

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

## T. Use of Technology

- What strategies the state has deployed to support recovery in ways that leverage ICT;

None. ADAD is monitoring the activities of the Hawaii State Office of Information Management and Technology in their effort to utilize ICT for servicing the public.

- What specific applications of ICTs the State BG plans to promote over the next two years;

At this time, ADAD does not have any plans to promote specific applications of ICT, e.g., text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, and telemedicine.

- What incentives the state is planning to put in place to encourage their use;

None, since ADAD currently has no plans for utilizing ICTs.

- What support system the State BG plans to provide to encourage their use;

None, since ADAD currently has no plans for utilizing ICTs.

- Whether there are barriers to implementing these strategies and how the State BG plans to address them;

The barriers include lack of funding and staffing to promote, deploy and support the application of ICTs and lack of knowledge on the effectiveness of specific applications of ICTs in supporting the recovery process for individuals.

- How the State BG plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;

ADAD currently has no plans, but is willing to participate in efforts with other organizations.

- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels;

ADAD currently has no plans to do this.

- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

This is not applicable, since ADAD currently has no plans to use ICTs.

## IV: Narrative Plan

### U. Technical Assistance Needs

Narrative Question:

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States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

## U. Technical Assistance Needs

### 1. What areas of technical assistance is the state currently receiving?

ADAD is currently receiving technical assistance and training related to evaluation, data collection and reporting, coalition building, workforce development, and capacity building for the substance abuse prevention service system.

### 2. What are the sources of technical assistance?

SAPT Block Grant and State funds support the technical assistance provided by various departments of the University of Hawaii and the Coalition for a Drug-Free Hawaii as well as consultants from organizations outside of the State such as the Western Center for the Application of Prevention Technologies (WestCAPT) and Community Anti-Drug Coalitions of America (CADCA).

However, the unique geography, demography and diverse cultures of Hawaii present special challenges in addressing workforce development and training priorities. It is a great expense to conduct trainings for State employees, key stakeholders, and community service providers due to the fees required by experts and trainers from other States, as well as the travel costs incurred by participants and partners from the neighbor islands. Dependence on air travel between geographically isolated islands presents a challenge to statewide project coordination, and inadequate transportation in rural areas presents a challenge to accessibility of services.

### 3. What technical assistance is most needed by state staff?

Regarding substance abuse treatment and recovery services, technical assistance needed by ADAD staff includes the following areas: evaluation of treatment cultural activities relating to efficacy while protecting the integrity of the activity; conducting a rate study; review of the WITS system in relation to State policies and procedures to determine what policy, procedural, and IT changes will be required to meet standards as set forth in the Affordable Care Act; and evaluation of ADAD's current system for measuring treatment outcomes at the client level and to develop a plan to improve on monitoring and reporting meaningful outcomes to stakeholders.

Regarding substance abuse prevention services, technical assistance needed by ADAD staff includes the following areas: development of skills to train, coach, and provide technical assistance to community-based organizations; knowledge of current research on effective, evidence-based programs and strategies; the ability to assess effectiveness of purchased services and provide follow through support for program implementation and evaluation; and developing and implementing a systematic procedure of reviewing and approving prevention programs. Additionally, ADAD staff would like to conduct another Gap Analysis to see the infrastructure and capacity improvement made/sustained over the past years since the end of the SPF-SIG. For this to happen, resources to conduct survey, qualitative interviews with stakeholders, data analysis and finally, reporting results are needed.

4. What technical assistance is most needed by behavioral health providers?

ADAD maintains open communication with substance abuse providers through a feedback system used in training programs. Participants are asked to provide their insights into their needs in providing quality care and services.

Technical assistance needed by substance abuse treatment providers include the following areas: clinical skills development or implementation of treatment modalities; training to improve effectiveness of clinical supervision; continuing improvement in the process of recovery, integrating behavioral health needs and vocational services for clients; continuing services for electronic medical records and process improvement for administrative functions.

Regarding technical assistance needed by substance abuse prevention providers, during the evaluation of the SPF-SIG implementation from 2010-2012, it was determined that a lack of familiarity and training with evidence-based programs led providers to select programs based on superficial understanding of their characteristics or presence on a particular list and not necessarily programs that could best serve their clients. Therefore, technical assistance for providers to become more experienced with the Logic Model approach to planning and implementing prevention services would be beneficial.

Also, survey responses from training conducted in 2012 indicated that providers are interested in more in-depth assistance on using secondary data and primary data, data collection, and analysis methods. The majority of both treatment and prevention respondents listed training in process and outcome evaluation as high priority as well as training on needs assessment and the process of establishing their program as an evidence-based program.

## IV: Narrative Plan

### V. Support of State Partners

#### Narrative Question:

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The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.<sup>45</sup> This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

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<sup>45</sup> SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

#### Footnotes:

1. Since SAMHSA did not require the State to obtain letters of support or memoranda of understanding from other government agencies for this SAPT Block Grant application plan, none were solicited.

## V. Support of State Partners

ADAD has developed strategic partnerships with key government agencies through various service contracts as well as through participation on various State initiatives. They include the following:

### The State Medicaid Agency - Department of Human Services, Med-QUEST Division

The Department of Human Services, Med-QUEST Division administers the State Medicaid Program. ADAD meets with and maintains communications with the Med-QUEST Division regarding their plans, changes and limits, and the implementation of the Affordable Health Care Act, especially issues affecting the provision and utilization of substance abuse treatment services.

### The State Justice System

Hawaii's criminal justice system is comprised of two major components: the State Judiciary that is responsible for the population of individuals under court supervision (i.e. probation, conditional release, and drug courts) and the Department of Public Safety and the Hawaii Paroling Authority which are responsible for the populations on supervised release, in transition from incarceration, and on parole. Through collaboration with the Judiciary and the Department of Public Safety and the Hawaii Paroling Authority, ADAD has contracts with providers to provide integrated case management (ICM) and substance abuse treatment services for offenders on supervised release, furlough, probation or parole. For a description of these State-funded services, please refer to Sec. I-Justice in this application. In addition, ADAD is an active participant of the Clean and Sober Homes and Halfway Houses Task Force convened by the Director of Health in response to State legislation to assist adult offenders in preparing for release and reintegration back to the community. ADAD is also an active participant in the Hawaii Interagency Council on Homelessness convened by Hawaii's Governor.

### The State Department of Education

ADAD provides contracted school-based outpatient substance abuse treatment to middle school and high school age adolescents statewide. ADAD had offered this level of substance abuse treatment to all middle and high schools in the State including Charter and Hawaiian Immersion schools, and all but one high school accepted. Recovery support services such as transportation and translation services have recently been included to the continuum of care. ADAD and its contracted providers work closely with the Department of Education personnel to ensure that all students being referred to treatment are being supported not only for their substance abuse treatment needs but in a well-rounded support network to ensure success in school. In addition to serving children in the school setting, ADAD continues to provide contracted substance abuse treatment services to adolescents in the community-based setting. This service consists of intensive outpatient, outpatient, and early intervention services for middle and high school aged adolescents. State funds are used to support these school-based and community-based treatment services for adolescents.

## The State Child Welfare/Human Services Department

ADAD's contracted substance abuse treatment services for pregnant women and women with dependent children include working with women who have active cases with the Child Welfare Services (CWS) of the Department of Human Services. Substance abuse treatment providers are required to consult with CWS and document goals and objectives for the child and parent while in treatment. ADAD also contracts with the Judiciary Family Court of the First Circuit for Family Drug Court services for pregnant women and women with dependent children whose children are placed at risk by parental involvement in substance abuse and who also have open cases with CWS. The Family Drug Court program provides intensive family case management services through substance abuse treatment matching and coordination of the entire system of care between treatment and the Family Court.

## State Partnerships Regarding Epidemiology Data and Substance Abuse Prevention

The Office of Public Health Studies at the University of Hawaii Department of Public Health Sciences, supported with funds from ADAD, provides technical assistance in the area of data trend analysis, data infrastructure tracking and monitoring, and technical support to assist ADAD in its Strategic Prevention Framework efforts. The Office of Public Health Studies also supports the Hawaii State Epidemiological Workgroup (SEOW). The Workgroup is comprised of voluntary members, primarily directors, epidemiologists or data managers, from government, educational and community agencies involved in research or data collection. The primary function of the SEOW is to confirm the science of the methods used in data collection as well as to review and assess outcome measures related to substance abuse.

ADAD is a member of the Hawaii Student Health Survey Committee, which includes other Department of Health programs, the DOE, and consultants from the University of Hawaii. Due to the DOE's requirements for the Youth Risk Behavioral Survey (YRBS), Youth Tobacco Survey (YTS), and the Student Alcohol, Tobacco, and Other Drug Use Survey to be administered jointly, and the need to obtain parental consent for middle and high school students to participate in such surveys, the Hawaii Student Health Survey Committee developed an integrated survey for the 2011 administration of the YRBS which combined items from each of the three former surveys. This interagency collaboration has continued to complete the administration of the 2013 YRBS and plan for future years.

## IV: Narrative Plan

### W. State Behavioral Health Advisory Council

#### Narrative Question:

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Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

#### Footnotes:

## W. State Behavioral Health Advisory Council

SAMHSA's requirement for a State advisory council for services for individuals with a mental disorder does not apply to the SAPT Block Grant. The State Council on Mental Health (SCMH) is a requirement for the Center for Mental Health Services (CMHS) Block Grant which provides funds for the Adult Mental Health Division and Child and Adolescent Mental Health Division of the Department of Health. For a description and the composition of the SCMH, please refer to the 2014-2015 Mental Health Block Grant Application Plan.

The Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS), which is a Governor-appointed board, advises the Governor, the Director of Health and other State departments on matters relating to substance abuse prevention, treatment and enforcement. Commission membership consists of representatives from pharmacology, medicine, community and business affairs, youth action, education, legal defense, enforcement and the corrections segments of the community. One of the members appointed to HACDACS, who must be knowledgeable about the community and the relationships between mental health, mental illness and substance abuse, is jointly appointed to the SCMH (see HRS §329-2). In addition, the Department of Health's Deputy Director of Behavioral Health Administration serves as an ex-officio, non-voting representative to both HACDACS and the SCMH.

## IV: Narrative Plan

### Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

#### Footnotes:

1. SAMHSA's requirement for a State advisory council for services for individuals with a mental disorder does not apply to the SAPT Block Grant. The State Council on Mental Health (SCMH) is a requirement for the Center for Mental Health Services (CMHS) Block Grant which provides funds for the Adult Mental Health Division and Child and Adolescent Mental Health Division of the Department of Health. For a description and the composition of the SCMH, please refer to the 2014-2015 Mental Health Block Grant Application Plan.

## IV: Narrative Plan

### Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)	<input type="text"/>	
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies	<input type="text"/>	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text"/>	

\* 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?

#### Footnotes:

1. SAMHSA's requirement for a State advisory council for services for individuals with a mental disorder does not apply to the SAPT Block Grant. The State Council on Mental Health (SCMH) is a requirement for the Center for Mental Health Services (CMHS) Block Grant which provides funds for the Adult Mental Health Division and Child and Adolescent Mental Health Division of the Department of Health. For a description and the composition of the SCMH, please refer to the 2014-2015 Mental Health Block Grant Application Plan.

## IV: Narrative Plan

### X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

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Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

## X. Enrollment and Provider Business Practices Including Billing Systems

If/when Congress approves SAMHSA's proposal to require States to set aside a minimum of 3% of their Block Grant allotment to assist providers in improving their enrollment, billing, and business practices, ADAD will allocate funds accordingly. ADAD already uses Block Grant funds for the continued development and enhancement of the WITS system, an electronic health record and contract billing system.

ADAD's information technology strategy for supporting its contracted substance abuse treatment providers is to design, develop, implement, enhance, and maintain a fully operational electronic health record and billing system that is:

- (1) HIPAA compliant;
- (2) 42 CFR, Part 2 compliant;
- (3) Capable of electronically billing any government or private payer;
- (4) Capable of providing standard and ad hoc reports; and
- (5) Meaningful Use compliant.

- Outreach and enrollment support for individuals in need of behavioral health services.

There are no current plans to use Block Grant funds for outreach and enrollment support into health insurance.

- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.

As funds become available, WITS will be enhanced to support the Meaningful Use provisions of the Affordable Care Act. WITS is currently Meaningful Use Phase 1 module certified.

- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.

WITS is already an accounts receivable system for providers' contracts with ADAD and an accounts payable system for ADAD. WITS can match payment to claims, do account aging, and compliance monitoring through its reporting systems. Future plans include enhancing WITS to allow providers to electronically bill other State and local government agencies, Medicaid, and commercial payers. Once this enhancement is completed, providers will be able to monitor their accounts receivable for all government and third party payers. WITS will also be upgraded to comply with the International Classification of Diseases, Tenth Revision (ICD-10) and Current Procedural Terminology (CPT) code add-ons for billing.

- Third-party contract negotiation.

Currently, each provider negotiates their own third party contract(s).

- Coordination of benefits among multiple funding sources.

The third party billing enhancement to WITS will enable coordination of benefits among third party payers.

- Adoption of health information technology that meets meaningful use standards.

As stated above, WITS will be enhanced as funds become available to support the Meaningful Use provisions of the Affordable Care Act. WITS is currently Meaningful Use Phase 1 module certified.

## IV: Narrative Plan

### Y. Comment on the State BG Plan

Narrative Question:

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Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

## Y. Comment on the State Block Grant Plan

ADAD facilitates public and community input and comment through several mechanisms. Periodic meetings are convened with administrators and staff of the community-based organizations contracted by ADAD. ADAD provides information and solicits input on plans, policies, SAPT Block Grant and State funding, and other issues that affect the service providers. ADAD also receives input on service utilization, operational needs, problems and concerns. Information from service providers is used in the development of ADAD's plans for the use and allocation of Block Grant funds.

ADAD actively participates in many interagency coalitions, task forces, committees and work groups comprised of government and community-based organizations. These activities help to facilitate public input, ensure ongoing identification of community needs and resources, coordinate substance abuse plans and services, and guide allocation of funds.

In planning and contracting for services, ADAD follows State laws, regulations and procedures, i.e., Hawaii Revised Statutes (HRS), Chapter 103F and implementing administrative rules, that govern the basic planning, procuring and contracting of health and human services by State agencies. The objective is to ensure the fair and equitable treatment of all service providers delivering health and human services on behalf of State agencies by using a standardized procurement process and by optimizing information-sharing, planning and service delivery efforts. The State Procurement Office, which is within the Department of Accounting and General Services, serves as the central authority on State procurement statutes and rules. Community input is an integral part of the planning and procurement process. Prior to issuing an RFP, State agencies must issue a request for information (RFI) to obtain community input on the services being planned for procurement. A Governor-appointed Community Council advises or assists the administrator of the State Procurement Office. The Council's duties include securing input from providers and facilitating provider participation in the process used by State agencies to assess needs, plan, budget and purchase health and human services.

During this application planning period of July 1, 2013 to June 30, 2015 (as described in Step 2 of this application), ADAD is currently using the FFY 2013 SAPT Block during the first year of ADAD's new four-year contract period for substance abuse treatment and recovery support services and also to help maintain the second year of contracts for substance abuse prevention services. Then from July 1, 2014 to June 30, 2015, the FFY 2014 SAPT Block Grant will be used to cover the second contract year for treatment and recovery support services and third-year extensions of prevention service contracts.

This 2014-2015 SAPT Block Grant application plan was made available at <http://health.hawaii.gov/substance-abuse/survey/> for public review and comment. The notice for solicitation of public comment was published in September 2013 in the *Honolulu Star-Advertiser*, *Hawaii Tribune-Herald*, *West Hawaii Today*, *The Maui News*, and *The Garden Island*, in accordance with State publication requirements for statewide public notices. These five newspapers together cover all four of Hawaii's counties.

## I: State Information

### Assurance - Non-Construction Programs

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

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

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

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

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

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

Name: Loretta J. Fuddy  
 Title: Director of Health  
 Organization: Hawaii State Department of Health

Signature:  Date: 9/26/13

Footnotes:

# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

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

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

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

### 3. Certifications Regarding Lobbying

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

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

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

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

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

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

### 5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	Loretta J. Fudd
Title	Director of Health
Organization	Hawaii State Department of Health

Signature:  Date: 9/26/13

#### Footnotes:



## I: State Information

### Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3) - Fiscal Year 2014

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

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

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

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

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

Name of Chief Executive Officer (CEO) or Designee:   
 Title:

Signature of CEO or Designee<sup>1</sup>:  Date: 9/26/13

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

**Footnotes:**



**cc COPY**

**EXECUTIVE CHAMBERS  
HONOLULU**

**NEIL ABERCROMBIE  
GOVERNOR**

**April 28, 2011**

**TO: Loretta J. Fuddy, A.C.S.W., M.P.H.  
Director of Health**

**SUBJECT: Designation of Signature Authority to the Director of Health for the Annual  
Substance Abuse Prevention and Treatment Block Grant Application**

The Director of the Department of Health is hereby designated as the State of Hawaii's signature authority for the Substance Abuse Prevention and Treatment (SAPT) Block Grant Uniform Application that is submitted annually to the Substance Abuse and Mental Health Services Administration. The Director of Health is hereby authorized to sign all Funding Agreements, Certifications and Assurances that must be signed and submitted for the annual SAPT Block Grant Application, annual Synar Report, and related documents. This designation will remain in effect until such time as it may be rescinded.

**NEIL ABERCROMBIE  
Governor, State of Hawaii**