Hawaii

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

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 03/17/2016 7.03.29 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

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	Dixie
Last Name	Thompson
Agency Name	Department of Health, 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	dixie.thompson@doh.hawaii.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	9/30/2015 11:44:29 PM
Revision Date	3/17/2016 7:02:42 PM

V. Contact Person Responsible for Application Submission

First Name	Jan
Last Name	Nishimura
Telephone	808-692-7513
Fax	808-692-7521
Email Address	jan.nishimura@doh.hawaii.gov

Footnotes:

1. Contact Person for the Grantee of the Block Grant is Alcohol and Drug Abuse Division (ADAD) Division Chief who also functions as the Single State Agency (SSA) Director. Position has been vacant since mid-September 2014. Temporary assignment to Dixie Thompson.

2. Person Responsible for Substance Abuse Information Relating to Treatment:

Name: Wendy Nihoa
Telephone: (808) 692-7523
Email: wendy.nihoa@doh.hawaii.gov

3. Person Responsible for Substance Abuse Information Relating to Prevention:

Name: Dixie Thompson
Telephone: (808) 692-7510
Email: dixie.thompson@doh.hawaii.gov

4. Written comments on the FFY 2016-2017 Substance Abuse Prevention and Treatment Block Grant Application Plan may be submitted to the Department of Health, Alcohol and Drug Abuse Division, 601 Kamokila Blvd., Rm. 360, Kapolei, HI 96707, Attention: Block Grant Application.

State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1928	Additional Agreements	42 USC § 300x-28
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Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
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Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to 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.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Director of Health

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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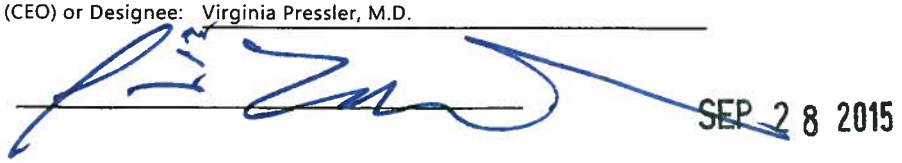
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, an summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the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

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

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

Signature of CEO or Designee[1]: 

Date Signed: SEP 28 2015

Title: Director of Health

mm/dd/yyyy

EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

April 9, 2015

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

SUBJECT: Designation of Signature Authority to the Director of Health for the Substance Abuse Prevention and Treatment Block Grant Application, Annual Synar Report and Related Documents

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 Block Grant (SABG) Application, Annual Synar Report and related documents that are submitted 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 much be signed and submitted for the SABG Application, Annual Synar Report and related documents. This designation will remain in effect until such time as it may be rescinded.

DAVID Y. IGE
Governor, State of Hawai'i

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

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

In reply, please refer to:
File:

May 14, 2015

MEMORANDUM

TO: Keith Y. Yamamoto
Deputy Director of Health

Lynn N. Fallin
Deputy Director of Behavioral Health Administration

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

SUBJECT: Designation of Alternate Signature Authority for the Substance Abuse Prevention and Treatment Block Grant Application, Annual Synar Report, and Related Documents

Governor David Ige designated signature authority to me, as the Director of the Department of Health (DOH), for the Substance Abuse Prevention and Treatment Block Grant (SABG) Application, Synar Report and related documents required for the SABG. In case of my absence and unavailability, the Deputy Director of Health, who is the DOH second in command, is authorized to sign all Funding Agreements, Certifications and Assurances for the SABG Application, Synar Report, and related documents. If the Deputy Director of Health and I are both absent and unavailable, then the Deputy Director of Behavioral Health Administration (BHA) is authorized to sign all Funding Agreements, Certifications and Assurances for the SABG Application, Synar Report, and related documents because the Alcohol and Drug Abuse Division is directly under the BHA Deputy Director.

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

1. This 2016-2017 Block Grant Application Plan is for the Substance Abuse Prevention and Treatment Block Grant (SABG) and provides information on the substance abuse treatment and prevention systems. For information on the mental health services system, please refer to the Center for Mental Health Services Block Grant (MHBG) Application Plan.

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 Block Grant (SABG) 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 with which 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 economic recession and previous State budget deficits resulted in significant statewide budget cuts and required reductions in State funding for contracted services and loss of positions. 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 69.9 percent of the State's population of 1,419,561 as of July 1, 2014, 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 13.7 percent, Maui County has 11.5 percent, and Kauai County has 5.0 percent. Also, according to the Census Bureau, 77.0 percent of Hawaii's

population is comprised of minorities (race and ethnicity other than non-Hispanic White race only) and 23.0 percent of Hawaii's population is of mixed race.

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 SABG 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.

For information on specialized services for pregnant women and women with dependent children, please see Sec. 19-Pregnant Women and Women with Dependent Children in this application.

Injection drug users (IDUs) are provided with specialized services through ADAD's contracted opioid addiction recovery services program that includes outreach services to encourage IDUs to utilize the program's treatment services and to accept referrals and linkages to appropriate resources in the community. All ADAD-funded treatment programs are contractually required to comply with ADAD's Wait List Management and Interim Services Policy and Procedures that include service provisions for IDUs. If an ADAD-funded treatment program does not have the capacity to admit an IDU to treatment within 14 days of the initial request for treatment, the program must refer the individual to another treatment program that can admit the wait-listed

individual to treatment within 14 days. If no treatment program has the capacity to admit the IDU within 14 days, then the program must provide interim services within 48 hours, or refer the IDU to the ADAD-designated Opioid Therapy Outpatient Treatment Program to receive interim services. IDU clients in interim services must be admitted to treatment within 120 days of the initial request for treatment.

All ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of Public Law (P.L.) 102-321, to routinely make available tuberculosis (TB) services to all their clients either directly or through arrangements with public or nonprofit agencies. If the substance abuse treatment program is unable to accept a person requesting TB services, the program shall refer the person to a provider of TB services. TB services include but are not limited to the following: counseling; testing to determine whether the individual has contracted TB and to determine the appropriate form of treatment; and treatment. The Department of Health's Communicable Disease Division, Tuberculosis Control Branch provides needed TB services to ADAD clients in treatment for substance abuse.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment's (CSAT) list of "designated states" for the Federal fiscal year (FFY) 2016 SABG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000 population. (See 42 USC §300x-24(b) and 45 CFR §96.128). 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 SABG award for HIV early intervention services. This option does not apply to Hawaii since Hawaii was not "designated" within the last three years. Thus, no SABG 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.

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 Hawaii Pathways Project (HPP) provides supportive housing services to chronically homeless individuals, including homeless veterans on Oahu, with substance use disorders, co-occurring substance use and mental health disorders, or serious mental illnesses (SMI). Services include assertive outreach, case management, and treatment services. HPP is based on the Pathways Housing First model, the only evidence-based program recognized by the national Registry of Evidence-Based Programs and Practices that provides comprehensive housing and treatment services without preconditions of the individual's alcohol or drug use. HPP has four goals: (1) individuals served will live in sustainable, permanent housing; (2) individuals will receive Medicaid and other mainstream entitlements; (3) the project will provide community-based evidence-based treatment for substance use and psychiatric disorders that is client driven

and recovery oriented; and (4) the project will provide a range of recovery resources and supports including peer navigation and peer support. ADAD is receiving funding for HPP from CSAT's Cooperative Agreement to Benefit Homeless Individuals for States (CABHI-States) for three years through September 29, 2016.

Substance Abuse Prevention Services

ADAD's prevention service system focuses 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. 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.

In accordance with State procurement procedures and requirements, ADAD conducts request for information (RFI) sessions to obtain community input related to existing substance abuse prevention issues and priorities, the need for related prevention services, and the community capacity to address the needs and provide the prevention services that ADAD intends to procure. Topics of the RFI include identifying at-risk populations, target services, definitions of community, assessment of local capacity, and potential partnerships and collaboration efforts related to proposed service needs.

In addition to the information gathered from community members and stakeholders, ADAD utilizes primary national and state-level data sources and secondary data sources to determine needs and capacity. Further information to inform the development of substance abuse prevention service requests and identify strengths and challenges of the prevention infrastructure in each of the counties is obtained from the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) evaluation reports completed in 2012 and 2013 and the most recent Hawaii epidemiological profiles for each of Hawaii's four counties. Such reports and profiles are available at http://health.hawaii.gov/substance-abuse/survey/.

ADAD-contracted substance abuse prevention programs, funded by Block Grant or State funds, have been focusing on the provision of evidence-based curricula, programs, practices and strategies targeting at-risk youth and their families. Current services and programs 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 continues to support the Prevention Resource Center (PRC), Hawaii's Regional Alcohol and Drug Awareness Resource (RADAR) Center, which houses Hawaii's most comprehensive resources on drug abuse, prevention, and related substance abuse issues available through its

lending library, resource clearinghouse, and technical assistance services. Information from the PRC is available at http://www.drugfreehawaii.org/index.php/PRC.
To reduce youth access to tobacco products, ADAD focuses on implementing and maintaining compliance with SABG requirements for the Synar Program (42 USC 300x-26 and 45 CFR 96.130 (e)). ADAD's Annual Synar Report is available at http://health.hawaii.gov/substance-abuse/survey/. Also, 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 inspections of retail outlets throughout the State using FDA Commissioned Officers and underage volunteers in controlled, observed undercover buy operations.

To support and strengthen the prevention system and improve Hawaii's prevention data collection and management system, ADAD contracted with the University of Hawaii to provide technical assistance for customizing Knowledge-Based Information Technology (KIT) Solutions based management information system to replace the Center for Substance Abuse Prevention (CSAP's) Minimum Data Set (MDS) 4 System software. ADAD named this system the Hawaii Information System for Substance Abuse Prevention (HISSAP) which is used to obtain data from Block Grant funded prevention programs on types of services and activities conducted and information on service populations. ADAD's contracted prevention providers piloted HISSAP in July 2010 and started utilizing a second, refined version of HISSAP in July 2013. Since ADAD does not have assigned staff with expertise in the area of prevention data collection systems and technology, ADAD is dependent on consultants for technical assistance related to the development, maintenance, and sustaining of HISSAP and must also rely on available secondary data sources and contracted service providers to identify needs and gaps.

ADAD collaborates with other Department of Health programs, the Hawaii State Department of Education (DOE), and consultants from the University of Hawaii to develop and administer a student survey to assess youth risk behaviors. Due to the 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, an integrated survey which combines items from each of the three former surveys is developed and administered in partnership with those agencies that have a stake in the survey results.

For further information on ADAD's prevention services and activities, please see Sec. 9-Primary Prevention for Substance Abuse in this application.

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/. Hawaii is a member board of the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC/AODA). The IC&RC is a voluntary international organization comprised of substance abuse credentialing boards representing 43 states, the U.S. military, various Indian Health Service Organizations, U.S. territories, and a range of countries. As a member board, Hawaii subscribes to the international standards prescribed by the IC&RC and published in the IC&RC guidelines (website: http://internationalcredentialing.org). Counselors certified in Hawaii have reciprocity with other IC&RC member boards, providing the other member board offers a similar type credential.

ADAD provides numerous training and educational opportunities annually for those obtaining an initial credential, and for those renewing their credentials, required bi-annually. ADAD also collaborates with other organizations and service professionals to provide trainings which have been approved for contact hours that may be applied towards meeting the educational requirements for certification and renewal.

Planning Steps

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

Narrative Question:

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

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

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

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

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

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

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 Request for Information (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 SABG 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 maintaining 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

ADAD is currently in the middle of its four-year contract period for treatment and recovery support services from July 1, 2013 to June 30, 2017. The SABG application planning period of July 1, 2015 to June 30, 2017, covers the third and fourth year of ADAD's current four-year contracts for treatment and recovery support services. The Federal fiscal (FFY) 2015 SABG

award is being utilized to support the third year of ADAD's current four-year contracts. The FFY 2016 SABG will be utilized to continue the treatment and recovery support services provided by ADAD's current contracted providers during the fourth and last year of the current contract period, i.e., State fiscal year (SFY) 2017 (July 1, 2016-June 30, 2017). This helps to maintain continuity and provide stability for service providers and clients especially during recent years of uncertain funding on the Federal and State levels. Contract modifications, in accordance with the State procurement process, are executed throughout the contract period to adjust funding levels of contracts based on availability of SABG and State funds, service needs, and providers' utilization of funds.

The planning process for the current four-year contract period followed State procurement requirements and procedures which preceded the first year of the contract period, i.e., SFY 2014 (July 1, 2013-June 30, 2014). Planning activities for ADAD's 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. ADAD utilized information from RFI sessions and various data sources to identify unmet needs and critical gaps within the Hawaii treatment infrastructure.

The following is a description of data sources that were used in planning for substance abuse treatment and recovery services by types of service populations funded by the SABG and/or State funds for the current four-year contact period from July 1, 2013 to June 30, 2017.

Adult Population: In planning for substance abuse treatment and recovery support services for the adult population, 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 is exploring 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.

The University of Hawaii Center on the Family, under a contract from ADAD, recently produced the report "Alcohol and Drug Treatment Services Report: Hawai`i, 5-Year Trends (2010-2014)." The report focuses on substance abuse treatment services provided by agencies that were funded by ADAD during State fiscal years 2010 to 2014. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents 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. The report is available at http://health.hawaii.gov/substance-abuse/files/2015/09/ADTreatmentServices2014.pdf.

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 data from ADAD's Web Infrastructure for Treatment Services (WITS) system, an electronic health record and billing system for ADAD-contracted substance abuse treatment and recovery service providers. 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), data for SFY 2012 from WITS was available. 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 continue to be supported by both SABG and State funds. ADAD's current four-year contracts 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 2016 SABG, 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 SABG 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.

The application period of July 1, 2015 to June 30, 2017, also covers the planning period for ADAD's upcoming four-year contract period for treatment and recovery support services from July 1, 2017 to June 30, 2021. Planning and information gathering activities have already begun for the development of the next set of RFPs for adult and adolescent substance abuse treatment services. RFI meetings were recently conducted and/or scheduled throughout September 2015 on the islands of Oahu, Kauai, Maui, Hawaii (in Kona and Hilo), Lanai, and Molokai to obtain community input on services needed. ADAD plans to publish the next set of RFPs in the fall of 2016 for new contracts to begin July 1, 2017. The most recent data and pertinent information available from local, State and national data sources will be utilized to inform the next set of

RFPs to address community needs and gaps for the treatment and recovery support service system.

Substance Abuse Prevention Services

During this SABG application planning period of July 1, 2015 to June 30, 2017, ADAD is using FFY 2015 SABG and State funds to support the fourth and last year of current four-year prevention contracts during SFY 2016 (July 1, 2015 to June 30, 2016). Current 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 FFY 2016 SABG award, in accordance with State procurement procedures and requirements, will be used to support new contracts at the start of SFY 2017 (July 1, 2016 to June 30, 2017). As described earlier, the typical service contract is four years. 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.

Planning for procurement of prevention services includes ADAD conducting RFI sessions to gather provider and community input related to service gaps and needed services. In addition, ADAD utilizes data from primary data sources which include the Hawaii Youth Risk Behavior Survey (YRBS), Hawaii Behavioral Risk Factor Surveillance System (BRFSS), and the National Survey on Drug Use and Health (NSDUH). These data sources inform the community profiles developed by the State Epidemiological Outcomes Workgroup (SEOW) and the ADAD Epidemiological (EPI) Team described below. For current contracted services, ADAD obtained information from the "Hawaii Strategic Prevention Framework-State Incentive Grant (SPF-SIG) Infrastructure and Capacity Assessment Results-Final Analysis," "Hawaii Epidemiological Profiles for Substance Abuse Prevention," and "Epidemiological Profile of Alcohol Related Behaviors among Youth," as well as updated versions for each of Hawaii's four county profiles which provide information on the strengths and challenges of the prevention infrastructure in each of the counties. State reports and current profiles are available at http://health.hawaii.gov/substance-abuse/survey/ and http://health.hawaii.gov/substance-abuse/survey/hiepi-profile2014/

Broad based agreement among those involved in the alcohol, tobacco and other drug use prevention efforts in Hawaii is that families, schools, and communities can be safe and drug-free. The preferred strategies to achieve that goal are to increase protective factors and decrease risk factors and build community capacity to address substance abuse issues and make social changes locally. Underage alcohol consumption and marijuana use have been identified as the continuing issues to be addressed along with a growing misuse of prescription drugs in some communities for some populations. Stakeholders have recommended the need to start prevention programs at earlier stages of adolescence to achieve a decline in alcohol prevalence among youth in the higher grades and delay the first initiation of alcohol use for youth. Community feedback and data sources indicate ethnic differences and the need for culturally appropriate and evidenced-based programs for the highest rate groups such as Native Hawaiians and Caucasians. Among Asian ethnicity groups, Filipino adolescents have rates as high as Caucasians or Native Hawaiians for some of the indicators, signaling a growing need for prevention efforts targeting

this population in particular. The involvement of community coalitions and families in substance abuse prevention efforts has also been an identified needed service component.

As described earlier, 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 is often too small to yield meaningful data, particularly at the substate or community level, or Hawaii may be totally excluded from a survey. For any data source that has alcohol use indicators, it is important to collect data from a larger sample size in order to be able to report data by detailed ethnic groups instead of using aggregated ethnicity categories such as "Asian" or "Native Hawaiian and Pacific Islanders." This is especially crucial for communities in Hawaii which are ethnically and culturally diverse, as detailed ethnicity data will help guide the design and implementation of policies and intervention programs that better address health disparities and health needs for specific ethnic groups. In current 2013 data, the BRFSS has only a few indicators about alcohol consumption: alcohol use in the past 30 days, heavy drinking (having more than two drinks per day) in the past 30 days, and binge drinking (having 5 or more drinks for men or 4 or more drinks for women on an occasion) in the past 30 days. Alcohol indicators from SAMHSA's National Outcome Measures (NOMs), such as age at first use, perceived risk of harm of use, disapproval of substance use, and driving while under the influence of alcohol, would be especially important additions to the survey.

Additionally, alcohol and substance use prevalence and behaviors particularly among college students are unclear since there is a data gap for the college-age population (typically 18 to 24 years). Although the Hawaii BRFSS and the NSDUH collect data from people aged 18 and older or 12 or older respectively, they do not collect data specifically from college students. While NSDUH data can be analyzed by college-aged individuals (for example, age from 18 to 24), the population includes all individuals in this age range, including individuals who are currently not enrolled in a college. The University of Hawaii at Manoa campus has participated in the National College Health Assessment (NCHA) and it was administered by the Manoa Alcohol Project (MAP) in 2012; however, the data was not representative of all college students in Hawaii because only one of eighteen college and university campuses in Hawaii participated. Therefore, participating in NCHA would be recommended for all college and university campuses in Hawaii in order to gain alcohol or substance use data with good quality that is representative of college students in Hawaii. State-level data specifically among college students would be in demand in order to see prevention program needs for this population in particular. This data gap could be filled by establishing a statewide health survey for college students in which multiple campuses representing Hawaii participate in order to understand and monitor behaviors surrounding alcohol and substance use in this unique population.

State Epidemiological Workgroup

The Hawaii State Epidemiological Outcomes Workgroup (SEOW) was initiated in March 2006 under the Strategic Prevention Framework State Incentive Grant (SPF-SIG) and currently provides guidance to the ADAD Epidemiology (EPI) Team through a subcontract agreement with the University of Hawaii, Office of Public Health Studies funded by the Strategic Prevention Framework Partnerships for Success (SPF-PFS) grant. The SEOW membership is

comprised of directors, epidemiologists and data managers from the government, community, and educational institutions in Hawaii. The EPI Team facilitates the SEOW and provides technical assistance and training for the State and community level stakeholders and sub-recipients in evidence-based programs, data usage, program evaluation, grant writing, needs assessment, and other identified training needs. It is anticipated that the revived SEOW will provide additional support to inform ADAD prevention funding decisions, 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.

The SEOW determined youth prevalence related indicators as priority as well as alcohol related crime and fatalities, social connectedness and retention. The indicators considered are as follows:

- Alcohol consumed in past 30 days
- Alcohol consumed before age 13
- Alcohol 30-day binge use
- Drove after drinking
- Alcohol positive in fatal crash
- Marijuana used past 30 days
- Marijuana used before 13
- Any illicit drug consumed in past 30 days
- Perceived risk of harm of alcohol use
- Disapproval of substance use
- Family communication around substance use
- Youth seeing a prevention message

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Quality and Data Collection Readiness

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

   Web Infrastructure for Treatment Services System

   For data collection and reporting of substance abuse treatment and recovery services, ADAD uses the Web Infrastructure for Treatment Services (WITS) system. WITS is an electronic health record and billing system for ADAD-contracted substance abuse treatment and recovery service providers. WITS is used to collect information that includes demographic, assessment, admission, discharge, and followup data on clients and utilization data on ADAD-funded services. ADAD uses data from WITS to report on Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMs) required by SAMHSA. ADAD's contracted providers can run their own ad hoc reports as needed to obtain data from WITS. Each provider's ad hoc reports are restricted to their own data. Approximately 80 standard reports and an additional 800 ad hoc reports can be generated based on WITS data. WITS has over 750 users (logons) with an average of 200-300 active users per work day.

   The WITS contract billing system is used by providers to submit claims for payment of services rendered under ADAD contracts. Claims are adjudicated by ADAD fiscal staff using WITS to generate invoices. Originals and hard copies of invoices are used as source documents to process payments through the State's central payment (check writing) system. WITS is HIPAA compliant, 42 CFR Part 2 compliant (Confidentiality of Alcohol and Drug Abuse Patient Records), and Meaningful Use Phase I module certified. ADAD is a member of the WITS Collaborative Partnership comprised of over 30 states and local governments to facilitate cost sharing and enhancements.

   ADAD relies on two positions contracted through the University of Hawaii (UH) to oversee the maintenance, functionality, and ongoing enhancements of WITS, conduct trainings for ADAD staff and providers on system use and data management, and provide help desk support to providers. ADAD has a separate contract with FEI.com, Inc., to support and maintain WITS system software and network infrastructure, third-party billing functionality, and ad hoc reporting system, as well as to analyze, design, develop, and implement enhancements requested by ADAD.

   Hawaii Information System for Substance Abuse Prevention

   As initially described under Step 1 regarding prevention services, 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. 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. 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.

For SFY 2016, ADAD has continued to contract with UH to maintain HISSAP and plan for transition for SFY 2017 data collection. The UH in turn has subcontracted with MOSAIX SOFTWARE Solutions, LLC to implement the system. UH manages the design and overall maintenance of HISSAP which is hosted by MOSAIX SOFTWARE Solutions. All communication and direct contact with MOSAIX SOFTWARE Solutions regarding HISSAP is conducted by UH.

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 MOSAIX SOFTWARE Solution regarding any system questions. The future plan for the system is to add capacity to provide client level data in the following areas:

- Outcomes for the services provided
- Evaluation of the services
- Performance of each individual client
- Feedback from the participants regarding services and their impacts
- Analysis of the client data collected

Since ADAD's current contract with UH to maintain HISSAP ends July 31, 2016, it is currently uncertain how HISSAP will be maintained after the contract ends. Thus, ADAD is conducting planning and information gathering, following the State procurement process, to pursue a data collection service.

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

The WITS system and HISSAP are specific to substance abuse services. Data are collected from ADAD-contracted service providers.

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

   Using the WITS system, ADAD is currently able to collect data on the draft measures at the individual client level (without client-identifying information) and report aggregated data regarding employment (full and part-time), number of arrests in the past 30 days at admission and discharge, and current living situation which includes homelessness (not in past 30 days).

   SAMHSA's proposed measures for primary prevention will not be client-level, but will continue to be population-level measures. Reporting on population-level measures will primarily depend on state-level data available from national data sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH).

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

   In order to be able to collect and report on client-level measures not currently collected, additional resources and sufficient time will be needed to implement changes to the WITS system. Will SAMHSA provide additional funds to collect and report on new measures? ADAD needs to know this before it can proceed. SAMHSA must provide the technical specifications on new measures, including what questions need to be asked and what responses will be valid for reporting purposes. The process to implement changes to the WITS system in order to be able to collect and report on new measures includes working collaboratively with ADAD's contracted providers to ensure that they understand the changes. This includes understanding how the measures will affect their operations, how they can use the data collected, and when the data collection changes are scheduled to occur.

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

Technical assistance (TA) needs related to this section include: continued maintenance and hosting of the WITS system and HISSAP including system software, network infrastructure and system upgrades; development of training materials and documentation on system use; conducting trainings for ADAD staff and providers on system use including data entry, data management and reporting; analysis, design, development and implementation of system enhancements that include collection and reporting of new measures; help desk support; and analyses of client and service data to support program planning, monitoring, and allocation of resources.

ADAD appreciates the recent CSAT-funded TA that provided information to ADAD staff and treatment providers on research considerations in treatment assessment and planning. ADAD is in need of continued TA and training for ADAD staff and providers to improve ADAD's data collection and monitoring systems regarding treatment outcomes measures.

Planning Tables

Table 1 Priority Areas 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 provide services for children of pregnant women and women with dependent children (PWWDC) with substance abuse treatment needs up to twelve (12) years of age.

Objective:

To maintain service contracts 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 objective:

Scope of services for PWWDC contracts for the remaining two-years (July 1, 2015-June 30, 2017) of the current four-year (July 1, 2013-June 30, 2017) contract period to include treatment and supportive services for children up to twelve (12) years of age with substance abuse treatment needs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Execution of PWWDC contracts with a scope of service to include a provision for treatment and supportive services for children up to the age of twelve (12).
Baseline Measurement:	Effective July 1, 2013, there was at least one (1) contract executed in each of Hawaii's four counties (Oahu, Maui, Kauai and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance abuse treatment needs.
First-year target/outcome measurement:	Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance abuse treatment needs in SFY 2016.
Second-year target/outcome measurement:	Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Oahu, Maui, Kauai and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance abuse treatment needs in SFY 2017.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS – Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08) – Recitals
6. AG Form 103F7 (10/08) – Provider's Acknowledgement
7. Scope of Services
8. AG Form 103F11 (10/08) – Time of Performance
9. AG Form 103F12 (10/08) – Compensation and Payment Schedule
10. AG Form 103F8 (9/08) – Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) – Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) – General Conditions for Health & Human Services Contracts

13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)
Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgement (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment or Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures::

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 2

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

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

To maintain enhanced services for opioid injection/intravenous drug users (IDUs). Enhanced services include a broad spectrum of treatment options for opioid addiction.

Objective:

To maintain service contracts for enhanced opioid services for IDUs.

Strategies to attain the objective:

Scope of services for opioid service contracts for the remaining two-years (July 1, 2015-June 30, 2017) of the current four-year contract (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 contracts with a scope of service to include a provision which expands IDU services by reducing the severity and disabling effects related to opioid addiction services by broadening the spectrum of treatment options to best meet the needs of opioid users.

Baseline Measurement: Effective July 1, 2013, there was at least one (1) contract executed to provide statewide enhanced services for IDUs.

First-year target/outcome measurement: Maintain a minimum of one (1) contract to provide enhanced services for IDUs in SFY 2016.

Second-year target/outcome measurement: Maintain a minimum of one (1) contract to provide enhanced services for IDUs in SFY 2017.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS – Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08) – Recitals
6. AG Form 103F7 (10/08) – Provider's Acknowledgement
7. Scope of Services
8. AG Form 103F11 (10/08) – Time of Performance
9. AG Form 103F12 (10/08) – Compensation and Payment Schedule
10. AG Form 103F8 (9/08) – Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) – Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) – General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)
Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgement (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment or Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures::

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 3

Priority Area: Recovery Support Services

Priority Type: SAT

Population(s): PWWDC, IVDUs, Other (Other Adults)

Goal of the priority area:

To provide recovery support services to include transportation and translation for adults, PWWDC, and IDUs with substance abuse treatment needs.

Objective:

To maintain service contracts for recovery support services to include transportation and translation for adults, PWWDC, and IDUs with substance abuse treatment needs.

Strategies to attain the objective:

Scope of services for recovery support for the remaining two years (July 1, 2015-June 30, 2017) of the current four-year contract (July 1, 2013-June 30, 2017) to include transportation and translation for adults, PWWDC, and IDUs with substance abuse treatment needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of PWWDC, IDU, and Adult contracts with a scope of service to include a

	provision for transportation and translation.
Baseline Measurement:	Effective July 1, 2013, there was at least one (1) contract executed for each of the target populations, i.e., adults, PWWDC, and IDUs, to provide recovery support services including transportation and translation.
First-year target/outcome measurement:	Maintain a minimum of at least one (1) contract to provide recovery support services including transportation and translation for each of the target populations, i.e., adults, PWWDC, and IDUs, with substance abuse treatment needs in SFY 2016.
Second-year target/outcome measurement:	Maintain a minimum of at least one (1) contract to provide recovery support services including transportation and translation for each of the target populations, i.e., adults, PWWDC, and IDUs, with substance abuse treatment needs in SFY 2017.

Data Source:

Executed contract; contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS – Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08) – Recitals
6. AG Form 103F7 (10/08) – Provider's Acknowledgement
7. Scope of Services
8. AG Form 103F11 (10/08) – Time of Performance
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12. AG Form 103F (10/08) – General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)

Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
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5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment or Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures::

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 4

Priority Area: Quality Substance Abuse Prevention Services

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To prevent the use and abuse of alcohol, tobacco, and other drugs by youth in communities statewide.

Objective:

To fund community-based prevention efforts to prevent youth substance use through the implementation of culturally competent, evidence-based prevention programs and strategies.

Strategies to attain the objective:

1. Provide communities with resources, technical assistance and specific training around effective coalitions, data collection, use of data, developing strategic plans, evaluation, cultural competence, sustainability and other prevention topics identified to foster implementation of the strategic prevention framework (SPF) to support and sustain their prevention efforts.

2. Provide technical assistance and funding to community organizations and coalitions to implement individual and/or environmental prevention strategies to address risk factors, protective factors and/or local conditions associated with youth substance use.

3. Provide technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of alcohol, tobacco and other drugs, including educating community members and law enforcement officials about the benefits of enforcing alcohol, tobacco and drug laws.

4. Provide technical assistance and funds to support actions that engage communities to establish programs that increase knowledge about tobacco, alcohol, prescription drug misuse, marijuana use and other drug problems as well as policies to address the problems and enhance resilience.

5. Increase competencies of the prevention workforce by promoting the Prevention Specialist Certification and providing opportunities for professional development.

6. Obtain data from funded prevention programs on types of services and activities conducted and information on service populations.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percent of evidence-based programs and strategies implemented by contracted community-based organizations to address issues related to the use of alcohol, tobacco and other drugs among youth ages 12-20 years old.
Baseline Measurement:	32% of funded prevention interventions are evidence-based. (SFY2014)
First-year target/outcome measurement:	50% of funded prevention interventions are evidence-based.
Second-year target/outcome measurement:	60% of funded prevention interventions are evidence-based.

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 agency 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 the contractors during data input may distort the actual outcome measure retrieved from HISSAP; inconsistent definitions and data collection methods.

Indicator #:	2
Indicator:	Percent of contracted community based organizations utilizing the Strategic Prevention Framework to address substance abuse issues in their communities as demonstrated by a completed or in progress assessment, plan, and evaluation of prevention programs and interventions.
Baseline Measurement:	No contracted organizations required to implement SPF (SFY2015)

First-year target/outcome measurement: 15% of the prevention funded programs have initiated components of SPF in preparation for the new contracts awarded for SFY 2017.

Second-year target/outcome measurement: 38% of the funded community organizations have chosen effective prevention interventions for implementation based on completed assessment and planning steps.

Data Source:

(1) Hawaii Information System for Substance Abuse Prevention (HISSAP); (2) Program Quarterly and Annual Reports; (3) Program Monitoring Reports; (4) Surveys and questionnaires completed by contracted agencies.

Description of Data:

(1) HISSAP is being enhanced to support SPF components and provider's evaluation efforts; (2) review of narrative status and evaluation provided on annual program reports submitted by contracted organizations; (3) dates and content details of training and technical assistance provided to contracted agencies to enhance SPF implementation efforts.

Data issues/caveats that affect outcome measures::

Delayed implementation of the various components of the SPF due to inability of the state to provide sufficient training and technical assistance to communities; delays in procurement process and procedures may shorten time within the SFY 2017 for services to proceed; development of the consistent evaluation tool for prevention organizations may affect the degree of increased capacity to utilize the tool; delayed enhancement to HISSAP may affect the ability to measure the outcome; local information gathered and presented may be flawed or biased relative to the service organizations' capacity and depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation; and inadequate resources and capacity to engage assistance and services of evaluators.

Indicator #: 3

Indicator: Prevention specialists and community organizations are provided technical assistance and training opportunities related to implementing the Strategic Prevention Framework (SPF), including identifying, implementing and evaluating evidence-based prevention programs and strategies.

Baseline Measurement: Six (6) opportunities provided during SFY 2015.

First-year target/outcome measurement: Ten (10) opportunities for TA and training by end of SFY 2016.

Second-year target/outcome measurement: Fifteen (15) opportunities for technical assistance and training by end of SFY 2017.

Data Source:

(1) Registration flyers, agendas, sign-in sheets, handouts and materials distributed; (2) Participant Evaluation/Comment Forms; (3) Number of certification units (CEs); (4) Assessment completed by workforce development contractor.

Description of Data:

(1) Summary reports with participant information and details of content delivered during training and/or technical assistance; (2) Registry of Certified Prevention Specialists; (3) Follow up surveys and interviews with participants.

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 2016 SABG. 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

SABG 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 SABG 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 is included in Hawaii’s SABG Report submitted annually to SAMHSA by December 1.

Planning Tables

Table 2 State Agency Planned Expenditures

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

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$6,034,779		$0	$0	$15,472,248	$0	$0
a. Pregnant Women and Women with Dependent Children*	$613,498		$0	$0	$2,241,788	$0	$0
b. All Other	$5,421,281		$0	$0	$13,230,460	$0	$0
2. Substance Abuse Primary Prevention	$2,011,594		$0	$1,818,913	$2,350,500	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$423,493		$0	$344,467	$1,654,335	$0	$0
11. Total	$8,469,866	$0	$0	$2,163,380	$19,477,083	$0	$0

* Prevention other than primary prevention

Footnotes:

1. Amounts in Column A are based on the Federal Fiscal Year (FFY) 2016 SABG estimated allotment for Hawaii which is planned to be spent during State Fiscal Year (SFY) 2017 (July 1, 2016 to June 30, 2017). Amounts for SFY 2016 (July 1, 2015 to June 30, 2016) were previously reported to SAMHSA in Hawaii's 2015 Mini-application Plan in the required update for Table 4-SABG Planned Expenditures based on the final FFY 2015 SABG 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 separate funds are shown for 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.

4. According to CSAT's list of "designated states" for the FFY 2016 SABG, 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 SABG 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.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

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

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

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	$
Individual 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	$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$
Total	$0

Footnotes:

1. Table 3 is not filled in because it is not a required table per SAMHSA's FY 2016-17 Block Grant Application instructions (OMB approval #0930-0168) at http://www.samhsa.gov/grants/block-grants. Data were not available and/or listed categories were not applicable.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$6,034,779
2 . Substance Abuse Primary Prevention	$2,011,594
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$423,493
6. Total	$8,469,866

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

1. Although no separate funds are shown for 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 2016 SABG, 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 SABG 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.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		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	

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Section 1926 Tobacco	Universal	$96,540
	Selective	
	Indicated	
	Unspecified	
	Total	$96,540
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		$96,540
Total SABG Award*		$8,469,866
Planned Primary Prevention Percentage		1.14 %

*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. Primary prevention planned expenditures including planned expenditures related to the Synar program are reported in Table 5b which is based on the Institute of Medicine prevention categories. According to the 2016-2017 SABG Application Plan Instructions, 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.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$547,577	
Universal Indirect	$1,223,617	
Selective	$120,000	
Indicated	$120,000	
Column Total	$2,011,194	
Total SABG Award*	$8,469,866	
Planned Primary Prevention Percentage	23.75 %	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

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

Footnotes:

1. Table 5c is not filled in because it is not a required table per SAMHSA's FY 2016-17 Block Grant Application instructions (OMB approval #0930-0168) at http://www.samhsa.gov/grants/block-grants.

2. Footnote 2 added December 3, 2015: Per BGAS revision request received December 3, 2015, to complete Table 5c, this optional table has been filled in. Aside from the Native Hawaiian target population, please note that ADAD does not track prevention funds allocated to or expended for specific substances or populations.

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$100,000	$0	$0	$100,000
2. Quality Assurance	$96,535	$188,227	$0	$284,762
3. Training (Post-Employment)	$34,000	$0	$0	$34,000
4. Education (Pre-Employment)	$0	$0	$0	
5. Program Development	$2,180	$10,770	$0	$12,950
6. Research and Evaluation	$0	$0	$0	
7. Information Systems	$210,000	$581,260	$0	$791,260
8. Total	$442,715	$780,257		$1,222,972

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

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

Footnotes:

Sec. 1-Health Care System and Integration

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

   It is unclear what level, extent or duration of substance abuse services will be covered under various Medicaid plans or QHPs.

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

   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.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

   As of this writing, no detailed monitoring process has been identified.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

   ADAD will not be involved in reviewing any complaints or possible violations of MHPAEA. The Hawaii State Department of Commerce and Consumers Affairs and its Regulated Industries Complaints Office is the State agency responsible for reviewing such complaints or possible violations.

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

   In developing ADAD's next package of RFPs for substance abuse treatment services, changes will be in concert with those made by the Department of Human Services Med-QUEST Division which is the State's Medicaid Office.

   Please note that the Hawaii Health Connector, i.e., the Hawaii health insurance exchange, is in the process of transitioning to the Healthcare.gov platform by October 2015, as a federally-supported state-based marketplace.

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

   ADAD's WITS system has been enhanced to enable ADAD-contracted substance abuse treatment providers to directly submit electronic claims to third party payers and to process electronic claims decisions such as payments and adjustments received from third party

payers. The enhancement is currently being tested for each of the State's Medicaid payers (HMSA, Aloha Care, Ohana Care, United Health Care, and Kaiser) and will be implemented for each ADAD provider over the next twelve months.

ADAD's Hawaii Pathways Project (HPP) provides supportive housing services to chronically homeless individuals, including homeless veterans on Oahu, with substance use disorders, co-occurring substance use and mental health disorders, or serious mental illnesses (SMI). Services include assertive outreach, case management, and treatment services. ADAD is receiving funding for HPP from CSAT's Cooperative Agreement to Benefit Homeless Individuals for States (CABHI-States) for three years through September 29, 2016.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

   ADAD has contracted with two FQHCs, the Waianae Coast Community Mental Health Center and the Waikiki Health Center. ADAD contracted 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).

8. Are state behavioral health facilities 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.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

   Upon admission to ADAD-contracted substance abuse treatment programs, 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 WITS system includes fields for providers to enter clients' responses to questions on tobacco use upon admission and discharge. The following 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?

10. Indicate tools and strategies used that support efforts to address nicotine cessation. (Examples) • Regular screening with a carbon monoxide (CO) monitor • Smoking cessation classes • Quit Helplines/Peer supports • Others

    The Department of Health's Tobacco Prevention and Education Program (TPEP) conducts the State's major educational and information activities on tobacco prevention and control. Information on tools and strategies that support efforts to address nicotine cessation are available at TPEP's website http://health.hawaii.gov/tobacco/ which includes access to the Hawaii Tobacco Quitline.

    ADAD, in collaboration with other organizations, schedules and co-sponsors training for providers and other health professionals specific to nicotine cessation. Training topics include the following: basic tobacco intervention skills and assessing nicotine dependence, effects of nicotine (to include all forms of consumption), resources for supporting those with nicotine disorder, environmental effects of tobacco smoke, smoking laws, and pharmacotherapy. In addition, ADAD has co-sponsored trainings with the Medical and Allied Health Professions for substance abuse service providers and other health care providers in obtaining a Tobacco Intervention Skills Certification. Also as mentioned above, ADAD requires its contracted substance abuse treatment providers to spend in each contract year one percent (1%) of their total contracted amount for tobacco cessation activities.

11. The behavioral health providers screen and refer for: (Examples) • Prevention and wellness education; • Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and, • Recovery supports.

    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.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

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

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

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

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

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Sec. 2-Health Disparities

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

   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, 5-Year Trends (2010-2014)" produced by the University of Hawaii Center on the Family under a contract from ADAD. The report focuses on substance abuse treatment services provided by agencies that were funded by ADAD during State fiscal years 2010 to 2014. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents 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. The report is available at http://health.hawaii.gov/substance-abuse/files/2015/09/ADTreatmentServices2014.pdf.

   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. ADAD tracks enrollment in substance abuse prevention services by each prevention provider and contract. The type of prevention services and/or objectives is different for each curriculum. Though ethnicity, gender, and age of program participants are collected in HISSAP, ADAD does not track outcomes by race, gender, or age.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above 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 uses HISSAP to measure and track services that address disparities based on the contracted providers' assessment of the individual communities. ADAD works with community-based agencies, the 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.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

   For ADAD's current four-year contract period (July 1, 2013 to June 30, 2017) 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 can be tracked through the WITS system. Many providers try to employ a multi-ethnic, multi-cultural staff to help meet the service needs of their clients.

   Prevention service providers assess the needs of their individual communities and conduct ongoing assessment of program implementation and effectiveness to determine if identified needs change during the course of the service period.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

   As described above, ADAD's makes available translation or interpreter services as a reimbursable recovery support service provided by ADAD's contracted substance abuse treatment and recovery providers.

5. Is there state support for cultural and linguistic competency training for providers?

   ADAD partners with other State, county, and community-based agencies to provide training and educational opportunities to address cultural competence for providers.

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

Areas of technical assistance needed include "how to" for establishing criteria for cultural programs most effective with local populations, evaluating cultural competency of programs, and implementing and sustaining evidence-based cultural practices.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

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

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

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

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

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

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

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

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

d. Provider involvement in planning value-based purchasing.

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

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

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

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

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

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

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[59] Ibid, 47, p. 41

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

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

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

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

[64] http://psychiatryonline.org/

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

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

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

Footnotes:

Sec. 3-Use of Evidence in Purchasing Decisions

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

   The ADAD training coordinator provides workshops on evidence-based and promising practices for substance abuse treatment and prevention in collaboration with national entities that include CSAT's Addiction Technology Transfer Center (ATTC), the National Association for Alcoholism and Drug Abuse Counselors (NAADAC), Community Anti-Drug Coalitions of America (CADCA), and the National Institute on Drug Abuse (NIDA).

   ADAD's program specialists for substance abuse prevention also track and disseminate information regarding evidence-based or promising practices. Currently, ADAD's contracted (Block Grant funded) Prevention Resource Center assists in providing updated information regarding evidence-based or promising practices. ADAD contractors from the University of Hawaii provide data collection, data analysis and evaluation services. During the SFY 2016-17 period, ADAD intends to revive the Evidence-Based Practices Workgroup that was first initiated during the previous Hawaii SPF-SIG and ended in September 2012.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

   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.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

   Since this question relates to the SMHA, it does not apply to the SABG Application.

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

   For emerging and promising practices regarding substance abuse treatment and prevention, ADAD relies on information from SAMHSA's TIPS and NREPP, NIDA's Principles of Drug Addiction Treatment, CADCA, National Institutes of Health (NIH), CSAP's Western Center for the Application of Prevention Technologies (WestCAPT), Office of National Drug Control Policy (ONDCP), as well as national registry lists from the Department of Justice (Office of Juvenile Justice and Delinquency Prevention) and Department of Education, and other organizations that conduct research and report findings. For cultural-based treatment activities, ADAD relies on the Indigenous Evidence Based Effective Practice Model from the Cook Inlet Tribal Council, Inc., International Initiative for Mental Health Leadership Forum, Alaska, May 2007 as a guide for emerging and promising practices (as defined by a Western framework). ADAD shares information on emerging and promising practices with providers, state partners and stakeholders.

5. Which value based purchasing strategies do you use in your state:

   a. Leadership support, including investment of human and financial resources.

      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.

   b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

ADAD relies on data from its on-site reviews of programs as well as its WITS system to identify better quality and monitor the impact of quality improvement interventions.

c. Use of financial incentives to drive quality.

Not at the present time. However, ADAD is currently receiving technical assistance funded by CSAT where this is being explored for treatment services.

d. Provider involvement in planning value-based purchasing.

As required by the State procurement process, ADAD holds request for information (RFI) sessions to obtain provider and community input on purchasing of services.

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

ADAD is currently receiving technical assistance funded by CSAT on the use of accurate and reliable measures of quality for treatment services.

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

ADAD is currently receiving technical assistance funded by CSAT on outcomes-based assessment and service planning to improve service quality for treatment services.

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

Not at the present time.

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

As noted above, ADAD is currently receiving technical assistance funded by CSAT on outcomes-based assessment and service planning to improve service quality for treatment services. ADAD staff will need to be trained on this model and its implementation.

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

Not at the present time.

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

ADAD appreciates receiving the current CSAT-funded TA noted above and is in need of continued TA in those areas. TA is also needed in designing and implementing rigorous evaluation processes to assess evidence-based, emerging and promising practices.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

Footnotes:

1. The section on Prevention for Serious Mental Illness does not apply to the SABG Application. This section applies only to the Center for Mental Health Services Block Grant (MHBG) Application. SAMHSA’s MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2016-2017 MHBG Application Plan for information on this section.

Environmental Factors and Plan

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

Narrative Question:

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

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

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

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

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

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

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

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

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

Footnotes:
1. The section on Evidence-Based Practices for Early Intervention (5 Percent Set-Aside) does not apply to the SABG Application. This section applies only to the MHBG Application. SAMHSA's MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2016-2017 MHBG Application Plan for information on this section.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

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

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

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

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

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

Footnotes:

1. ADAD does not have any plans to implement a voucher program.

2. At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

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

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

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

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

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

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

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

Footnotes:

Sec. 7- Program Integrity

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

   In planning and contracting for services to be funded by SABG and State funds, ADAD follows State laws and procedures established in the Hawaii Revised Statutes (HRS), Chapter 103F and implementing regulations in the Hawaii Administrative Rules (HAR) that govern for fairness and quality, the basic planning, procuring, and contracting of health and human services by executive branch departments and agencies. The objective of the HRS and 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 policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

   Federal program requirements are conveyed to intermediaries and providers through the narrative and description included in the Request for Proposals (RFP) and 103F contract awards.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

   a. Budget review;

      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;

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

   c. Expenditure report analysis;

      Invoices, expenditure reports and supporting documents are submitted to ADAD 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;

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. Client level encounter/use/performance analysis data; and

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.

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. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

As described above, ADAD follows State laws and procedures established in HRS, Chapter 103F and implementing regulations in HAR that govern 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://spo.hawaii.gov/?s=cost+principles

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

ADAD assists substance abuse treatment and prevention providers in adopting practices that promote compliance with program requirements, including quality and safety standards in a

variety of ways. ADAD provides accreditation to substance abuse facilities that provide services 24 hours a day (designated as Residential Treatment Programs, aka Special Treatment Facilities and Therapeutic Living Programs) and are required to be licensed by the Department of Health's Office of Health Care Assurance (OHCA). The accreditation standards are based on HAR, Title 11, Department of Health, Chapter 98 (Special Treatment Facility). The program requirements include quality and safety standards.

ADAD certifies substance abuse counselors and program administrators. Certification services are also provided for the Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate. In collaboration with community-based organizations, other State agencies, and federal agencies and organizations, ADAD provides training opportunities for in-service and professional development for service providers.

ADAD staff conduct desktop and onsite monitoring of compliance with State and federal requirements identified in contract agreements for treatment and prevention services. ADAD's prevention staff periodically review prevention providers' Community Action Plans (CAP) and provide assistance with CAP development and implementation.

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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 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:

- Providers shall not use the funds from ADAD 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.

- 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.

- Providers shall maximize reimbursement of benefits through any QUEST Insurance and other applicable medical programs.

- Providers shall comply with the Department of Human Service's QUEST Insurance program and other applicable medical program policies.

- Providers shall refund to the ADAD any funds unexpended or expended inappropriately.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

8. Tribes

Narrative Question:

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

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

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

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

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

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

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

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

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

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

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

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

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

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

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

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

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

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

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

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

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

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

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

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

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

Footnotes:

Sec. 9-Primary Prevention for Substance Abuse

1. Please indicate if the state has an active SEOW. If so, please describe.

   Hawaii has an active SEOW. The Hawaii SEOW was initiated in March 2006 under the Strategic Prevention Framework State Incentive Grant (SPF-SIG) and currently provides guidance to the ADAD Epidemiology (EPI) Team which is contracted and funded by the Strategic Prevention Framework Partnerships for Success (SPF-PFS) grant. The SEOW membership is comprised of directors, epidemiologists and data managers from the government, community, and educational institutions in Hawaii. The EPI Team facilitates the SEOW and provides technical assistance and training for the State and community level stakeholders and sub-recipients in evidence-based programs, data usage, program evaluation, grant writing, needs assessment, and other identified training needs.

   - The types of data collected by the SEOW (i.e., incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);

     Types of data collected include alcohol and drug related indicators selected based on SAMHSA's National Outcomes Measures (NOMs). Prevalence rates by age, gender and ethnicity are considered as well as the Healthy People 2020 Objectives.

   - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and

     Populations are by: age, i.e., youth (12-18) and adults (18+); ethnicity (Native Hawaiian, Other Asian, Other Pacific Islander, Caucasian, Filipino, Japanese); and county (Honolulu, Hawaii, Maui, Kauai).

   - The data sources used (i.e., archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

     The primary data sources for the 2014 State Epidemiological Profile (http://health.hawaii.gov/substance-abuse/files/2013/05/2014State_Alcohol_Profile_Youth_Adults.pdf) include the NSDUH http://www.samhsa.gov/data/NSDUH/2k10ResultsTables/NSDUHTables2010R/HTM/TOC.htm and the Hawaii Youth Risk Behavior Survey (http://www.hhdw.org/cms/uploads/Resources/2013%20YRBS%20Report%20State_Final.pdf) administered odd numbered years to middle and high school students.

     Secondary data sources include the Hawaii Health Data Warehouse (HHDW) http://www.hhdw.org/ and the Substance Abuse Prevention Planning and Epidemiology Tool (SAPPET) https://www.sappet-epi.com/. HHDW administers the design, development and management of a centralized repository for the State's health surveillance data. It was created to standardize the collection, management and reporting

of Hawaii's health data, support the Healthy People 2010 Initiative, and it currently addresses and monitors the Healthy People 2020 Objectives.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

   State-level data including estimates on the use of tobacco products, alcohol, illicit drugs and mental health were obtained from the *Alcohol, Tobacco, and Illegal Drug Use from the Substance Abuse and Mental Health Statistics* found on SAMHSA's Office of Applied Studies (OAS) http://www.oas.samhsa.gov/Data.cfm and data from NSDUH http://www.samhsa.gov/data/NSDUH/2k10ResultsTables/NSDUHTables2010R/HTM/TOC.htm to assist in identifying priorities and goals for the request for proposals (RFP) issued for current services. Information was also obtained from local data sources including the "Hawaii Strategic Prevention Framework-State Incentive Grant (SPF-SIG) Infrastructure and Capacity Assessment 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. Secondary data sources, e.g., HHDW described above, also are used to support decisions regarding priorities and goals of planned services. Data reports on Hawaii from primary data sources are available on HHDW website http://www.hhdw.org/ by health category, data source, ethnicity, county and Healthy People 2020 Objectives.

   Updated profiles for youth and adult drug and alcohol indicators found at http://health.hawaii.gov/substance-abuse/survey/ and the above mentioned data sources continue to be utilized as future RFP for services are developed. Additionally, community meetings are conducted to get input and feedback related to the available data and needs related to the prevention of substance abuse and use from providers and stakeholders to further inform the decision making. Feedback and data are reviewed and requests for proposals to address the needs are developed and issued following State procurement guidelines and requirements. Submitted proposals are reviewed and awarded based on the strength of the capacity of the applicant and the description of the service to meet the identified need.

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

   ADAD provides awareness and education related to the Strategic Prevention Framework (SPF) process, evidence-based practices (EBP) and strategies, and prevention workforce capacity. To further awareness, implementation and promotion of EBP, community-based organizations and substance abuse prevention professionals statewide are provided ADAD-sponsored training and educational opportunities that disseminate information and improve workforce skills related to evaluation, environmental strategies, evidence-based programs, capacity building, coalition building, assessment and data collection. ADAD provides continued 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 initiated during the implementation of the SPF-SIG project.

ADAD continues to support the Hawaii Prevention Resource Center (PRC) to ensure prevention practitioners and the general public have access to up-to-date research, substance abuse treatment and prevention resources, and curriculum models. PRC houses resources on the prevention of alcohol, tobacco and other drug use and related issues and provides lending library, resource clearinghouse, and technical assistance services. Further development of a website specific to the SPF and prevention efforts along with improvements to the Hawaii Information System for Substance Abuse Prevention (HISSAP) are planned as additional resources for the workforce and prevention system for the SFY 2016-17 period.

Contracted community-based agencies are encouraged to support workforce development and increase the number of Certified Prevention Specialists at their respective agencies to comply with contract language requiring such support. Additionally, ADAD continues to sponsor Substance Abuse Prevention Skills Training (SAPST) and through Training of Trainers is building a core of local trainers to advance the State's capacity to increase and enhance the prevention workforce. A new service contract to conduct an assessment and develop a strategic plan for workforce development will be executed during the current State fiscal year.

4. Please describe if the state has:

   a. A state licensing or certification program for substance abuse prevention workforce;

      ADAD provides certification services for Certified Prevention Specialist (CPS) pursuant to State law (HRS §321-193(10) and regulations (Hawaii Administrative Rules, Title 11, Dept. of Health, Chapter 177.1). Information on the certification process and requirements is available at http://health.hawaii.gov/substance-abuse/counselor-certification/. Interested applicants complete the International Certification and Reciprocity Consortium (IC & RC) International Written Prevention Specialist Examination and submit an application including documentation of hours and signed code of ethics for review.

   b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

      ADAD collaborates with other State agencies and community organizations and professionals to provide training sessions that have been approved for continuing education/contact hours (CEs) that may be applied toward meeting the education requirements for certification and/or renewal of certification. Additionally, federal resources for technical assistance are utilized to further training opportunities for prevention practitioners. CSAP's Center for the Application of Prevention Technologies (CAPT) and the Community Anti-Drug Coalitions of America (CADCA) have responded and assisted with ADAD requests to address workforce development. A new service

contract is in place to assist with the logistics of procuring services of consultants, trainers, and facilities to conduct relevant training workshops and courses.

c. A formal mechanism to assess community readiness to implement prevention strategies.

Historical information from the SPF-SIG grant period is available and the SPF-PFS will continue to assist in assessing current capacity. Periodic surveys of the workforce and training participants, as well as ongoing monitoring of service contracts help identify training needs and capacity of prevention practitioners. Additionally, a new service contract will be executed to assist with assessing capacity and readiness and to develop a plan to increase capacity.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

ADAD uses the data and profiles compiled by the EPI Team to inform the understanding of consumption and needs. Risk and protective factors for substance use among youth in all domains – peer and individual, family, school/work and community are considered as well. For youth 12-18 years old, overall rates of most drug usage indicators have not changed significantly over time. Current information (2013) indicates that marijuana is the most common illicit drug among youth. Except for marijuana use, youth rates of ever using illicit drugs were highest for prescription drugs without a doctor's prescription, followed by inhalants and the least common drug used was heroin. In general, Native Hawaiian, Caucasian, and other Pacific Islander youth had the highest rates of drug use in Hawaii. Data indicates no significant difference between males and females, though providers have indicated a persistent need for gender specific programming and services. There is also a need to continue an emphasis on culturally appropriate programs to address the needs of populations at high risk of substance use or abuse.

SPF-SIG evaluation and community assessments and conversations have indicated that communities could benefit from technical assistance to improve readiness and capacity to implement effective environmental strategies to address emerging substance abuse issues and behaviors. ADAD intends to provide resources to support coalition capacity to strengthen efforts to change behaviors and promote healthy communities.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the past five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

ADAD does not have such a strategic plan. *Hawaii's SPF-SIG Underage Drinking Prevention Plan* dated October 2008 and the *Substance Abuse Prevention Infrastructure Work Plan* dated November 2005 serve as reference for moving forward. The Department of Health strategic plan, which has objectives related to prevention and health promotion, was

developed for 2011-2014. The current DOH administration is developing a new overall strategic plan for the Department that will be available in the months to come.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds; describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

   ADAD does not have an active evidence-based workgroup. One objective of the Strategic Prevention Framework Partnerships for Success 2013 (SPF-PFS) project is to revive such a group to assist with decisions regarding appropriate strategies and the use of all prevention funding available to support implementation and coordination of evidence-based strategies to enhance the statewide prevention system.

8. Please list the specific primary prevention programs, practices, and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

   The selection of specific programs and strategies funded is based on the content of the proposals submitted in response to the requests for proposals (RFP). Funded prevention strategies are to have a positive impact on the promotion of health and wellness and the prevention of substance use and abuse. The funded strategies are to be consistent with the *IOM Report on Preventing Emotional and Behavioral Disorders* and include CSAP's six prevention strategies: information dissemination, education, alternative activities, problem identification and referral, community-based processes, and environmental strategies. The SABG primary prevention set-aside funds are awarded based on agencies' proposed plans for implementation of evidence-based programs and strategies identified on a national registry that effectively address the identified needs of target populations and communities. As determined to be needed, requested and justified, prevention dollars are used to support other steps of the Strategic Prevention Framework including assessment, planning, capacity building, cultural competence, sustainability, and evaluation efforts. Additionally, agencies are funded to enhance information dissemination and data collection for the prevention system. The FFY 2016 SABG will be used to fund the first year of ADAD's new contract period (up to four years) for new contracts to be awarded and executed beginning July 1, 2016.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

   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. Budgets and expenditures are approved and tracked by ADAD fiscal and program staff. In addition, as the Single State Authority (SSA) for Substance Abuse, ADAD is informed of

other federal grant proposals submitted by community-based, non-governmental organizations within our jurisdiction.

10. What process data (i.e., numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

    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.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

    ADAD intends to track the select indicators from SAMHSA's NOMs related to youth such as 30-day marijuana and alcohol use; age of first use; perceived harm of use; lifetime prescription drug use without doctor's prescription; 30-day binge drinking; and family communication around substance use.

    Further outcomes and impact of funded services will be determined by the SEOW, PFS evaluator, and the analysis and comparison of the Hawaii Youth Risk Behavior Survey results from 2013, 2015 and 2017. ADAD intends to work with an evaluator to enhance our ability to collect and report on outcome data from ADAD-funded providers as well as evaluate the prevention system as a whole.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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

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

Footnotes:

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 Emergencies, Critical Incidents, Complaints and Grievances

ADAD's Quality Assurance Improvement Office conducts investigations in response to critical incidents, complaints, and grievances. 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 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 an 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's 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. In addition, ADAD's Sentinel Events Policy & Procedures, which became effective August 6, 2014, was developed to establish uniform guidelines for a reporting system that is designed to track and document sentinel events and the follow-up of events reported to ADAD by contracted provider agencies.

The Department of Health maintains an All-Hazards Emergency Response Plan designed to set forth departmental roles and responsibilities in response to disasters, public health emergencies, or catastrophic incidents. ADAD representatives participate in disaster training exercises and emergency preparedness meetings and are queried for their expertise in helping with disasters and public health emergencies. ADAD has personnel who are trained in emergency disaster mental health counseling.

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 15th 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.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

11. Trauma

Narrative Question:

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

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

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

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

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

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

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

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

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

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

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

78 *Ibid*

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

Footnotes:

Sec. 11-Trauma

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

   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. Describe the state's policies that promote the provision of trauma-informed care.

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

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

   ADAD supports the use of evidence-based trauma-specific interventions.

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specfic interventions across the lifespan?

   ADAD schedules and sponsors training for treatment providers specific to trauma-related issues and affected groups. Training topics include the following: cultural impacts and issues in treatment; becoming an exceptional counselor by recognizing trauma; compassion fatigue for trauma-impacted providers; issues and barriers faced by gay, lesbian, bisexual, and transgender/transsexual clients; and suicide intervention skills. In addition, ADAD co-sponsors trainings and conferences with organizations in the military, the Institute on Violence, Abuse, & Trauma, Pacific Southwest Addictions Technology Transfer Centers, and the DOH Adult Mental Health Division.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

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

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

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

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

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

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

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

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

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

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

Footnotes:

Sec. 12- Criminal and Juvenile Justice

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

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

2. Are screening and services 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. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral

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

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 SABG funds for the purpose of providing treatment services in penal or correctional institutions of the State.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

   ADAD provides a Hawaii State credential as a Certified Criminal Justice Addictions Professional. ADAD provides criminal justice trainings, along with co-sponsoring local and national organizations, such as the Interagency Council on Intermediate Sanctions and the Pacific Southwest Addiction Technology Transfer Centers. The emphasis on trainings centers around cognitive behavioral therapy, trauma-based care techniques and recidivism.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

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

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

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

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

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

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

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

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

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

Footnotes:

Sec. 13-State Parity Efforts

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

   ADAD has not committed fiscal resources specifically for communication plans to educate and raise awareness about parity, however, ADAD staff have been engaged in discussions with the Hawaii Substance Abuse Coalition (coalition of substance abuse treatment and prevention providers) regarding employment-based health insurance coverage and Medicaid coverage which are administered by the Insurance Division of the Department of Commerce and Consumer Affairs and the Med-QUEST Division of the Department of Human Services, respectively. Act 186, Session Laws of Hawaii 2014, which became effective on July 1, 2014, requires health insurance policies and contracts issued in Hawaii to conform to Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements. Similarly, amendments to the State's Medicaid coverage have included MHPAEA parity provisions for coverage of substance abuse treatment.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

   ADAD has focused efforts on the complementing of Medicaid coverage to ensure that substance abuse treatment for consumers is covered without interruption upon enrollment under Medicaid. Legislation has been introduced in the Hawaii State Legislature but not enacted (S.B. 1036 in 2015 and H.B.2406, S.B. 2105, and H.C.R. 68 in 2012) to convene a working group or task force comprised of public and private sector entities to address affordability, the coordination of behavioral health care, and the State's role and responsibilities in implementing MHPAEA provisions.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

   Legislation has been introduced in the Hawaii State Legislature but not enacted (S.B. 1036 in 2015 and H.B.2406, S.B. 2105, and H.C.R. 68 in 2012) to convene a working group or task force comprised of public and private sector entities to address affordability, the coordination of behavioral health care, and the State's role and responsibilities in implementing MHPAEA provisions.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

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

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

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

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

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

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

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

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

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

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

Footnotes:

14. Medication Assisted Treatment

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

   ADAD has co-sponsored conferences and educational workshops which provided sessions on medication-assisted treatment for substance use disorders. These educational trainings included the Hawaii Addictions Conference co-sponsored with the University of Hawaii, Department of Psychiatry and workshops with the Community Health Outreach Work (CHOW) Project and Castle Medical Center.

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

   A broad and strategic outreach can include continuing education for physicians, nurses, psychologists, social workers, and other health and social service providers on understanding the nature of the opioid epidemic, issues related to substance abuse disorders among pregnant women, ways to screen for opioid use, and referral for appropriate treatment that includes access to medication-assisted treatment.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

   ADAD will continue to sponsor or co-sponsor conferences and educational workshops that will include the above areas.

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

Technical assistance would be needed to provide the appropriate trainings for various health and social service providers.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

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

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

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

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

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

Crisis Prevention and Early Intervention:

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

Crisis Intervention/Stabilization:

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

Post Crisis Intervention/Support:

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

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

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

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

Footnotes:

1. The section on Crisis Services does not apply to the SABG Application. This section applies only to the MHBG Application. SAMHSA's MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2016-2017 MHBG Application Plan for information on this section.

Environmental Factors and Plan

16. Recovery

Narrative Question:

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

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

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

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

employment

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

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

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

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

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

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

Footnotes:

Sec. 16-Recovery

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

   ADAD does not have such a plan. However, ADAD uses SABG and State general funds to contract for treatment and recovery support services such as therapeutic living programs (TLP), clean and sober housing, and continuing care services.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

   ADAD uses SABG and State general funds to contract for treatment and recovery support services such as TLPs, clean and sober housing, and continuing care services. TLPs serve persons requiring a residential setting, but who do not need the structure of a special treatment program or are transitioning from a more restrictive setting to independent living. TLPs aid residents in meeting basic needs and provide supportive services through an individualized recovery and discharge plan. 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. Clean and sober housing differs from a TLP in that residents do not require 24-hour supervision, rehabilitation, therapeutic services or home care. Adults share household expenses. Continuing care services provide services for the purpose of maintaining gains established in treatment and in support of the recovery process. Continuing care services consist of individual, group counseling, and case management for the purpose of relapse prevention.

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

   ADAD does not have such a plan that focuses on peer-delivered services.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

   ADAD provides training for the workforce on recovery principles, practices, and systems through a variety of training modalities that include training courses and workshops co-sponsored with individuals, local organizations, and national conferences. Recovery-related

topics are included in trainings on treatment planning, relapse prevention techniques, and discharge planning. In addition, providers may request from ADAD technical assistance regarding recovering systems. ADAD, through its training and technical assistance, promotes recovery as an ongoing system of care that can be augmented through the use of aftercare programs, self-organizations, and affiliation with peer support, mentoring, or coaching services. ADAD does not have an accreditation program, certification program, or standards for peer-run services at this time.

5 Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

Regarding innovative activities that support the implementation of recovery-oriented approaches, ADAD provides a per unit rate, i.e., a Healthcare Common Procedure Coding System (HCPCS) code for cultural activities in support of treatment and recovery. At the American Psychological Association (APA) Annual Convention in Honolulu in 2013, ADAD's clinical psychologist gave a presentation on cultural activities in support of treatment and recovery.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

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 substance abuse treatment and recovery plans. In its contracts with substance abuse treatment providers, ADAD provides funding for family counseling.

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

As described above, ADAD uses SABG and State general funds to contract for treatment and recovery support services such as TLPs, clean and sober housing, and continuing care services.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

No tracking of consumer outreach activities occurs.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

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. ADAD, in collaboration with other organizations, schedules and co-sponsors training for providers and other health professionals specific to nicotine cessation. Training topics include the following: basic tobacco intervention skills and assessing nicotine dependence, effects of nicotine (to include all forms of consumption), resources for supporting those with nicotine disorder, environmental effects of tobacco smoke, smoking laws, and pharmacotherapy. In addition, ADAD has co-sponsored trainings with the Medical and Allied Health Professions for substance abuse service providers and other health care providers in obtaining a Tobacco Intervention Skills Certification.

Upon admission to ADAD-contracted substance abuse treatment programs, all clients are required to be assessed, the adults using the Addiction Severity Index (ASI) and the adolescents 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.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

    As described above, ADAD uses SABG and State general funds to contract for services such as TLPs and clean and sober housing. TLPs serve persons requiring a residential setting, but who do not need the structure of a special treatment program or are transitioning from a more restrictive setting to independent living. TLPs aid residents in meeting basic needs and provide supportive services through an individualized recovery and discharge plan. 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. Clean and sober housing differs from a TLP in that residents do not require 24-hour supervision, rehabilitation, therapeutic services or home care. 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.

    ADAD's Hawaii Pathways Project (HPP) provides supportive housing services to chronically homeless individuals, including homeless veterans on Oahu, with substance use disorders,

co-occurring substance use and mental health disorders, or serious mental illnesses (SMI). Services include assertive outreach, case management, and treatment services. HPP is based on the Pathways Housing First model, the only evidence-based program recognized by the national Registry of Evidence-Based Programs and Practices that provides comprehensive housing and treatment services without preconditions of the individual's alcohol or drug use. ADAD is receiving funding for HPP from CSAT's Cooperative Agreement to Benefit Homeless Individuals for States (CABHI-States) for three years through September 29, 2016.

11. Describe how the state is supporting the employment and educational needs of individuals served.

    ADAD uses State funds to provide contracted integrated case management (ICM) and substance abuse treatment services for offenders on supervised release, furlough, probation or parole. ICM services include referrals to ancillary services such as GED classes, literacy programs, vocational rehabilitation, and other legal, dental, medical, psychiatric, and other health and human service resources or entitlements. Case managers must monitor offenders' vocational/educational assistance and progress. Substance abuse treatment programs for offenders, in cooperation with the ICM case management services provider, must assist in linking offenders to education and vocational training to increase marketability of offenders 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. Following successful discharge from substance abuse treatment, offenders must remain under the case management supervision services until a legitimate source of income or full-time student status is established; a stable living environment is secured; or a discharge from the criminal justice system occurs.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

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

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

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

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

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

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

Footnotes:

1. The section on Community Living and the Implementation of Olmstead does not apply to the SABG Application. This section applies only to the MHBG Application. SAMHSA's MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2016-2017 MHBG Application Plan for information on this section.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

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

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

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

Footnotes:

Sec. 18-Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?

   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 serious 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 has provided trainings for State agencies, service providers, and community members regarding evidence-based practices and mental health services in working with family systems and adolescents in treatment. ADAD has collaborative partnerships with other Department of Health programs and other State agencies such as the departments of Human Services, Attorney General, Public Safety, and Education, and the University of Hawaii, as well as community-based organizations 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.

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

   In accordance with the State procurement process, ADAD contracts with substance abuse treatment and recovery service providers to provide school-based outpatient substance abuse treatment to middle school and high school age adolescents statewide; however there has not been a specific identified liaison. During ADAD's Request for Proposal (RFP) planning process, communication is shared with the Hawaii State Department of Education (DOE) administration. Prior to submitting a proposal to ADAD, prospective service providers must obtain a Memorandum of Agreement that is signed by the principal of the specific school at which the substance abuse treatment services will be provided. The agreement specifies that the provider will have administrative and logistical support, and also specifies the responsibilities of both parties. The school-based treatment counselor becomes a part of the team established by the DOE to look at the individual needs of the adolescent.

7. What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

   The ADAD RFP for both adolescent community-based and school-based outpatient substance abuse treatment services describe the target population as middle-school and high-school aged adolescents. A child is not automatically cut off from services at a specific age. If the child is still going to school, the child should be able to receive school-based treatment services. Should a child require additional services beyond graduation from high school, referrals from the school-based provider can be made to an adult treatment agency.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

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

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

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

Footnotes:

Sec. 19-Pregnant Women and Women with Dependent Children

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

   When ADAD solicits for purchase of substance abuse treatment services through the State's procurement process, a Request For Proposals (RFP) is issued. In the RFP, it is clearly stated in the Scope of Work section that applicants must comply with P.L. 102-321 regarding treatment services for pregnant women and women with dependent children:

   a. Pursuant to Sec. 1922(c)(3), make available, either directly or through arrangements with other public or nonprofit agencies, prenatal care to women receiving services, and childcare while the women are receiving the services.
   b. Pursuant to Sec. 1927, comply with the following requirements:
      1) Give preference for admission to treatment to pregnant women who seek or are referred for and would benefit from treatment; and
      2) Advertise that pregnant women shall receive preference for treatment on any brochures or materials published by the agency.

   The RFP also contains the Wait List Management and Interim Services Policy and Procedures which specifies that the applicants must develop and implement a wait list policy that gives preference in admission to treatment for pregnant women and injection drug users in the following order:
   1) Pregnant injecting drug user,
   2) Pregnant substance abusers,
   3) Injecting drug users, and
   4) All others.

   After proposals are reviewed, contracts are developed for awarded providers. In the Scope of Work section of the contract, it specifies that the provider will provide services in accordance with the scope of work and clinical standards described in Scope of Work, Service Activities section of the RFP.

   In the first year of the contract, ADAD's Treatment and Recovery Branch (TRB) monitors providers by conducting a policy and procedures review. The monitoring protocol that is used contains the requirement specified above in P.L. 102-321. Each provider must have a policy in place. In addition, a policy regarding waitlist management and the preference for admission to treatment for pregnant women and injection drug users must also be present.

   Waitlist information is maintained by the Web Infrastructure for Treatment Services (WITS) system. Each ADAD funded provider shall input their waitlist information as it occurs. The waitlist information will contain the date of the initial referral, whether the individual is pregnant or an IDU, and date the individual was admitted to a program or removed from the waitlist. The waitlist is monitored by a TRB program specialist on a weekly basis. If a

provider does not have the capacity to immediately admit a pregnant woman to treatment, it must refer the woman to another program that can admit her. If no other program is available, interim services must be provided within 48 hours. If that is not possible, the provider must refer the pregnant woman to the ADAD-designated woman's agency which is The Salvation Army dba The Salvation Army – Family Treatment Services.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

   As stated above, all providers are contractually required to maintain their waitlist on the WITS system. Each week a waitlist report is generated for the TRB program specialist who is assigned the task of waitlist monitor. The program specialist reviews the waitlist to ensure that all pregnant women are admitted within 48 hours of the date they requested service. To date there has not been an issue of concern since all women have been served within the time allotment, however, should there be an instance when this is not met, a written notice will be sent to the provider to remind them of this policy requirement and further follow up will be conducted as needed.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

   As discussed in question 1, all providers are required to have policies in place that state they will provide interim services for a pregnant woman who has been wait-listed. If that is not possible, the provider must refer the pregnant woman to the ADAD-designated woman's agency, which is The Salvation Army – Family Treatment Services.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

   There are three program specialist positions within TRB that are responsible for contract development and monitoring of the funded providers. One of those three positions is assigned to monitor the weekly waitlist reports. In addition, TRB is headed by a public health program manager and is staffed with a clinical psychologist to assist with treatment issues.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)

   There is one provider on Oahu that provides residential services, Therapeutic Living Program (TLP), and Outpatient (OP), and clean and sober housing. They operate a licensed therapeutic nursery as well.

   There is one provider on Hawaii Island that provides Intensive Outpatient Program (IOP), OP, TLP, and clean and sober housing.

   There is one provider on Maui that provides IOP, OP, TLP, clean and sober housing.

There is one provider on Kauai that provides OP and clean and sober housing.

There is one provider on Lanai that provides IOP and OP.

There is one provider on Molokai that provides IOP and OP.

a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

   None.

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

   There are no providers on any of the islands contracted by ADAD to provide specialized substance abuse services to pregnant women where such services include MAT.

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)

   There is one provider on Oahu that provides residential services, Therapeutic Living Program (TLP), and Outpatient (OP), and clean and sober housing.

   There is one provider on Hawaii Island that provides Intensive Outpatient Program (IOP), OP, TLP, and clean and sober housing.

   There is one provider on Kauai that provides OP and clean and sober housing.

   There is one provider on Maui that provides IOP, OP, and clean and sober housing.

   There is one provider on Lanai that provides IOP and OP.

   There is one provider on Molokai that provides IOP and OP.

   a. How many of the programs offer medication assisted treatment for the women in their care?

      Although MAT is not an ADAD-contracted service for women with dependent children, one provider on Oahu and one provider on Maui provide MAT at their facility.

   b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

There are no providers on any of the islands contracted by ADAD to provide specialized substance abuse services to women with dependent children where such services include MAT.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

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

Footnotes:

1. 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://www.health.hawaii.gov/injuryprevention/home/reports-maps-data/library/. Click on Hawaii Injury Prevention Plan 2012-2017.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

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

Footnotes:

1. Since SAMHSA did not require the State to obtain letters of support or memoranda of understanding from other government agencies for this SABG application, none were solicited. Copies of ADAD's contracts or written agreements involving collaborations with other government agencies in conjunction with community service providers were previously provided to CSAT and CSAP for their technical and system reviews of ADAD-funded substance abuse treatment and prevention services.

Sec. 21-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 and reimbursement rates.

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. 12-Criminal and Juvenile 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

State Epidemiology (EPI) Team and State Epidemiological Outcomes Workgroup (SEOW): An epidemiology team from the Department of Public Health Sciences, University of Hawaii has a strong history of collaborations with ADAD. The EPI Team lends expertise in the area of data trend analysis, data infrastructure tracking and monitoring, and technical support to assist ADAD in its Strategic Prevention Framework (SPF) efforts and has contributed to strengthening the substance abuse prevention efforts in Hawaii. The EPI Team also is the lead for the Hawaii 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.

Hawaii Student Health Survey Committee: In 2011, the Hawaii State Department of Education (DOE) required the Youth Risk Behavioral Survey (YRBS), Youth Tobacco Survey (YTS), and the Student Alcohol, Tobacco, and Other Drug Use (ATOD) Survey to be administered jointly to respect limited classroom time for students. Therefore, ADAD collaborated with other Department of Health programs, the Department of Education, and consultants from the University of Hawaii to develop an integrated survey for 2011 administration which combined items from each of the three former surveys. The collaboration has continued for several years and recently guided the completion of the administration of the 2015 YRBS and plan for future years.

Tobacco Prevention & Education Program (TPEP): Department of Health, Chronic Disease Prevention & Health Promotion Division, Tobacco Prevention and Education Program (TPEP) conducts the State's major educational and informational activities on tobacco prevention and control including merchant and community education and policy development to support a reduction in youth access to tobacco. TPEP is a vital state partner in Synar and tobacco prevention efforts.

Hawaii Partnership to Prevent Underage Drinking (HPPUD): The HPPUD was created to address the problem of underage drinking in the State of Hawaii. The members of the

partnership represent county, State, and federal agencies, nonprofit organizations, private businesses, and community residents concerned with the health of Hawaii's youth.

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

At this time, technical assistance is not needed related to this section.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

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

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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

Footnotes:
1. SAMHSA's requirement for a State advisory council for services for individuals with a mental disorder does not apply to the SABG. The State Council on Mental Health (SCMH) is a requirement for the MHBG which provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. For a description and the composition of the SCMH, please refer to the 2016-2017 MHBG Application Plan.

Sec. 22-State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

SAMHSA's requirement for a State advisory council for services for individuals with a mental disorder does not apply to the Substance Abuse Prevention and Treatment 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 2016-2017 Mental Health Block Grant Application Plan.

The Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS), which is a Governor-appointed commission, 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 Hawaii Revised Statutes (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.

Public Input on the SABG Application 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, SABG 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 staff participate in 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., HRS §103F and implementing regulations under Hawaii Administrative Rules (HAR) §3-142, 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. In particular, State agencies are encouraged to seek planning information from service providers to improve service specifications for purchased services and progress towards desired outcomes.

During this application planning period of July 1, 2015 to June 30, 2017 (as described in Step 2 of this application), ADAD is currently using the FFY 2015 SABG award during the third year of ADAD's four-year contract period for substance abuse treatment and recovery support services and also to help maintain substance abuse prevention services during the fourth year of ADAD's four-year prevention contracts. Then from July 1, 2016 to June 30, 2017, the FFY 2016 SABG award will be used to support the fourth contract year for treatment and recovery support services and fund the first year of prevention service contracts awarded in accordance with State procurement procedures and requirements.

The 2016-2017 SABG Application Plan was made available at http://health.hawaii.gov/substance-abuse/survey/ for public review and comment.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
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 SABG. The State Council on Mental Health (SCMH) is a requirement for the MHBG which provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. For a description and the composition of the SCMH, please refer to the 2016-2017 MHBG Application Plan.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

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)		
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies		
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* 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 SABG. The State Council on Mental Health (SCMH) is a requirement for the MHBG which provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. For a description and the composition of the SCMH, please refer to the 2016-2017 MHBG Application Plan.