Hawaii

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 05/31/2018 10.01.58 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	2018
End Year	2019

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	Edward
Last Name	Mersereau
Agency Name	Department of Health, Alcohol and Drug Abuse Division
Mailing Address	Kakuhihewa Building, 601 Kamokila Blvd., Room 360
City	Kapolei
Zip Code	96707
Telephone	808-692-7507
Fax	808-692-7521
Email Address	edward.mersereau@doh.hawaii.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	9/29/2017 1:51:22 PM
Revision Date	5/31/2018 10:00:32 PM

V. Contact Person Responsible for Application Submission

First Name	John
Last Name	Valera
Telephone	808-692-7529
Fax	808-692-7521
Email Address	john.valera@doh.hawaii.gov

Footnotes:

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

Name: Ramon Ibarra
Telephone: (808) 692-7523
Email: ramon.ibarra@doh.hawaii.gov

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

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

3. Written comments on this FFY 2018-2019 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 2018

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 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

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Fiscal Year 2018

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, 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]: Virginia Pressler

Title: Director of Health

Date Signed: 9/28/2017

mm/dd/yyyy

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

Footnotes:

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:

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

Virginia Pressler

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.

17-003374

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 2018-2019 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 69.5 percent of the State's population of 1,428,557 as of July 1, 2016, 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 13.9 percent, Maui County has 11.6 percent, and Kauai County has 5.0 percent. Also, according to the Census Bureau, 74.2 percent of Hawaii's population is comprised of minorities (race and ethnicity other than non-Hispanic White race only) and 25.8 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. 11, Criterion 3: Pregnant Women and Women with Dependent Children in this application.

Persons Who Inject Drugs (PWIDs) are provided with specialized services through ADAD's contracted opioid addiction recovery services program that includes outreach services to encourage PWIDs 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 PWIDs. If an ADAD-funded treatment

program does not have the capacity to admit a PWID 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 PWIDs within 14 days, then the program must provide interim services within 48 hours, or refer the PWID to the ADAD-designated Opioid Therapy Outpatient Treatment Program to receive interim services. PWID 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) 2018 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. In September 2016, ADAD received approval for a No-Cost Extension, extending the HPP for 12 months, through September 29, 2017.

The State Targeted Response to the Opioid Crisis Grants (Opioid STR) program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The goal is to develop and provide opioid misuse prevention, treatment, and recovery support services for the purposes of addressing the opioid abuse crisis within the state of Hawaii and based on needs identified in the State's strategic plan.

Substance Abuse Prevention Services

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

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In accordance with State policies and procedures regulating the procurement of health and human services, ADAD conducts Requests for Information (RFI) to receive comments and gather data to inform and guide the development of the Request for Proposals (RFP) for the delivery of prevention services. RFI meetings held in each county gather input regarding the feasibility, practicality, readiness, anticipated costs, challenges, and/or interest in providing services to address substance abuse and prevention needs. Public agencies and non-profit community-based organizations provide feedback related to definitions of community, identified priorities, and the current capacity of communities to address the components of the Strategic Prevention Framework (SPF) and to implement the Center for Substance Abuse Prevention (CSAP) strategies and evidence-based programs to address substance use/abuse issues and priorities. Comments, suggestions and other feedback can also be sent to ADAD via email and fax. Additionally, ADAD considers recommendations made in the 2013 Strategic Prevention Framework State Incentive Grant (SPF-SIG) Final Evaluation Report and follow up and the State Epidemiology Outcomes Workgroup (SEOW) statewide and county profiles using available data

related to youth and adult use of alcohol and other drugs substance use from the past several years.

The information gathered during assessment and RFI phase determine much of the design and contents of RFPs that are issued. Efforts to continue the SPF-SIG focus and initiatives were included in the procurement of prevention services. The goal of the procurement for the contract period was to build the capacity of the community-based organizations throughout the State to implement and evaluate evidence-based interventions to prevent and reduce the use of alcohol and other substances and implement the SPF process to develop a comprehensive, coordinated, and sustainable substance abuse prevention system based on data driven decision-making process. The applicants were required to utilize data and develop logic models, as well as submit comprehensive strategic plans for the implementation of selected evidence-based programs and strategies which address the needs of their identified target population.

The general target populations identified for services were at-risk youth, ages 12-17 and young adults ages 18-20 and their families, schools and/or communities. Additionally, providers may target and include for prevention services populations identified below:

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

The RFP resulted in the award of contracts based on the best configuration of services to promote a statewide, culturally appropriate, comprehensive substance abuse prevention system of services to meet the needs of Hawaii's communities. Considerations for the allocation of funds to the applicants included, but were not limited to, assessed need for the proposed services; existing prevention issues and priorities; geographic areas and populations at risk; underserved geographic areas or populations; gaps in services within a geographic area; the community's readiness to implement evidence-based prevention services; the community-based organization's capacity for working with other community stakeholders including children and youth, and Native Hawaiian organizations; and cost effectiveness as determined by estimated per participant costs.

During this application planning period of July 1, 2017 to June 30, 2019, ADAD is using the FFY 2017 SAPT Block Grant along with State dollars to fund the second year of prevention contracts. The two-year contracts for prevention services may be extended for up to two additional twelve-month periods, ending on June 30, 2021. Awards for prevention services focused on supporting community efforts to prevent and reduce the use of alcohol, tobacco, and other drugs among children, youth, families, 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.

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

Programs and service activities related to reducing minors' use of and access to tobacco and alcohol overseen by ADAD include compliance support activities and public education and policy development focusing on limiting youth access to alcohol, strictly enforcing underage drinking laws, and promoting zero tolerance for underage drinking while creating positive outlets for youth. In addition to support the required Synar Amendment Compliance and Enforcement activities, 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 and tobacco product sales to minors and carrying out inspection of retail outlets throughout the State using FDA Commissioned Officers and underage volunteers in controlled, observed undercover buy operations.

Ongoing challenges to develop and sustain an effective service system do exist. There is a continued commitment to incorporate cultural values and traditions without compromising the integrity of selected evidence-based programs. The lack of locally evaluated evidenced-based culturally appropriate prevention programs and curricula challenge the effective service delivery to specific at risk populations such as homeless and/or Native Hawaiian populations. Additionally, the limited capacity and financial resources of community-based organizations to manage and maintain compliance with the fiscal reporting and management requirements of state and federal contract agreements creates challenges for the substance abuse prevention system at the community level. Prevention services may be delivered more effectively by local, smaller agencies in particular communities or for specific populations; however, the smaller organizations often lack the infrastructure necessary for billing and cost reimbursement processes or lack the workforce capacity to afford the manpower and staff required to conduct the financial or programmatic aspects of government contracts.

Certifications for Substance Abuse Professionals

ADAD certifies substance abuse counselors and program administrators pursuant to State law (HRS §321-193(10)) and regulations (Hawaii Administrative Rules, Title 11, Department 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 service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required 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 the 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 sets 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 use disorderprevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of 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**[1] 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.

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

Footnotes:

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

Current Unmet Needs and Critical Gaps

First, service gaps in Hawaii exist as a result of geographically remote locations with limited access to services, provider shortages, and disconnected systems of care. Geographically, the Hawaiian islands present unique challenges. The need to fly to other islands if necessary to obtain needed specialty services remains a constant issue for the State. For example, many individuals requiring inpatient psychiatric treatment on neighbor islands must be flown to Oahu, at significant cost to the State and disruption to the individual and their families. The service array on a specific island is often insufficient to meet the acute or chronic care needs of its population, particularly in relationship to behavioral health care. The transportation issue limits or prohibits islands form easily sharing resources, as might be an alternative in other states. In addition, rural areas suffer from a lack of access to services since most physicians are located in the Honolulu area.

According to a 2015 study by the Pew Charitable Trusts, while the national average is 32 providers per 1,000 people with drug or alcohol addiction, Hawaii has only about 20 providers per 1,000.

Second, the stigma associated with substance misuse remains the number one barrier to treatment, and therefore a key component to prevention and intervention planning. The language used to speak about substance use is critical to decreasing the negative impact of stigma. For example, ADAD's latest substance abuse treatment contracts that started October 1, 2017 has renamed its "treatment plans" to "health and wellness plans."

Third, a lack of coordinated entry among Hawaii treatment providers that stems from fragmented collaboration among providers on how to best care for individual clients who migrate from one treatment facility to another. Coordinated entry is an opportunity for providers who may not have communicated as regularly in the past to collaborate in new ways and simultaneously promote the standardization of assessments and referrals, and more quickly connect people to appropriate and tailored services. As innovative approaches develop through coordinated efforts, relationships with new partners are solidified, stakeholders grow in number and involvement, and access to services greatly improves.

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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

Starting October 1, 2017, ADAD will start the first year of its two-year contract period for treatment and recovery support services from October 1, 2017 to September 30, 2019, with the possibility of extensions for two more years ending September 30, 2021. The SABG application planning period of July 1, 2017 to June 30, 2019, covers the first and second year of ADAD's new four-year contracts for treatment and recovery support services. The Federal fiscal (FFY) 2017 SABG award is being utilized to support the first year of ADAD's new four-year contracts. The FFY 2018 SABG will be utilized to continue the treatment and recovery support services provided by ADAD's current contracted providers during the second year of the new contract period, i.e., State fiscal year (SFY) 2019 (July 1, 2018-June 30, 2019). 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 2018 (October 1, 2017-September 30, 2018). Planning activities for ADAD's two-year contract period included conducting RFI meetings in each of the State's four counties throughout the month of September 2015. 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 two-year contact period (with the possibility of extensions) from October 1, 2017 to September 30, 2019.

Adult Population: In planning for substance abuse treatment and recovery support services for the adult population, ADAD reviewed calendar year 2015 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. For the population 18 years of age and older, 22.9% received treatment for alcohol as the primary substance while 51.4% received treatment for methamphetamines. 2.4% of those receiving treatment were for alcohol and 8.3% of those receiving treatment for methamphetamines were in the 18-25-year age group. Regarding opioid use disorders for calendar year 2015, 40.2% of those 18 or older received treatment for heroin and 42.9% received treatment for abuse of oxycodone. Regarding substance abuse among the homeless for calendar year 2015, 29.6% of those 18 or older received treatment for alcohol and 50.5% received treatment for abuse of methamphetamines. These data indicate that the need for substance abuse treatment exists throughout the State. These data further suggest that methamphetamine remains the primary substance of abuse. However, substantial numbers of persons exhibit addiction to both alcohol and other drugs.

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.

ADAD is about to release the "Alcohol and Drug Treatment Services in Hawai`i, 2015" report 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 2015. 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 will soon be available on the ADAD website at http://health.hawaii.gov/substance-abuse/prevention-treatment/treatment/.

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, the Treatment Episode Data Set Report of April, 2014, ADAD's 2015 WITS data, the Hawaii Perinatal Alcohol Use Quick Facts, 2009-2011, and the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) Trend Report, 2004-2008 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 2011-2012 data for the U.S., 8.5% of pregnant women aged 15 to 44 drank alcohol in the past month, and 2.7% binge drank. Most alcohol use by pregnant women occurred during the first trimester (17.9%), which tapered off in the second trimester (4.2%) and third trimester (3.7%). The TEDS data indicates that female admissions aged 12 to 17 reported higher alcohol (21.7%) as their primary substance of abuse compared to men at 10.5%. The proportions of female and male admissions reporting methamphetamine/ amphetamines as their primary substance of abuse were similar across all age groups except for those aged 18 to 24, 8.9% female admissions reported primary methamphetamine/amphetamines compared to 3.7% male admissions. The highest proportions of primary abuse of prescription pain relievers were found among female admissions aged 18 to 24 and 25 to 34. In the 18 to 24 aged group, 17.6% female admissions compared to 12.8% male admissions. In the 25 to 34 age group, 19% female admissions compared to 12.2% male admissions reported prescription pain relievers as their primary substance of abuse. Within the aged 65 or older aged group, women reported prescription pain relievers as the primary substance of abuse 3 times more than men, 7.2% compared to 2.8%. According to the PRAMS Trend Report, in 2008 an estimated 19.5% of mothers reported binge drinking in the three months prior to pregnancy; and an estimated 8.5% report cigarette smoking at least one cigarette per day in the last three months of pregnancy. From 2004 – 2008 there was an average annual estimate of 18,350 resident births. Approximately 75% of those births occurred to women age 20-34 years of age. 18% was to women 35 years of age and older and 8.3% was to those under the age of 20 years of age.

Opioid Addiction (encompasses services for intravenous drug users): In planning for opioid addiction treatment and recovery services, ADAD reviewed data from the WITS system. The data indicated, by primary substance of abuse, that heroin accounted for 4.3% of treatment admissions; other opiates accounted for 6.3%, for individuals age 18 and older. Based on WITS data for calendar year 2015, ADAD's contracted providers reported total admissions of 5,809 ADAD-funded clients of which 10.7% had a primary substance use of heroin, non-prescription methadone or other opiate/synthetic drug. Of the 617 admissions due to misuse of opioids in calendar year 2015, 40.2% were admitted due to heroin, and another 42.9% were admitted because of abuse of oxycodone (Oxycontin).

On July 2017, Governor David Ige officially launched the State Opioid Action Initiative. This initiative brought together stakeholders from the public and private sector, and adopted both a public health and public safety focus. The overarching goal was to develop and implement a proactive coordinated statewide Action Plan on opioid and other substance misuse issues. The stakeholders produced the Hawaii Opioid Action Plan (Dec. 2017) that serves as a roadmap for a proactive and sustainable response to the opioid crisis seen in other states, a significant accomplishment but only a beginning. The Hawaii Opioid Action Plan is available at: https://health.hawaii.gov/substance-abuse/files/2013/05/The-Hawaii-Opioid-Initiative.pdf.

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 two-year contracts (with the possibility of two-year extensions) 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 addiction care coordination and substance abuse treatment services for offenders on supervised release, furlough, probation or parole, substance abuse treatment and recovery support services for the homeless, group recovery homes, 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 WITS calendar year 2015 treatment program admissions data, the PRAMS Trend Report for 2004-2008, the 2015 Recidivism Update by the Hawaii Interagency Council on Intermediate Sanctions (ICIS), information from the Hawaii State Judiciary, Hawaii State Department of Public Safety, and Hawaii Paroling Authority, the Hawaii Cancer Facts and Figures 2010 produced by the Cancer Research Center of Hawaii, and the Department of Health HIV/AIDS Surveillance Program Fact Sheet October 2015.

Another way ADAD supports services for substance use disorders is through recovery housing. The 2017 Homeless Point in Time Count for the State of Hawaii found of 7,220 homeless individuals of which 3,800 were unsheltered. On Oahu, of the 4,959 homeless individuals identified, 933 were identified as having a substance use disorder. Given the lack of affordable housing in Hawaii, encouraging the startup of more recovery houses is key to providing a stable living environment that assists the progress that was achieved through treatment services and serve as a transition towards independent living.

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.

Tuberculosis. Effective October 1, 2017, contracted substance use treatment providers are required to adopt a policy regarding tuberculosis (TB) and Hepatitis C which states that it provides for TB and Hepatitis C screening, referral and education as appropriate. The provider shall routinely make available TB services to all clients either directly or through arrangements with public or nonprofit agencies. If the provider is unable to accept a person requesting services, the provider shall refer the person to a provider of TB services. TB services shall

include, but not be limited to: counseling; testing to determine whether the individual has contracted the disease and to determine the appropriate form of treatment. Providers shall also maintain documentation for each employee of an initial and annual TB skin test or chest X-ray. Providers shall also give training for staff on the risks of TB and Hepatitis C for those abusing substances. Providers shall also submit, in the format specified by ADAD, TB screening/test results as part of the client's health record wherever applicable. For contractors who provide clean and sober housing, their policies and procedures must specify that all clients admitted are required to have a current TB clearance. As part of the general requirements for therapeutic living programs, providers shall also have on file documented evidence that every direct care staff or any individuals having contact with residents has an initial and annual TB clearance following current DOH policy. Providers are also to adopt an interim services policy that provides services to Pregnant Women and Injection Drug Users until they are admitted to the treatment program. At a minimum, such interim services shall include counseling and education about (a) HIV, Hepatitis C, and TB; (b) the risks of needle sharing; (c) the risks of transmission to sexual partners and infants; (d) steps that can be taken to ensure that HIV and TB transmission does not occur; and (e) referral for HIV or TB treatment services if necessary.

The application period of July 1, 2017 to June 30, 2019 also covers the planning period for ADAD's upcoming four-year contract period for treatment and recovery support services from October 1, 2017 to September 30, 2019, with the possibility of a two-year extension ending September 30, 2021. Planning and information gathering activities will commence in early 2018 for the development of the next set of RFPs for adult and adolescent substance abuse treatment services. RFI meetings that resulted in the current contracts that start October 1, 2017 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 2018 for new contracts to begin October 1, 2019. 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

To enhance the planning for the purchase of services and develop the request for proposals (RFP) for the prevention services currently funded by ADAD, a statewide request for information (RFI) was conducted to gather input related to the needed services. Topics of discussion centered on target populations, target services, ability to submit multiple proposals and multiple agencies collaborating to submit proposals and provide the services. There was broad based agreement among those involved in the drug prevention effort in Hawaii that families, schools, and communities can be safe and drug free, and the preferred strategy to achieve that goal is to increase protective factors and decrease risk factors. Additionally, comments gathered expressed the need for attention to workforce development and further support for increasing the skills and numbers of certified prevention specialists.

In addition to the RFI, national and local data sources were used to inform the data driven process to identify service needs and develop priorities and goals for the RFP. Information was

obtained from the results of statewide student surveys to obtain ongoing data to assess the nature and extent of substance use among Hawaii's youth, assess prevention and treatment needs, and measure risk and protective factors. Due to the Hawaii State Department of Education's (DOE) requirements, the Youth Risk Behavioral Survey (YRBS), Youth Tobacco Survey (YTS), and the Student Alcohol, Tobacco, and Other Drug Use Survey (SATOD) have to be administered jointly. Therefore, ADAD has been collaborating with other Department of Health programs, the DOE, and consultants from the University of Hawaii to develop an integrated survey which combines items from each of the three former surveys. The Diagnostic Statistical Manual (DSM) criteria used in the past to measure treatment need has been replaced with questions from CRAFFT, a research documented adolescent screening instrument. Epidemiological analyses and profiles and reports are available at: http://health.hawaii.gov/substance-abuse/survey/.

Presently, ADAD does not have staff with expertise in the area of data collection and technology. Until July 31, 2017, contracted providers submitted data regularly in to the Hawaii Information System for Substance Abuse Prevention (HISSAP) that was maintained by the University of Hawaii, Shidler College of Business; however, it has been determined this entity is no longer able to host data and provide technical assistance for ADAD contracted prevention services. Therefore, as of October 1, 2017, prevention data collection procedures have transitioned to an enhanced Hawaii-Web Infrastructure for Treatment Services (HI-WITS).

The same lack of staff and expertise issue creates the situation for ADAD to rely on the available secondary data sources and contracted service providers to identify needs and gaps. Without trained epidemiologists and evaluators, the local information gathered and presented may be flawed or biased relative to the service providers' depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation.

State Epidemiological Workgroup

The Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP) awarded a grant to ADAD in March 2006 to establish a State Epidemiological Outcomes Workgroup (SEOW) that would collect, analyze, and report substance use incidence and prevalence, as well as related data and National Outcome Measures (NOMs). The work of the SEOW was intended to direct and support a second grant, the Strategic Prevention Framework-State Incentive Grant (SPF-SIG), received by ADAD in September 2006. In accordance with CSAP requirements, Hawaii's SEOW was maintained with SPF-SIG funds. In 2007, the State Epidemiological Workgroup (SEW) was formed as a subcommittee. The SEW contributed to needs assessment, planning and evaluation processes through its role as an advisory body to the State Advisory Council (SAC) for the SPF-SIG. The SEW was not used for treatment planning since its role was advisory to the SAC which was prevention-based and specific to the SPF-SIG. The workgroup was 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 SEW was to confirm the science of the methods used in data collection as well as to review and assess outcome measures related to substance abuse. Though the funds for the SPF-SIG efforts in Hawaii ended in 2012, ADAD has attempted to continue to support the goals of the SPF-SIG project and the strategies of the SPF.

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

The functions and membership of the SEOW has been sustained through the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) five-year grant that was awarded by CSAP to ADAD in 2013. The SEOW updated profiles and recommendations regarding data gaps. To address the issues of substance abuse on a broader scale, all substances, age groups and indicators were taken into consideration for the priority selection process and the following are some of the indicators selected to be highlighted in the State and County Epidemiological Profiles: http://health.hawaii.gov/substance-abuse/files/2013/05/2014State_Drug_Profile_Youth_Adults.pdf

- Youth consumption within past 30 days (alcohol, marijuana, cocaine, any illicit drug)
- Adult consumption within past 30 days (alcohol, marijuana, any illicit drug)
- Consumption before the age of 13 (alcohol, marijuana)
- Adult binge use (alcohol)
- Consumption within last 3 months of pregnancy (alcohol)
- Youth substance abuse or dependence (alcohol, any illicit drug)
- Adult substance abuse or dependence (alcohol, any illicit drug)
- Youth perceived risk from marijuana use
- Drivers in fatal crash that were alcohol positive
- Youth driving after alcohol consumption
- Adult driving after alcohol consumption
- Deaths by drug overdose
- Mental health admissions reporting any use of alcohol

According to the Hawaii SEOW, led by the PFS Epidemiology Team, Hawaii has data limitations and gaps in the substance abuse and mental health areas, specifically prescription drug misuse, substance abuse by ethnic sub-groups, specific populations, and mental health related comorbidities. These gaps should be addressed in order to expand the knowledge base of specific populations, substances, risk, and protective factors and assist in proper allocations of resources. Available state-level substance abuse data was compiled and examined by substance, indicator type, ethnicity, age group, and units measured. The following is a list of data gaps that have been identified.

- Prescription drug misuse

Although prescription drug misuse is designated as a national epidemic, Hawaii has limited data on this topic. Currently the only indicator available is "use of any prescription drug within a lifetime."

- Data by ethnicity

  The ethnic make-up of Hawaii is unique compared to the rest of the states. The majority of the individuals are of Asian race. In addition, a substantial proportion of the population consists of Native Hawaiians and Pacific Islanders. Since each ethnicity has different culture, history, traditions, and social characteristics, it would be more useful if the data was segregated by ethnic sub-groups (Native Hawaiians, Micronesian, Samoan, Vietnamese, Japanese, Chinese, etc.).
- Consistent indicators

  A consistent set of indicators to measure each substance will be useful in comparing the priorities by substance. Certain substances, such as alcohol are thoroughly measured whereas others, such as heroin, are not.
- Adult indicators

  Although youth substance use patterns may predict the substance use behaviors in the adult phase of an individual, a set of summary statistics is still more accurate than estimated data. Currently there are more indicators measured amongst youth than adults. Consistent indicators should be used to track prevalence.
- Mental health related

  Additional mental health related indicators other than mental health admission records will be useful in examining the mental health and substance abuse association.
- Additional Substances

  Additional data is needed on other substances such as methamphetamine, heroin, synthetics, and prescription drugs.

The above information, 2014 State and County Epidemiology Profiles, planned updated community profiles in SFY2018, and the sustained state- and community-level monitoring systems under the lead of the SEOW continue to inform and guide decision making and planning as ADAD procures future prevention services.

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.

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 follow-up 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 in the field of substance abuse treatment 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.

   Presently, ADAD does not have staff with expertise in data collection and technology. Until July 31, 2017, contracted providers submitted data regularly in to the Hawaii Information System for Substance Abuse Prevention (HISSAP) that was maintained until recently by the University of Hawaii, Shidler College of Business; however, it has been determined this entity is no longer able to host data and provide technical assistance for ADAD contracted prevention services. Therefore, as of October 1, 2017, prevention data collection procedures have transitioned to an enhanced Hawaii-Web Infrastructure for Treatment Services (HI-WITS). It is anticipated that this enhancement will serve an

additional 25-50 active users in the field of substance abuse prevention per work day.

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 Hawaii WITS system is specific to substance abuse services. Data are collected from ADAD-contracted service providers.

   ADAD has worked on a data sharing agreement with the other divisions within the Department of Health, Behavioral Health Administration, namely the Adult Mental Health Division and the Child and Adolescent Mental Health Division. As of April 2018, a data sharing agreement was drafted and is in the process of being executed between ADAD, the Adult Mental Health Division, the Hawaii State Hospital which houses the seriously mentally ill and the Child and Adolescent Mental Health Division.

   ADAD continues to participate in monthly meetings with the Hawaii Medicaid program (Med-QUEST) is working to coordinate the integration of substance use disorder services into the Section 1115 waiver and is exploring the feasibility of developing a data sharing agreement.

   On a statewide note, the state of Hawaii is moving towards developing a larger data system known as the All Payer Claims Database (APCD). Data submission into the APCD is overseen by the Department of Health, State Health Planning and Development Agency (SHPDA). The APCD is funded by a CMMS grant that started in 2013 and ends in 2018. The APCD is a multi-agency partnership including eight (8) agencies, which include SHPDA, DOH, Department of Human Services (DHS)-Med-QUEST Division, Employer-Union Health Benefits Trust Fund (EUTF), ETS, Budget & Finance (B&F), Department of Commerce and Consumer Affairs (DCCA) - Insurance Division, and the University of Hawaii (UH). This collaboration has built a strong foundation for interagency healthcare services planning and public health data analytics. The purpose is to analyze Employer-Union Health Benefits Trust Fund and Med-QUEST for claims data. The claims will be for health care services provided for an estimated 50% of the State's population. The claims data will be examined to track and better understand healthcare costs. Gathering the health claims data from government employees and those individuals covered by Med-QUEST is provided, through SHPDA's authority. The University of Hawaii, Telecommunications and Social Informatics Research Program's Pacific Health Informatics and Data Center will support finding answers to research questions poised from academics, insurers, providers, community groups, and government agencies about costs, quality and ways to improve healthcare services. To date, a steering committee comprised of representatives from the eight agencies has met monthly, interim administrative rules were drafted, provided version 1.0 of the APCD Data Submission Guide to insurance companies in November, 2017, and memorandums of agreement (MOA) between SHPDA and the other agencies were initiated. The MOA with EUTF was executed in January 2017. The MOA between SHPDA and UH was executed in September, 2017. The SHPDA and Med-QUEST MOA was in

negotiations as of December 2017.

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)?

   ADAD has provided (and attached) comments to the Proposed Client-Level Measures (CLD) developed for the block grant programs.

   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?

   ADAD has provided (and attached) comments to the Proposed Client-Level Measures (CLD) developed for the block grant programs.

   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 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 previous 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.

Domain	Measure Name (NQF/Block Grant)	Description	Hawaii SABG Current Capacity to Report	Hawaii SABG Future Capacity to Report	Types of Adjustments Needed to Submit Performance Measure	TA Needed to Make These Adjustments	Perceived or Actual Barriers to Such Data Collection and Reporting
**Perception of Care--(Patient-Centered/ Family Involvement in Care)	**CAHPS_HEDIS** Medicaid Children; Medicaid Adult; Commercial Adult	**CAHPS_HEDIS:** **Medicaid Child** 1. In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care? (Definitely yes, Somewhat yes, Somewhat no, Definitely no). 2. In the last 6 months, how often did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child? (Never, Sometimes, Usually, Always). 3. Shared Decision Making Composite (5.0H)--3 questions-- Did you and a doctor or other health provider talk about the reasons you (or your child) might want to take a medicine? (Y/N); Did you and a doctor or other health provider talk about the reasons you (or your child) might not want to take a medicine? (Y/N); When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you (or your child)? (Y/N). 4. In the last six months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice was best for you? (Y/N). **Medicaid Adult/ Commercial Adult**	Not collected	See footnote 2	See footnote 3	No TA requested at this time	Proposed enhancement may cost about $100,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Reduced Morbidity--(Suicide)	**NQF-0104**--Major Depressive Disorder/Suicide Risk Assessment. **NQF-1364/1365**--Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	**NQF-0104--**Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. **NQF-1365--**Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	No. WITS does not track MDD. WITS does ask if client needs a mental health assessment, and asks if client has a psychiatric problem in addition to alcohol/drug problem. These questions are asked upon admission and upon discharge.	Keep questions on whether client needs a mental health assessment, and if client has a psychiatric problem in addition to alcohol/drug problem.	See footnote 1	See footnote 1	N/A
* Reduced Morbidity--(Suicide)	Percentage of Adults with Serious Thoughts of Suicide in the Past Year	NSDUH - SUI02 - [IF SUI01=1] During the past 12 months, did you make any plans to kill yourself?	Not collected	See footnote 2	See footnote 3	No TA requested at this time	Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Reduced Morbidity--(Decrease in Mental Health Symptoms)	**NQF-0710**-Depression Remission at 12 Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	See footnote 1	See footnote 1	N/A	See footnote 1	N/A
**Reduced Morbidity--(Smoking Cessation)	**NQF--0028** Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	**NQF-0028**-Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.	WITS collects tobacco use information on clients admitted to an substance abuse treatment program only. No information on tobacco cessations programs are collected in WITS.	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement cannot be determined at this time and may exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Reduced Morbidity-(Cardiovascular Disease)	**NQF-2602:** Controlling High Blood Pressure for People with SMI.	Waiting formal NQF endorsement	See footnote 1	See footnote 1	N/A	See footnote 1	N/A

**Reduced Morbidity-(Diabates)	**NQF-2603:** Diabetes Care for People with SMI: Hemoglobin A1c (HbA1c) Testing.	Waiting formal NQF endorsement	See footnote 1	See footnote 1	N/A	No TA requested at this time	N/A
**Reduced Morbidity-(ED Follow-up)	**NQF--2605**: Follow-Up after Discharge from the ED for Mental Health or Alcohol or Other Drug Dependence.	Waiting formal NQF endorsement	WITS collects six-month follow up surveys (post-discharge) only	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed follow-up survey enhancement cannot be determined at this time and may exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
*Reduced Morbidity (Reduced Tobacco Use Among the Population)	Reduced Tobacco Use	Percentage of individuals 12 or older who used any tobacco product in the past 30 days.	WITS collects Primary, Secondary and Tertiary Substance Use Problem data at admission, discharge and six-month follow up but does not have this "Past 30 days" question	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Reduced Morbidity--(Abstinence from Alcohol Use)	**NQF-2152**--Unhealthy Alcohol Use: Screening and Brief Counseling **OR** Number of Patients Identified as needing treatment for alcohol use disorder who receive treatment and significantly reduce or stop using alcohol at follow up measurement period or discharge	**NQF-2152**--Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user. **OR** Percentage of patients 18 or older screened for and identified needing treatment for alcohol use disorder who have reduced or stopped using alcohol at time 2 (or discharge)	WITS collects Primary, Secondary and Tertiary Substance Use Problem data at admission, discharge and six-month follow up (including alcohol). WITS has screening tools for alcohol use disorder but use of these tools are not required.	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement is not determined at this time, and cost may exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
*Reduced Morbidity (Underage Drinking)	Underage Drinking	Percentage of individuals 12-20 who have used alcohol in the past 30 days	WITS collects Primary, Secondary and Tertiary Substance Use Problem data at admission, but does not have this "Past 30 days" question	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Reduced Morbidity (Misuse of Presription Drugs)	Prescription Drug Misuse	Percentage of patients identified as needing treatment for prescription drug misuse who received treamtent and significantly reduced or stopped use at follow up measurement period or discharge	WITS collects data on specific drug codes when collecting Primary, Secondary and Tertiary Substance Use Problem data, whether at admission, disclarge or follow-up	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement may be necessary if the SSRS Report created in WITS yields no meaningful results. If needed, cost of enhancement is unknown at this time.
*Reduced Morbidity (Presription Drug Misuse)	Presciption Drug Misuse	Percentage of individuals aged 12 and older who reporting initiating illicit presciption drug use in the past month	WITS collects Primary, Secondary and Tertiary Substance Use Problem data at admission, discharge and six-month follow up but does not have this "Past month" question	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Reduced Morbidity (Marijuana)	Marijuana Use	Percentage of patients aged 12 and older identified as needing treatment for marijuana use disorder and receive treatment who significantly reduce or stop using marijuana at follow up period or discharge	WITS collects age of first use. WITS also collects data on specific drug codes when collecting Primary, Secondary and Tertiary Substance Use Problem data, whether at admission, disclarge or follow-up	See footnote 2	See footnote 4	No TA requested at this time	Hawaii DOH-ADAD needs to train its staff to learn and generate SSRS Reports in WITS.

*Reduced Morbidity (Marijuana)	Marijuana Use	Percentage of individuals 12 and older who report initiating marijuana use in the past year	WITS collects data on specific drug codes when collecting Primary, Secondary and Tertiary Substance Use Problem data, whether at admission, disclarge or follow-up but does not have this "Past year" question	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
***Purpose	Employment	Number of adults employed with substance use and/or mental health disorder who are employed Full Time Part Time Structured Activity	WITS collects data on Employment Status upon admission, discharge and follow-up. WITS also asks if client participated in a self-help group in the last 30 days.	See footnote 2	See footnote 4	No TA requested at this time	Hawaii DOH-ADAD needs to train its staff to learn and generate SSRS Reports in WITS.
***Purpose	Education	Average Daily Attendance	WITS collects data on Highest Education Level Completed upon admission, discharge and follow-up but does not track average daily attendance for its school-based treatment contracts. WITS does track attendance in prevention curriculum activities.	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Proposed enhancement to calculate average daily attendance is undetermined at this time and may exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
**Criminal Justice	Criminal Behavior	Number of adults 18 and older who incur new criminal charges while in treatment	WITS asks about number of arrests in the last 30 days upon admission, discharge and six-month follow up	See footnote 2	See footnote 4	No TA requested at this time	Hawaii DOH-ADAD needs to train its staff to learn and generate SSRS Reports in WITS.
*Criminal Justice	`Criminal Behavior	Number of DWI and DUI Arrests	WITS ask about number of arrests, but not specifically on driving while intoxicated (DWI) or driving under the influence (DUI).	See footnote 2	See footnote 4	No TA requested at this time	Hawaii DOH-ADAD needs to train its staff to learn and generate SSRS Reports in WITS.
Housing	Stable Housing	Living situation past 30 days	WITS collects Living Arrangement at admission, discharge and six-month follow up but does not have this "Past 30 days" question	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Providers need to be trained to enter correctly to minimize blank entries. Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.
Homelessness	Homelessness	Past 30 days homeless	WITS collects Living Arrangement at admission, discharge and six-month follow up (includes values such as Homeless-Alone or Homeless-W/Partner) but does not have this "Past 30 days" question	See footnote 2	See footnotes 3 and 4	No TA requested at this time	Providers need to be trained to enter correctly to minimize blank entries. Proposed enhancement may cost about $20,000 and exceed the current pre-approved contract amount as approved by the State Chief Information Officer (CIO). The pre-approval process for the current contract may involve an additional two months to raise the ceiling for the current contract, not including another three months to execute a contract modification.

* Prevention only
** Treatment Only
***Both Treatment and Prevention

1. This 2018-2019 Block Grant Application Plan is for the Substance Abuse Prevention and Treatment (SABG) provides information on substance abuse treatment prevention systems. For mental health services system, please refer to Center Mental Health Services MHBG) Plan. 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.
2. No plans to increase capacity to report at this time.
3. Not currently in the Hawaii WITS system. Significant enhancements are necessary to add these questions to an existing screen or to create a new screen, and to make these questions required.
4. Hawaii's WITS system also has an ad-hoc reporting system called Sequel Server Reporting System (SSRS). A new SSRS report has to be created and tested to determine the system's ability to report this performance measure.

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 next two-year (October 1, 2017 - September 30, 2019) 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, 2017, 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 2018.

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 2019.

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 Injection Drug Users (includes intravenous drug users)

Priority Type: SAT

Population(s): PWID

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 next two-year (October 1, 2017 - September 30, 2019) contract period 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, 2017, 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 2018.

Second-year target/outcome measurement: Maintain a minimum of one (1) contract to provide enhanced services for IDUs in SFY 2019.

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, PWID, Other

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 next two-year (October 1, 2017 - September 30, 2019) contract period 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, 2017, there was at least one (1) contract executed for each of the target populations, i.e., adults, PWWDC, and IDU, 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 2018.

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 2019.

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 #: 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:

ADAD has six strategies to attain this objective:

a. Provide communities with resources, technical assistance and specific training around effective coalitions, data collection and the use of data, capacity building, 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 local prevention efforts.

b. Provide technical assistance and funds 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 substance use by youth and their families.

c. 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 policies and laws.

d. 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 negative consequences of use and to promote protective factors and resilience.

e. Build capacity and increase competencies of the prevention workforce by promoting the Prevention Specialist Certification and providing opportunities for professional development.

f. 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: 64% of funded prevention interventions are evidence-based in SFY2017.

First-year target/outcome measurement: 70% of funded prevention interventions are evidence-based by end of SFY2018.

Second-year target/outcome measurement: 80% of funded prevention interventions are evidence-based by end of SFY 2019.

Data Source:

(1) Prevention Data Collection System; (2) Comprehensive Strategic Plans, including logic models and data reporting template submitted by contracted agency; and (3) Subrecipient Quarterly Narrative Reports.

Description of Data:

(1) The number of times (cycles) evidence-based curricula and strategies were implemented and NOMs data as collected electronically each month following service; and (2) Review of plans and notes written by contracted agency on reporting forms which capture 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 data collection system; 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

	completed or in progress assessment, plan, and evaluation of prevention programs and interventions.
Baseline Measurement:	50% of the funded community organizations have initiated components of the SPF and have chosen effective prevention programs for implementation based on completed assessment and planning steps (SFY2017).
First-year target/outcome measurement:	65% of the funded community organizations, have completed or in progress assessment, comprehensive strategic plans, and evaluation of prevention programs and interventions by end of SFY 2018.
Second-year target/outcome measurement:	78% of the funded community organizations have evaluated the implementation prevention programs to determine effectiveness and plan for sustainability of outcomes by end of SFY 2019.

Data Source:

ADAD has identified four data sources for this indicator:

1. Program Quarterly Reports;
2. Program Monitoring Reports;
3. Comprehensive Strategic Plans submitted by contracted agencies; and
4. Surveys and questionnaires completed by contracted agencies.

Description of Data:

Review of status and evaluation progress as reported provided on written program reports and updated comprehensive strategic plans submitted by contracted organization; and 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::

ADAD has identified five issues or caveats that affect outcome measures:

1. Delayed implementation of the various components of the SPF due to inability of the state to provide sufficient training and technical assistance to communities;
2. Delays in procurement process and procedures may shorten time for services to proceed;
3. Development of the consistent evaluation tool for prevention organizations may affect the degree of increased capacity to utilize the tool;
4. 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
5. inadequate resources and capacity to engage assistance and services of evaluators.

Indicator #:	3
Indicator:	Number of technical assistance and training opportunities related to implementing the Strategic Prevention Framework (SPF), including identifying, implementing and evaluating evidence-based prevention programs and strategies provided to prevention specialists and community organizations.
Baseline Measurement:	Fifteen (15) opportunities provided during SFY2017
First-year target/outcome measurement:	Eighteen (18) opportunities for TA and training by end of 2018.
Second-year target/outcome measurement:	Twenty (20) opportunities for technical assistance and training by end of 2019.

Data Source:

Data sources include: Registration flyers, Agendas, Sign In Sheets, Handouts and materials distributed, Participant Evaluation/Comment Forms; Number of certification units (CEs); and Assessments completed by workforce development contractor.

Description of Data:

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

Data issues/caveats that affect outcome measures::

Limited relevant and ongoing opportunities for onsite training and mentoring for trainees and prevention specialists seeking

certification due to prohibitive costs or limited funds may 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 & Public Health Nursing 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 2018 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.

4. For Priority 3 (Recovery Support Services), ADAD selected "Other" but did not specify a subcategory of "Other" such as Adolescents or Homeless because ADAD intended to say that its recovery support contracts were also meant to serve "Other Adults" as well as PWWDC and IDUs.

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$6,381,092		$0	$4,086,437	$16,095,441	$0	$0
a. Pregnant Women and Women with Dependent Children**	$2,713,900		$0	$0	$0	$0	$0
b. All Other	$3,667,192		$0	$4,086,437	$16,095,441	$0	$0
2. Primary Prevention	$2,127,030		$0	$362,620	$2,350,500	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. Early Intervention Services for HIV	$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)	$75,000		$0	$493,059	$2,418,323	$0	$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	**$8,583,122**	**$0**	**$0**	**$4,942,116**	**$20,864,264**	**$0**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

1. Amounts in Column A are based on the Federal Fiscal Year (FFY) 2018 SABG estimated allotment for Hawaii which is planned to be spent during State Fiscal Year (SFY) 2019 (July 1, 2018 to June 30, 2019). Amounts for SFY 2020 (July 1, 2019 to June 30, 2020) will be reported to SAMHSA in FFY 2019 application.

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 2018 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.

5. Per BGAS revision request and email issued on 5/9/18, Table 2 was revised to to reflect the final FY 2018 SABG allocation.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	556	67
Women with Dependent Children	6000	323
Individuals with a co-occurring M/SUD	7000	373
Persons who inject drugs	1863	274
Persons experiencing homelessness	1517	495

Please provide an explanation for any data cells for which the stats does not have a data source.
Not applicable. Each data cell has a data source.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$6,381,092
2 . Primary Substance Abuse Prevention	$2,127,030
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV*	
5 . Administration (SSA Level Only)	$75,000
6. Total	**$8,583,122**

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 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 45 CFR § 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 the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/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 a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. 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 will be allowed to obligate and expend 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 2018 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.

3. Table 4 updated per the Consolidated Appropriations Act, 2018 (P.L. 115-141).

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Section 1926 Tobacco	Universal	$100,000
	Selective	
	Indicated	
	Unspecified	
	Total	**$100,000**
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$100,000**
Total SABG Award*		**$8,583,122**
Planned Primary Prevention Percentage		**1.17 %**

*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 2018-2019 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.

2. Per BGAS revision request and email issued on 5/9/18, Table 5a was revised to reflect the final FY 2018 SABG allocation.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$904,140
Universal Indirect	$452,138
Selective	$120,852
Indicated	$16,400
Column Total	**$1,493,530**
Total SABG Award*	**$8,583,122**
Planned Primary Prevention Percentage	**17.40 %**

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

Footnotes:

1. Amount of primary prevention funds reported on Table 4, row 2, that are planned to be expended on Non-Direct-Services/System Development for SABG Prevention (Table 6): $633,500

2. Per BGAS revision request issued on 3/22/18 following an email from the CSAP State Project Officer, Table 5b was revised to exclude primary prevention funds planned to be expended on Non-Direct-Services/System Development.

3. Per BGAS revision request and email issued on 5/9/18, Table 5b was revised to reflect the final FY 2018 SABG allocation.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

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

Footnotes:

1. 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.

2. Per BGAS revision request and email issued on 5/9/18, no revisions to Table 5c were necessary to reflect the final FY 2018 SABG allocation.

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems		$433,500	$433,500	
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment			$200,000	
4. Planning Council Activities (MHBG required, SABG optional)				
5. Quality Assurance and Improvement		$77,000		
6. Research and Evaluation		$13,298		
7. Training and Education		$73,400		
8. Total	**$0**	**$597,198**	**$633,500**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

1. Per BGAS revision request and email issued on 5/9/18, Table 6 was revised to reflect the final FY 2018 SABG allocation.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] 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.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder 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.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services 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.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. 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 M/SUD 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 EHRs and telehealth are examples of important strategies to promote integrated care.[33] 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, treatment, 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[34] and ACOs[35] 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. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] 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 in finding a provider.[41] 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 work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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. The 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. The SSAs and SMHAs should collaborate with their states? 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. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, 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.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] 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 and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Regarding the integration of substance use disorders with co-occurring disorders:

Starting October 1, 2017, ADAD's treatment purchase of service contracts were modified to where providers are now paid for giving motivational enhancement and addiction care coordination services.

Motivational Enhancement Services provide counseling for the purpose of establishing commitment to behavior change. It may include motivational interviewing techniques, curriculum-based activities and cognitive-behavioral strategies to challenge thoughts, attitudes and beliefs. Motivational Enhancement Services consist of individual and process or educational group counseling.

Addiction Care Coordination actively assists and supports client access to needed health, behavioral health and other community supports in a way that ensures communication among and between the client and any stakeholders in the client's wellness to improve positive outcomes. The overall goal of Addiction Care Coordination is to support the client's development of protective factors, supports and other skills to achieve overall health and wellbeing. Addiction Care Coordination is a service that is coordinated with, and coordinates on behalf of, treatment and recovery support services for the client. Addiction Care Coordination includes any of the following:

a) Face-to-face or electronic contact with the client.
b) Direct or electronic contact with professionals or significant individuals who are stakeholders in the treatment and/or recovery support process and who are vital to the positive outcomes of the episode of care.

Addiction Care Coordinators must also meet certain education, training, experience and/or credentialing requirements.

ADAD is also meting monthly with the Department of Human Services, MedQUEST Division who is the state Medicaid agency, to coordinate review of substance use disorder service payment and eligibility, and to possibly integrate substance use services into their Section 1115 Waiver request.

Regarding the integration of substance use disorders with mental health and primary health care:

ADAD also continues to implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) project through a separate grant from SAMHSA. The SBIRT model advocates for enhanced relationships between behavioral health, women's health, and primary care, and is an essential tool for building the connectedness necessary to increase resilience, informed decision making, and transitional skills needed to prevent relapse. ADAD is currently implementing SBIRT through purchase of service contracts in primary care settings in six Federally Qualified Health Centers (FQHCs) and up to 25 smaller primary care practices (PCPs) over five years. SBIRT interventions will be delivered to adults 19 and over.

ADAD is also in the process of working with the Department of Health, HIPAA Office to develop and finalize a data sharing agreement with other divisions within the Department of Health, Behavioral Health Administration (BHA), such as the Adult Mental Health Division, the Hawaii State Hospital, and the Child and Adolescent Mental Health Division. This will enable each division within the BHA to better track longitudinally their client's or patient's progress and use of behavioral health services over time as well as inform better data evaluation.

Furthermore, ADAD is working closely with the Department of Public Safety, Narcotics Enforcement Division as well as the Department of the Attorney General to implement the Hawaii Opioid Action Plan, which was finalized in December, 2017 and took a multi-agency collaborative approach which was initiated by the Governor of Hawaii to prevent the opioid crisis from migrating to Hawaii. A copy of the Hawaii Opioid Action Plan is available here: https://health.hawaii.gov/substance-abuse/files/2013/05/The-Hawaii-Opioid-Initiative.pdf.

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. In September 2016, ADAD received approval for a No-Cost Extension, extending the HPP for 12 months, through September 29, 2017.

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/.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

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 was successfully tested for each of the State's Medicaid payers (HMSA, Aloha Care, Ohana Care, United Health Care, and Kaiser) and will continue to be implemented by each ADAD treatment provider.

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. In September 2016, ADAD received approval for a No-Cost Extension, extending the HPP for 12 months, through September 29, 2017.

ADAD is developing a working relationship to integrate substance use disorder services and future purchase of service procurements with the State of Hawaii Medicaid agency, known as the MedQUEST Division of the State of Hawaii, Department of Human Services (MedQUEST) (http://humanservices.hawaii.gov/mqd/). For ADAD, the impetus for this working relationship was due in part to a combination of three technical assistance projects that are combined into one project and funded by SAMHSA through their contractor JBS International on the use of accurate and reliable quality performance measures for treatment services. The goal is for ADAD to learn from its sister single-state agency (SSA) from the State of Oklahoma who has developed a

model performance management system. The goals of this technical assistance are (1) to identify/consolidate key performance indicators based on the data ADAD currently collects; (2) develop evidence-based clinical practice guidelines for ADAD's treatment and recovery services branch; and (3) develop a consolidated matrix of quality of care indicators for all ADAD programs. For MedQUEST, the impetus to collaborate with ADAD came because they are soon to issue a new Request for Proposals (QUEST Integration RFP) for Hawaii health plan insurers that seeks closer integration of primary health care and behavioral health services to eligible Medicaid members. MedQUEST requires that the services be provided in a managed care environment with reimbursement to qualifying health plans based on fully risk-based capitated rates. MedQUEST is requesting feedback from ADAD and the other behavioral health divisions within the Department of Health. The QUEST Integration RFP is planned for release in early 2018. 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.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

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

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

i) heart disease ○ Yes ◉ No

ii) hypertension ○ Yes ◉ No

viii) high cholesterol ○ Yes ◉ No

ix) diabetes ○ Yes ◉ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

ADAD will not be involved in reviewing any complaints or possible violations of the Mental Health Parity and Addiction Equity Act of 2008 (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.

According to SAMHSA's Special Report entitled "Medical Necessity in Private Health Plans," the lack of a Federal definition of "medical necessity" poses difficulties for the enforcement of the MHPAEA.

ADAD continues to work with the Department of Human Services, MedQUEST Division who is the state Medicaid agency, to coordinate review of substance use disorder service payment and eligibility, and to possibly integrate substance use services into their Section 1115 Waiver request.

10. Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section

As described in Section 1, item 2 above, ADAD is currently receiving technical assistance funded by SAMHSA through their contractor JBS International on the use of accurate and reliable quality performance measures for treatment services.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], 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, sexual/gender minorities, orientation 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, etc.) 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)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS 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 HHS Secretary's top priority in the Action Plan is to "assess 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."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. 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[51]. 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 populations 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 and is 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.

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

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

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

[48] **http://www.thinkculturalhealth.hhs.gov**

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

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

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

Please respond to the following items:

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

a) Race	◉ Yes	○ No
b) Ethnicity	◉ Yes	○ No
c) Gender	◉ Yes	○ No
d) Sexual orientation	○ Yes	◉ No
e) Gender identity	○ Yes	◉ No
f) Age	◉ Yes	○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? ○ Yes ◉ No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

With respect to Section 2, item 1, 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 or gender identity.

The DOH Surveillance, Evaluation & Epidemiology Office (SEEO) of the Chronic Disease Prevention & Health Promotion Division (CDPHPD) in 2017 released its inaugural health report on Hawai'i's Sexual and Gender Minority communities. Hawai'i's sexual and gender minorities—including, but not limited to, transgender people, bisexual persons, lesbian women, and gay men—have unique health experiences and needs, and the report highlights some of the disparities in health outcomes affecting these communities, and shares opportunities to reduce these gaps in health equity. The report was recently shared with ADAD's substance abuse prevention staff at a recent State Epidemiological Outcomes Workgroup quarterly meeting, and is found here: http://health.hawaii.gov/surveillance/files/2017/05/HawaiiSexualandGenderMinorityHealthReport.pdf.

ADAD is about to release the "Alcohol and Drug Treatment Services in Hawai`i, 2015" report 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 2015. 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 will soon be available on the ADAD website at http://health.hawaii.gov/substance-abuse/prevention-treatment/treatment/.
Enrollment in substance abuse prevention services is tracked through 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.

With respect to Section 2, item 2, 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 tracks 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.

With respect to Section 2, item 3, for ADAD's upcoming four-year contract period (October 1, 2017 to September 30, 2021) 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.

With respect to Section 2, item 4, ADAD partners with other State, county, and community-based agencies to provide training and educational opportunities to address cultural competence for providers.

With respect to Section 2, item 5, ADAD's training plan does not include the Culturally and Linguistically Appropriate Services (CLAS) Standards. However, ADAD treatment contracts do pay for translation services if the client asks the provider for a language interpreter. ADAD also provides training on community cultural diversity needs of population groups such as native Hawaiians, Micronesians, the LGBTQ community, and those affected by HIV/STDs.

With respect to Section 2, item 6, 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.

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.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse 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 IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. 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[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. 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."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, 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, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. 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 Protocol Series **(TIPS)**[57] are best practice guidelines for the SUD treatment. The 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 SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[58] 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 M/SUD services.

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[52] 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

[53] 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.

[54] 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.

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

[56] **http://psychiatryonline.org/**

[57] **http://store.samhsa.gov**

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [x] Use of financial and non-financial incentives for providers or consumers.
- **d)** [x] Provider involvement in planning value-based purchasing.
- **e)** [ ] Use of accurate and reliable measures of quality in payment arrangements.
- **f)** [ ] Quality measures focus on consumer outcomes rather than care processes.
- **g)** [ ] Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

With respect to Section 3, item 1, ADAD's Quality Assurance and Improvement Office 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, the Evidence-Based Practices Workgroup (EBW) first initiated during the previous Hawaii SPF-SIG and ended in September 2012, was revived. The EBW is in the process of developing criteria and protocols for reviewing strategies and programs to determine effectiveness and eligibility for evidence-based status.

For substance abuse treatment services, information was included in ADAD's RFP for treatment services. The following is an excerpt from RFP 440-17-1:

"The APPLICANT shall incorporate evidence-based practices and promising practices in any substance abuse service. According to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), an evidence-based practice is "A practice that is based on rigorous research that has demonstrated effectiveness in achieving the outcomes that it is designed to achieve." A promising practice comes from "Outcomes based on an evidence base which produced sufficient evidence of a favorable effect." The APPLICANT may consult the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol Series (TIPS) (http://www.ncbi.nlm.nih.gov/books/NBK82999/), SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP: http://www.samhsa.gov/nrepp), the National Institute on Drug Abuse (NIDA) (https://www.drugabuse.gov/) and/or access website resources listed in Attachment E-7."

For substance abuse prevention services, ADAD's RFP requested that proposed services include the implementation of evidence-based programs and strategies that effectively address the risk and protective factors and service needs identified in the proposals. The proposed strategies were to have documented evidence of effectiveness as determined by research and included on a federal registry of EBI or reported with positive effects on the target outcome in peer-review journals. 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.

For emerging and promising practices regarding substance abuse treatment and prevention, ADAD relies on information and guidance 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 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.

With respect to Section 3, items 2a through 2h, ADAD uses the following value based purchasing strategies:

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 and non-financial incentives for providers or consumers.

ADAD's new round of substance abuse treatment contracts (October 1, 2017 – September 30, 2019, with the possibility of two year extensions ending September 30, 2021) will for example pay for a client's assessment, even if the client was referred to another provider who can handle the level of care the client needs. This incentive is available to the provider if they do care coordination for the client by referring them to another treatment program.

ADAD's new treatment contracts also moved away from the cost reimbursement method of payment for services and shifted towards tiered rate payment structures for each treatment service (Outreach, Motivational Enhancement, Interim Care, Assessment, Placement Determination, Addiction Care Coordination, Health and Wellness Planning (formerly called Treatment Plans), Residential, Detoxification, Day Treatment, Intensive Outpatient, Outpatient, Continuing Care, Opioid services, Clean and Sober Housing, Therapeutic Living Program, Transportation, and Translation). These tiered rates were designed to move a client along the continuum of care so as to prevent clients from being "stuck" in a treatment modality for a long time, and freeing up contract funds for other clients who require that acuity level of care.

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.

Not at the present time. However, ADAD is currently receiving technical assistance funded by CSAT through their contractor JBS International on the use of accurate and reliable quality performance measures for treatment services.

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

Not at the present time. However, ADAD is currently receiving technical assistance funded by CSAT through their contractor JBS

International on the use of accurate and reliable quality performance measures for treatment services.

g. Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P))..

Not at the present time. However, ADAD will partner with the department's State Health Planning and Development Agency in the creation of an All Payer Claims Database which was signed by the Governor as Act 139, 2016 Session Laws of Hawaii on June 29, 2016. The enabling state legislation is found here: http://www.capitol.hawaii.gov/session2016/bills/GM1241_.PDF.

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

Not at the present time. However, ADAD is currently receiving technical assistance funded by CSAT through their contractor JBS International on the use of accurate and reliable quality performance measures for treatment services.

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, particularly in the area of performance management. This TA will also focus on designing and implementing rigorous evaluation processes to assess evidence-based, emerging and promising practices.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ○ Yes ◉ No

2. Are there any concretely planned initiatives in our state specific to self-direction? ○ Yes ◉ No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed:

b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

e) What, if any, research and evaluation activities are connected to the initiative?

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

ADAD already in its new two-year substance abuse treatment contracts emphasize and incentivize providers to do care coordination as a billable service. These new contracts which start October 1, 2017 also have two-year extensions ending on September 30, 2021. ADAD will continue to emphasize care coordination in the future.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

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

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

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 U.S.C. §§ 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 U.S.C. § 300x-55(g), 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 made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify 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 use disorder prevention, treatment and recovery 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 MHBG and SABG. 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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 respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? (●) Yes ( ) No

3. Does the state have any activites related to this section that you would like to highlight?

With respect to Section 7, item 1, 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.

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

ADAD also employs the following program integrity activities 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.

ADAD also uses Cost Principles established by the Hawaii State Procurement Office to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered. The Cost Principles for HRS, Chapter 103F are available at http://spo.hawaii.gov/for-state-county-personnel/programs/procurement/solicitation/health-human-services/methods-of-procurement/competitive-procurement/cost-principles-hrs-chapter-103f-purchases-of-health-and-human-services/.

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With respect to Section 7, item 2, 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.

Please indicate areas of technical assistance needed to this section

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

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

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**[59] 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 approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

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.

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activites related to this section that you would like to highlight?

Please see footnote 1 below.

Please indicate areas of technical assistance needed to this section

Footnotes:

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

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ( ) Yes ( ) No

- [x] Data on consequences of substance using behaviors
- [x] Substance-using behaviors
- [x] Intervening variables (including risk and protective factors)
- [ ] Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [ ] Adults (ages 27-54)
- [ ] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)
- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [ ] State - developed survey instrument
- [x] Others (please list)

Youth Tobacco Survey (YTS)
Community feedback gathered at Requests for Information (RFI) that are required by state law for health and human services procurements

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

ADAD used 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 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.

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); 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), including 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 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.

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 assessment results 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.

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. 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).

ADAD opened a Request for Information (RFI) starting July 9, 2015 to receive comments and data to inform and guide the development of the Request for Proposals (RFP) to promote a statewide, culturally appropriate, comprehensive substance abuse prevention system of services to meet the needs of Hawaii's communities. RFI meetings were held in each county during the month of July to gather input regarding the feasibility, practicality, readiness, anticipated costs, challenges, and/or interest in providing services to address substance abuse prevention needs. A total of more than twenty-seven attendees representing public agencies and non-profit community-based organizations provided feedback related to their definitions of community, identified priorities, and the current capacity of communities to address the components of the Strategic Prevention Framework (SPF), the Center for Substance Abuse Prevention (CSAP) strategies, and implement evidence-based programs and strategies to address substance use/abuse issues and priorities. Comments, suggestions and other feedback were also sent to ADAD via email and fax.

In conjunction with the RFI, priority issues to be addressed in the RFP were also influenced by past reports and available data. ADAD considered recommendations made in the 2013 Strategic Prevention Framework State Incentive Grant (SPF-SIG) Final Evaluation Report and follow up consultation. The Hawaii State Epidemiology Outcomes Workgroup (SEOW) also provided state and county epidemiological profiles using available data related to youth and adult use of alcohol and other drugs substance use from the past several years. As first identified during the SPF-SIG grant period and further supported by the findings of the SEOW, underage drinking remains a substance abuse prevention priority. Alcohol use is more prevalent among youth ages 12-17 and young adults ages 18-20 than any other substance. According to the Youth Risk Behavior Survey (YRBS), 38.4% of 12th grade students, 25.7% of 11th grade students, 19.3% of 10th grade students, and 18.3% of 9th grade students reported having at least one drink of alcohol in the past 30 days in 2013.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

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.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

Service contracts are in place to assist with the logistics of procuring services of consultants, trainers, and facilities to conduct relevant training workshops and courses. ADAD provides awareness and education related to the Strategic Prevention Framework (SPF) process, evidence-based practices (EBP) and strategies to build the capacity of the prevention workforce. 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.

Additionally, 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. 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.

Contracted community-based agencies are required to support workforce development and increase the number of Certified Prevention Specialists at their respective agencies. 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.

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 is underway as additional resources for the workforce and prevention system for the SFY 2017-19 period.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ○ Yes ◉ No

If yes, please describe mechanism used

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ○ Yes ○ No ◉ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ○ Yes ◉ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ○ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

ADAD has revived an evidence-based workgroup under the Strategic Prevention Framework Partnerships for Success 2013 (SPF-PFS) grant project 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. Currently the criteria and review process are under development with plans to initiate implementation in SFY18.

Does the state have any activities related to this section that you would like to highlight?

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

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 specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies include:

INFORMATION DISSEMINATION
Health Fairs
Media Ready
Drug-free awareness community events
School Presentations

List continues in 2.b. below.

b) Education:

LifeSkills Training
Positive Action Curriculum
Project Alert Curriculum
STARS for Families
Project Venture Curriculum
Second Step Curriculum

List continues in 2.c. below.

c) Alternatives:

Project Venture camps
Family Strengthening
Positive Action Alternative activities
Strengthening Family Night
Project Alert Alternative Activities
Parenting and family management
Media Ready

List continues in 2.d. below.

d) Problem Identification and Referral:

STARS for Families- psychoeducation

List continues in 2.e. below.

e) Community-Based Processes:

Prevention Resource Center
Coalition and interagency collaboration
Prevention Workforce Training

List continues in 2.f. below.

f) Environmental:

Synar Activities
Coalition and interagency collaboration to address local policies

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

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.

Does the state have any activities related to this section that you would like to highlight?

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

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- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☑ Other (please describe):

ADAD collects data from program services on a regular basis through electronic data reporting system. 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. Unique client level data is gathered in the following areas: budget and spending reports; service details and number of people served; and program goals.

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

☐ Binge use

☐ Perception of harm

c) ☐ Disapproval of use

d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☑ Other (please describe):

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.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Are you considering any of the following:

Targeted services for veterans	( ) Yes (•) No

c) Expansion of services for:

(1)	Adolescents	(•) Yes ( ) No
(2)	Other Adults	( ) Yes (•) No
(3)	Medication-Assisted Treatment (MAT)	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (•) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? (•) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (•) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (•) Yes ( ) No

5 Are you considering any of the following:

- **a)** Open assessment and intake scheduling (•) Yes ( ) No
- **b)** Establishment of an electronic system to identify available treatment slots (•) Yes ( ) No
- **c)** Expanded community network for supportive services and healthcare (•) Yes ( ) No
- **d)** Inclusion of recovery support services (•) Yes ( ) No
- **e)** Health navigators to assist clients with community linkages ( ) Yes (•) No
- **f)** Expanded capability for family services, relationship restoration, custody issue (•) Yes ( ) No
- **g)** Providing employment assistance (•) Yes ( ) No
- **h)** Providing transportation to and from services (•) Yes ( ) No
- **i)** Educational assistance (•) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In general, ADAD identifies compliance issues and corrective actions through contract monitoring and also through corrective action plans.

The waitlist is also generated weekly.

Award Identification
The sub-recipient (in this case the PWWDC Provider) is informed of their initial contract award by the Competitive Purchases of Services Statement of Findings and Decision which informs the sub-recipient of the amount awarded, identifies other applicants who were selected for this RFP, and the technical review committee comments, which includes general comments and conditions of acceptance for proposals that are recommended for funding. The reviews of proposals are conducted by the Treatment and Recovery Branch (TRB) for substance abuse treatment programs. Once the Statement of Findings and Decision are completed, the contracts for each award are completed by the TRB Program Specialists.

During-the-Award Monitoring
After the contract is awarded, the accountants and Administrative Officer (AO) III in ADAD will monitor the agencies reported use of funds for the contracts on an annual basis. When the contract is finalized and executed at the Administrative Services Office (ASO), a copy of the contract is forwarded to ADAD. ADAD will create and send a purchase order (PO) to ASO to encumber funds for the contract. The pink copy of the PO is sent back to ADAD once the fund is encumbered and it is kept in the fiscal contract folder with the accountant or AO III. If the contract is a multiple year contract, ADAD will create and send a PO to ASO to encumbered funds accordingly for the contracted amount at the beginning of each subsequent year.

On Site Monitoring / Desktop Review (Treatment)
In the first year of a new contract, ADAD conducts on-site contract orientations. During this visit, ADAD requests a tour of the facility in order to understand and visualize how services will be implemented. An orientation of the contract is conducted with key staff, in order to review the scope of the contract, terms of the contract, policy and procedure monitoring process, funding, WITS (the management information system utilized by ADAD), clinical requirements and any questions that the provider may have.

A desk top review of the provider's Policies and Procedures, is also scheduled within the first year of the contract. During the desk top review, the Contract Manager will complete the Treatment and Recovery Branch (TRB) Contract Compliance Monitoring Protocol to evaluate compliance with policies and procedures in the following areas: General, personnel, other administrative personnel files, and other administrative wait list capacity management. After the protocol is completed, it is sent to the provider,

along with a cover letter, signed by the TRB Chief, informing them of the results of the desk top review. If the report has findings, ADAD will indicate that a Plan of Correction (POC) will need to be submitted within 30 days. After the POC is submitted, the TRB monitor will then evaluate the POC for effectiveness of the corrective action measures. Once the POC is deemed acceptable, a final letter of acceptance will be sent to the provider.

In the second and third years of the contract, desk top reviews are completed at ADAD by either Contract Managers and or Clinical Psychologist. The Program Specialist protocols evaluate administrative requirements, scope of work requirements and waitlist capacity management. The Clinical Psychologist protocols evaluate clinical services, treatment curriculum review, and facility standards which include interviews of staff and consumers. Random test sampling is performed to ensure compliance with the scope of the contract and work requirements. The desk top review consists of reviewing program and clinical notes and billing information that are submitted by the providers. Prior to viewing the client information, which is considered to be Protected Health Information (PHI), the TRB staff must obtain approval to view the information, and request proper log-on authorization in order to review the WITS data, for the sake of monitoring. A follow-up site visit may or may not be scheduled depending on the additional information that would need to be verified. The site visit for these monitoring years, would be to verify client sign-in sheets, interviews with staff, and interviews with client to verify service satisfaction and appropriateness of treatment services, as well as to follow up on any previous POCs for quality control.

Treatment Contract Managers are assigned a number of contracts, which are tracked on the 'Contract Caseload' schedule. They are responsible for conducting the reviews for their assigned contracts each quarter, of each year. The contracts are constantly being reviewed and monitored, in conjunction with the Fiscal section, for optimal utilization review, in order to minimize lapsing funds. Increasing or decreasing contract amounts require a contract modification. The Clinical Psychologist, is responsible for monitoring all clinical aspects of all of the contracts.

On-site monitoring for the fourth year is mainly for those contracts with previous findings which required a POC. The priority for selection of on-site monitoring for the fourth year depends on the severity of the findings or correction action plan in the previous year.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs — ( ) Yes (●) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — ( ) Yes (●) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support — ( ) Yes (●) No
- **d)** Service expansion to specific populations (military families, veterans, adolescents, older adults) — ( ) Yes (●) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

ADAD identifies compliance issues and corrective actions through contract monitoring and the use of corrective action plans. ADAD utilizes the same procedures and strategies to monitor program compliance for PWID activities and services. Please see response to Criterion 3, item 6.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — ( ) Yes (●) No

2. Are you considering any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — ( ) Yes (●) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — ( ) Yes (●) No
- **c)** Established co-located SUD professionals within FQHCs — ( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

ADAD does annual monitoring of SSA-contracted providers for TB screening and when appropriate, referral for TB services. ADAD utilizes the same procedures and strategies to monitor program compliance for SUD activities and services. Please see response to Criterion 3, item 6.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas — ( ) Yes (●) No
- **b)** Establishment or expansion of tele-health and social media support services — ( ) Yes (●) No
- **c)** Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — ( ) Yes (●) No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	(●) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	( ) Yes (●) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Not applicable

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Are you considering any of the following:

- **a)** Workforce development efforts to expand service access — ◉ Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ◉ Yes ○ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ○ Yes ◉ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ○ Yes ◉ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ○ Yes ◉ No
- **f)** Explore expansion of service for:
  - **i)** MAT — ◉ Yes ○ No
  - **ii)** Tele-Health — ○ Yes ◉ No
  - **iii)** Social Media Outreach — ◉ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ◉ Yes ○ No

2. Are you considering any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ○ Yes ◉ No
- **b)** Establish a program to provide trauma-informed care — ○ Yes ◉ No
- **c)** Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — ◉ Yes ○ No

2. Are you considering any of the following:

- **a)** Notice to Program Beneficiaries — ◉ Yes ○ No
- **b)** Develop an organized referral system to identify alternative providers — ◉ Yes ○ No
- **a)** Develop a system to maintain a list of referrals made by religious organizations — ◉ Yes ○ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ◉ Yes ○ No

2. Are you considering any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No
- **c)** Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (•) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (•) Yes ( ) No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — (•) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (•) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (•) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (•) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (•) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Two sub-recipients were identified to undergo independent peer review.

3. Are you considering any of the following:

a) Development of a quality improvement plan — ( ) Yes (•) No

b) Establishment of policies and procedures related to independent peer review — (•) Yes ( ) No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (•) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (•) No

If YES, please identify the accreditation organization(s)

i) [ ] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No
- **b)** Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

- **a)** Recent trends in substance use disorders in the state (●) Yes ( ) No
- **b)** Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No
- **c)** Preformance-based accountability (●) Yes ( ) No
- **d)** Data collection and reporting requirements (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No
- **b)** Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No
- **c)** Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No
- **d)** State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

- **a)** Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

- **a)** Tuberculosis ( ) Yes (●) No
- **b)** Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

- **a)** Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No
- **b)** Professional Development ( ) Yes (●) No
- **c)** Coordination of Various Activities and Services ( ) Yes (●) No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Hawaii State administrative regulations which govern Mental Health are not covered here because such regulations apply 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 2018-2019 MHBG Application Plan for information on this section.

For the SABG Application Plan, current state administrative regulations administered by ADAD are contained in Hawaii Administrative Rules (HAR) Chapter 177.1, "Certification Standards for Substance Abuse Counselors, Program Administrators, Prevention Specialists, Clinical Supervisors, Criminal Justice Addictions Professionals, and Co-Occurring Disorders Professional Diplomate." http://health.hawaii.gov/opppd/files/2015/06/11-177.1.pdf.

Hawaii Revised Statutes, Sections 321-191 to 198:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0191.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192_0005.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0005.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0007.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0194.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0195.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0196.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0197.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0198.htm

Hawaii Revised Statutes, Sections 329-1 to 4:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0001.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0002.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0003.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0004.htm

Footnotes:

1. For Criterion 3, item 5.f., ADAD is considering expanded capability for family services only.

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

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.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? (•) Yes ( ) No

Does the state have any activities related to this section that you would like to highlight?

ADAD's Quality Assurance and Improvement Office (QAIO) plan to incorporate strategies and delivery systems for performance to promote workforce recruitment, retention and training efforts. ADAD will collaborate with Mental and Substance Use Disorder (SUD) providers, prevention providers, Medicated programs and primary care providers to share information about a full range of health and wellness programs. ADAD will also team with local and national providers in working to foster integrated developing models for performance of service for the professionals.

ADAD plan involves:

1. Development the use of telehealth technologies for frontier/rural areas by providing education to introduce awareness, utilizing and implementation of telehealth technologies. See Telehealth technologies: train the trainers, July 2013, http://www.attcnetwork.org/userfiles/file/NFAR_TOT_Manual_7-9-13.pdf.
2. The quality assurance system shall identity strength and deficiency, indicate corrective action to be taken, validate corrections and recognize and implement innovative, efficient and effective methods for overall program and professional improvement within the workforce.
3. Work with primary care providers, SUD, prevention, and Medicaid providers in continuous training and education in areas such as medication-assistance treatment, opioid addiction, and screen, brief intervention, and referral to treatment (SBIRT).
4. Develop a plan to collaborate with the State Drivers Education, Impaired Driving Task Force, and City counties for data collection of assessment, treatment referrals and substance used identified with impaired driving.
5. Develop a partnership with Hawaii's Mental Health Division to promote a program recovery support using the established by SAMHSA recovery support. See Recovery and recovery support, October 5, 2015, https://www.samhsa.gov/recovery.

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

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening 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.

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. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 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.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ○ Yes ◉ No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ○ Yes ◉ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ◉ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ◉ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

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.

ADAD plans to collaborate with the Adult Mental Health Division in supporting peer support services (see Hawai'i certification peer specialist at http://health.hawaii.gov/amhd/consumer/hcps/). The plan is to review the current support services and structure specificity that incorporate SUD. ADAD has collaborated with providers in approving educational credits for peer recovery training.

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.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

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 mental and substance use problems. Youth 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.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

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 M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.

[62] 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**

[63] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? — (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? — (●) Yes ( ) No

3. Does the state provide cross-trainings 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? — (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? — (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

With respect to Section 14, item 1, coordination of services with the criminal justice systems is an integral component of ADAD's contracted Integrated Addiction Care Coordination (IACC) 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 uses only State funds to provide contracted IACC 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 IACC 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 IACC services, must be referred to ADAD's contracted IACC agency for assessment and approval for IACC services. IACC 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.

ADAD's contracted IACC 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. IACC 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 IACC 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 IACC 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.

Starting July 1, 2018, ADAD received a one-year $200,000 general fund appropriation from the Hawaii State Legislature to work with the Governor's Coordinator on Homelessness to conduct a pilot program called Law Enforcement Assisted Diversion (LEAD). LEAD is a community-based diversion program for people whose criminal activity is due to behavioral health issues. LEAD is a pre-booking or pre-arrest diversion program. In LEAD, low-level offenders for whom probable cause for arrest exists are diverted from arrest or booking by immediately referring them to harm reduction, non-abstinence based, individualized case management and treatment. The funds are to develop a lead pilot within a targeted area that could serve as a model for other jurisdictions in the state. More information on Hawaii's LEAD program is found here: http://www.chowproject.org/lead.html.

With respect to Section 14, item 2, ADAD plans to work with law enforcement to implement the LEAD pilot program in a targeted area on the island of Oahu. As described above, the LEAD pilot targets low- level offenders for whom probable cause for arrest exists are diverted from arrest or booking by immediately referring them to harm-reduction, non-abstinence based, individualized case management and treatment.

With respect to Section 14, item 3, 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.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in 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 MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

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. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** [x] Methadone
- **b)** [ ] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [ ] Naltrexone (oral, IM)
- **f)** [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

ADAD has co-sponsored conferences and educational workshops which provided sessions on medication-assisted treatment for substance use disorders. 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 like the Community Health Outreach Work (CHOW) Project to sponsor and promote training sessions in evidence-based practices.

ADAD has also received a one-year, $2,000,000 State Targeted Response to the Opioid Crisis grant (HI-STR) awarded through the U.S Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP). The grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). One of ADAD's objectives is to increase MAT services through its new treatment provider contracts which start October 1, 2017. This new contract allows providers to be eligible to bill MAT services in both outpatient and inpatient settings in one of two ways:

1) Hire qualified staff to provide MAT services on site; or
2) Develop a partnership with a pre-existing opioid treatment program to provide on-site MAT services to enrolled clients.

Please indicate areas of technical assistance needed to this section.

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

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved 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, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD 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 recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] 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**[65],

"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 following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☐ Crisis Intervention Team/Law Enforcement
- **e)** ☐ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ WRAP Post-Crisis
- **b)** ☐ Peer Support/Peer Bridgers
- **c)** ☐ Follow-up Outreach and Support
- **d)** ☐ Family-to-Family Engagement

e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☐ Follow-up crisis engagement with families and involved community members

g) ☐ Recovery community coaches/peer recovery coaches

h) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed 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 2018-2019 MHBG Application Plan for information on this section.

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are 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. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
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:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. 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.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ○ Yes ◉ No

b) Required peer accreditation or certification? ○ Yes ◉ No

c) Block grant funding of recovery support services. ◉ Yes ○ No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ○ Yes ◉ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services for adults with SMI and children with SED in Hawaii is provided through the Adult and Mental Health Division and the Child and Adolescent Mental Health Divisions of the Department of Health, respectively. This item does not apply to the SABG Application. This item 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 2018-2019 MHBG Application Plan for information on this item.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery and support services for substance use disorders in Hawaii are provided through ADAD-contracted treatment services and include the following: Continuing Care, Clean and Sober Housing, Therapeutic Living Programs, Transportation, Translation services and Childcare.

5. Does the state have any activities that it would like to highlight?

With respect to Section 17, item 1.a., regarding training/education on recovery and recovery-oriented practice and systems including the role of peers in care, ADAD plans to collaborate with the Adult Mental Health Division in supporting peer support services (see http://health.hawaii.gov/amhd/consumer/hcps/). The plan is to review the current support services and structure specificity that incorporate SUD. ADAD has collaborated with providers in approving educational credits for peer recover training.

With respect to Section 17, item 1.b., regarding peer accreditation or certification, ADAD does not currently require peer accreditation or certification for peer specialist. ADAD's plan is to structure a certification program in the future that will support Certified Peer Recovery as indicated by The International Certification & Reciprocity Consortium (see http://www.internationalcredentialing.org/icrccertificate).

With respect to Section 17, item 1.c., Hawaii will use state general funds to fund of recovery support services.

With respect to Section 17, item 1.d., regarding the involvement of persons in recovery/peers/family members in planning, implementation or evaluation of the impact of the state's M/SUD system, ADAD plans to collaborate with the Adult Mental Health Division in supporting peer support services (see http://health.hawaii.gov/amhd/consumer/hcps/). The plan is to review the current support services and structure specificity that incorporate SUD. ADAD has collaborated with providers in approving educational credits for peer recover training.

With respect to Section 17, item 2, ADAD does not currently measure the impact of our consumer and community outreach activity.

With respect to any activities Hawaii ADAD wishes to highlight, starting October 1, 2017, ADAD will start the first year of its two-year contract period for treatment and recovery support services from October 1, 2017 to September 30, 2019, with the possibility of extensions for two more years ending September 30, 2021. These treatment contracts allow treatment providers to receive payment for both pre-treatment services, and cultural activities.

Pre-Treatment and Pre-Recovery Support Services include (1) Motivational Enhancement, (2) Outreach Services, and (3) Screening.

1) Motivational Enhancement Services provide counseling for the purpose of establishing commitment to behavior change. It may include motivational interviewing techniques, curriculum-based activities and cognitive-behavioral strategies to challenge

thoughts, attitudes and beliefs. Motivational Enhancement Services consist of individual and process or educational group counseling.
2) Outreach Services are a planned approach to engage and link those in need of substance abuse treatment and/or recovery support services with appropriate levels of care and needed services. The purpose of this approach is to reduce barriers related to access and or individual motivation. Outreach services are community based.
3) Screening is a process by which a client is deemed appropriate and eligible for admission to a particular alcohol and/or drug treatment program. The determination of a particular client's appropriateness for a program requires the counselor's judgement and skill and considers the program's environment and modality, as well as established patient placement criteria (e.g. ASAM). Important factors include the nature of the substance abuse, the physical condition of the client, the psychological functions of the client, outside support, previous treatment, and the client's motivation. It also considers the capacity of the particular agency to meet the presenting needs of the client. Eligibility is determined by evaluation of demographic characteristics, income level and referral source. Screening should address not only appropriateness for substance abuse treatment but also the need for health, behavioral health and recovery support services.

Cultural Activities

Treatment providers were encouraged during the RFP process that resulted in the new contracts to start October 1, 2017 to offer Cultural Activities in any modality of service. These provide adults and adolescents with structured learning experiences that increase knowledge in one's own or another's culture. These activities are geared to provide support for the recovery process. ADAD expected that a provider would provide cultural activities that reflect the ethnic backgrounds of clients served. ADAD also requested providers that planned to provide Native Hawaiian cultural activities to refer to guidelines as described in "Indigenous Evidence Based Effective Practice Model" produced by the Cook Inlet Tribal Council, Inc., May, 2007.
Treatment providers that plan to provide cultural activities were also encouraged during the RFP process to refer to SAMHSA's Treatment Improvement Protocol Series (TIPS) 59: Improving Cultural Competence for guidance:
http://store.samhsa.gov/shin/content//SMA14-4849/SMA14-4849.pdf

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

ADAD is currently receiving technical assistance funded by SAMHSA through their contractor JBS International on the use of accurate and reliable quality performance measures for treatment services.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

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 M/SUD 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 setting appropriate to the individual 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 for 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 settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based 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.

Please respond to the following items

1. Does the state's Olmstead plan include :

- housing services provided. ○ Yes ○ No
- home and community based services. ○ Yes ○ No
- peer support services. ○ Yes ○ No
- employment services. ○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

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?

Does the state have any activities related to this section that you would like to highlight?

Please 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 2018-2019 MHBG Application Plan for information on this section.

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. 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 emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental 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[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

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[69]. 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 point person 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 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

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 SUD and co-occurring M/SUD 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, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

[67]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.

[68]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.

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

[70]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**

[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ○ Yes ● No

b) The recovery and resilience of children and youth with SUD? ● Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

a) Child welfare? ● Yes ○ No

b) Juvenile justice? ● Yes ○ No

c) Education? ● Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ● Yes ○ No

b) Costs? ● Yes ○ No

c) Outcomes for children and youth services? ● Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ● Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ○ Yes ● No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system? ● Yes ○ No

b) for youth in foster care? ● Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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. 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. Does the state have any activities related to this section that you would like to highlight?

ADAD has established standards for individualized care planning that are reviewed and revised every contract cycle. For ADAD's current contract period from October 1, 2017 to September 30, 2019 with the possibility of extensions for two more years, 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.

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

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

Footnotes:

1. Section 19, items 1.a. and 4.b. do 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 2018-2019 MHBG Application Plan for information on this section.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

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 2018-2019 MHBG Application Plan.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	**0**	
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)		
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees		
Providers		
Vacancies		
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Persons in recovery from or providing treatment for or advocating for substance abuse services		
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

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 2018-2019 MHBG Application Plan.

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act,** , 2016 (P.L. 114-113) signed by President Obama on December 18, 2015[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of a SSP other than to purchase sterile needles or syringes. However, directing FY 2016 SABG funds to SSPs will require a modification of the 2016-2017 SABG Behavioral Assessment and Plan (Plan). States interested in directing SABG funds to SSPs must provide the information requested below and receive approval on the modification from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when modifying the Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016 the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs ,**

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above when requesting a modification to the state?s 2016-2017 Behavioral Health Assessment and Plan.

Please follow the steps listed below to modify the Plan:

- Request a Determination of Need from the CDC
- Modify the 2016-2017 Plan to expend FFY 2016 and/or FFY 2017* funds and support an existing SSP or establish a new SSP
- Include proposed protocols, timeline for implementation, and overall budget

- Submit planned expenditures and agency information on **Table A** listed below
- Obtain State Project Officer Approval
- Collect **all** SSP information on **Table B** listed below to be reported in the FFY 2019 SABG report due December 1, 2018

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-23(b)) and 45 CFR ? 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2016 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit an amendment to its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan amendment is applicable to the FY 2016 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2]Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.? 300x-31(a)(1)(F)) and 45 CFR ? 96.135(a)(6) explicitly prohibits the use of SABG funds to provide persons who inject drugs (PWID) with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2016 (P.L. 114- 113)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(a)) and 45 CFR ? 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(b)) and 45 CFR 96.128 requires ?designated states? as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes a SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all of the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a description of the elements of a SSP that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);

- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;
- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing a opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG funds used for SSP	SUD Treatment Provider	Number Of Locations (include mobile if any)	Narcan Provided
No Data Available					

Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table B

Syringe Service Program Name	# of Unique Individuals Served		*[Please enter total number of individuals served]*				
			HIV Testing	Treatment for Substance Use Conditions	Treatment for Physical Health	STD Testing	Hep C
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

Footnotes:

Environmental Factors and Plan

24. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, 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.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

This 2018-2019 Application Plan was made available for public review and comment at ADAD's website http://health.hawaii.gov/substance-abuse/survey/, where, as needed, it will be updated to reflect any revisions that may be required by SAMHSA for approval.

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

Footnotes:

Sec. 23-Public Input on the State Plan-Required

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.

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. ADAD follows the 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. In particular, State agencies are encouraged to seek information from service providers to improve service specifications for purchased services and progress towards desired outcomes.

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 requests for proposals (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.

The FFY 2017 SABG award is currently being utilized to support the first year of the current contract period, i.e., State fiscal year (SFY) 2018 (July 1, 2017-June 30, 2018) for treatment and recovery support services and the second year of the contract period for prevention service contracts awarded in accordance with State procurement procedures and requirements. The FFY 2018 SABG award, subject to SAMHSA's approval of the award notice to ADAD, will be used to support the second year of the next contract period for treatment and recovery support services and the third year of contracts for prevention services.

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.

This 2018-2019 Application Plan was made available for public review and comment at ADAD's website http://health.hawaii.gov/substance-abuse/survey/, where, as needed, it will be updated to reflect any revisions that may be required by SAMHSA for approval.