Hawaii

UNIFORM APPLICATION
FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/26/2019 9.03.04 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance
State Information

Plan Year
Start Year 2020
End Year 2021

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 Janelle
Last Name Saucedo
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 janelle.saucedo@doh.hawaii.gov

III. Expenditure Period
State Expenditure Period
From
To

IV. Date Submitted
Submission Date 9/26/2019 9:02:10 PM
Revision Date

V. Contact Person Responsible for Application Submission
First Name Rachel
Last Name Beasley
Telephone 808-692-8198
Fax 808-692-7521
Email Address rachel.beasley@doh.hawaii.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
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 2020-2021 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 2020

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

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

| Section   | Title                                                                 | Chapter               |
|-----------|                                                                     | 42 USC § 300x-21      |
| Section 1921 | Formula Grants to States          | 42 USC § 300x-21      |
| Section 1922 | Certain Allocations               | 42 USC § 300x-22      |
| Section 1923 | Intravenous Substance Abuse      | 42 USC § 300x-23      |
| Section 1924 | Requirements Regarding Tuberculosis and Human Immunodeficiency Virus | 42 USC § 300x-24      |
| Section 1925 | Group Homes for Recovering Substance Abusers                  | 42 USC § 300x-25      |
| Section 1926 | State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18 | 42 USC § 300x-26      |
| Section 1927 | Treatment Services for Pregnant Women                            | 42 USC § 300x-27      |
| Section 1928 | Additional Agreements                                                    | 42 USC § 300x-28      |
| Section 1929 | Submission to Secretary of Statewide Assessment of Needs            | 42 USC § 300x-29      |
| Section 1930 | Maintenance of Effort Regarding State Expenditures                  | 42 USC § 300x-30      |
| Section 1931 | Restrictions on Expenditure of Grant                                  | 42 USC § 300x-31      |
| Section 1932 | Application for Grant; Approval of State Plan                        | 42 USC § 300x-32      |
| Section 1935 | Core Data Set                                                             | 42 USC § 300x-35      |

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

<p>| Section   | Title                                                                 | Chapter               |
|-----------|                                                                     | 42 USC § 300x-51      |
| Section 1941 | Opportunity for Public Comment on State Plans                      | 42 USC § 300x-51      |
| Section 1942 | Requirement of Reports and Audits by States                       | 42 USC § 300x-52      |</p>
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions
to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
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 other Certifications summarized above.

State: ________________________________

Name of Chief Executive Officer (CEO) or Designee: Bruce S. Anderson, Ph.D. ________________________________

Signature of CEO or Designee: ________________________________

Title: Director of Health ________________________________ Date Signed: ________________________________

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Grants Management Officer  
Office of Financial Resources  
Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
5600 Fisher Lane, Rm. 17E20  
Rockville, MD 20857  

Dear Grants Management Officer,

Enclosed is the Funding Agreement – Certifications and Assurances that I have signed for Hawaii’s FFY 2020-2021 Substance Abuse Prevention and Treatment Block Grant (SABG) Application and Plan. Also enclosed are (1) copy of Governor Ige’s designation of signature authority to the Director of the Department of Health (DOH) for Hawaii’s SABG Application, Annual Synar Report and Related documents; and (2) copy of designation of alternate signature authority. In case of my absence and unavailability, alternate signature authority is designated to the DOH, Deputy Director of Health, and in case of the absence and unavailability of both the Director and Deputy Director of Health, then alternate signature authority is designated to the DOH Deputy Director of Behavioral Health Administration.

In accordance with application instruction from the Substance Abuse and Mental Health Services Administration (SAMHSA), the FFY 2020-2021 SABG Application Plan will be submitted electronically using SAMHSA’s Web-Block Grant Application System, by the October 1, 2019 due date.

We appreciate the continued opportunity to participate in the SABG Program which has been essential for the development and improvement of Hawaii’s statewide system of substance abuse services.

Sincerely,

[Signature]

BRUCE S. ANDERSON, Ph.D.  
Director of Health

Enclosures
July 5, 2018

TO: Bruce S. Anderson, Ph.D.
    Director of Health

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

The Director of the Department of Health is hereby designated as the State of Hawaii’s signature of authority for the Substance Abuse Prevention and Treatment Block Grant (SABG) Application, Annual Synar Report and related documents 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 must 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 Hawaii
July 1, 2019

MEMORANDUM

TO: Cathy Ross
Deputy Director of Health

Edward Mersereau, LCSW, CSAC
Deputy Director, Behavioral Health Administration

FROM: Bruce S. Anderson, Ph.D.
Director of Health

SUBJECT: Designation of Alternate Signature Authority for the Substance Abuse Prevention and Treatment Block Grant Application (SABG), Annual Synar Report and Related Documents, and Related Documents for Other Substance Abuse and Mental Health Services Administration Grants (SAMHSA)

Governor David Ige has designated signature authority to me, as the Director of the Department of Health (DOH), for the SABG Application, Synar Report and related documents, and other SAMHSA grants. 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 and other SAMHSA grants. If the Deputy Director 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, and documents for other SAMHSA grants to be submitted to the SAMHSA because the Alcohol and Drug Abuse Division is directly under the BHA Deputy Director.
State Information

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
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<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 nondiscrimination 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.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions...
to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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 


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee’s policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
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 other Certifications summarized above.

State: Hawaii

Name of Chief Executive Officer (CEO) or Designee: Bruce S. Anderson, Ph.D.

Signature of CEO or Designee: ______________________________

Title: Director of Health

Date Signed: 09/26/2019

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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)**

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**Signature:**

**Date:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**
Planning Steps

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

Narrative Question:
Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:
1. This 2020-2021 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 Strengths and Organizational Capacity of the Service System to Address the Specific Populations

Description of Substance Abuse Service Systems

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 a separate and distant location 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 115 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.

The state of Hawaii is in a period of economic expansion with unemployment rates reaching historical low levels. Albeit this economic expansion and low unemployment rate, the State remains cautious and recognizes that economic conditions can change rapidly and can be influenced by internal factors (such as changes in state procurement and contracting policy and procedures) and external factors (such as availability of federal funding). Within ADAD, staff turnover and attrition continue to pose challenges to ADAD's operations and may be related to the State’s current low unemployment rate.

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 planning areas that are consistent with the State's island counties. Oahu (City and County of Honolulu) is the major planning area that comprises 69.6 percent of the State's population of 1,421,658 based on estimates from the U.S.
Bureau of the Census, American Factfinder 5-year Estimates, 2013-2017. The other three planning areas consist of the neighbor island counties of Hawaii, Maui (which includes the islands of Maui, Molokai, and Lanai), and Kauai. The population percentage of each of these counties is as follows: Hawaii County, 13.8 percent; Maui County, 11.5%; and Kauai County 5.0 percent. Based on the Census Bureau 2010 Census population, 78.2 percent of Hawaii's population is comprised of minorities ("minority population" is defined by the Census Bureau as the population identifying their race and ethnicity as something other than non-Hispanic White race only) and 24.0 percent of Hawaii's population self-identify as multi-racial.

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 two to four years. This would generally commit the State to these services for the entire contract period. However, after the first contract year, contract continuation is subject to funding availability, satisfactory performance of contracted services, and the determination by the State that the services are still needed.

**Substance Abuse Treatment Services**

Supported by Block Grant and/or State general funds, ADAD provides access to substance use disorder (SUD) continuum of care (COC) treatment services to include residential services (including nonmedical 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 (PWWDC), people who inject drugs (PWID), offenders on supervised release, furlough, probation or parole, and the homeless.

ADAD is implementing a Community Addiction Resource Entry System (CARES). The intent is to create a system of care that includes all SUD COC treatment service providers, both those contracted and those not contracted with the State. This will provide a system of care that lowers the barriers to access treatment and offers avenues of referral to on-demand SUD treatment services; these referrals will define the appropriate type of service and service location. An additional CARES objective is to reduce the need or engagement of a waitlist. In order to reduce a waitlist need, the State intends that all clients, who enter into the SUD COC network, will be
referred to a state contracted service provider or will be referred to a non-network provider; thus, increasing access to services for all clients. These services are not limited to SUD COC treatment services and will include all community resources such as housing, mental health, primary care, judiciary, employment, education, and administrative.

For information on specialized services for pregnant women and women with dependent children, please see Sec. 10, 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) 2020 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.
Supported by the State general funds, ADAD ensures access to SUD COC treatment services for adolescents through contracted school-based and community-based substance abuse treatment programs. School-based treatment services are provided at nearly all 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.

The Youth Treatment Implementation Grant (YT-I) awarded to ADAD has provided the State the opportunity to expand access for SUD COC treatment services and mental health services to youth ages 12-26. Through the YT-I grant, ADAD has collaborated with the Child and Adolescent Mental Health Division (CAMHD) to create expansion and coordination for multiple systems. This grant has presented the opportunity to create a direct referral process between SUD and mental health (MH) service providers. This link between SUD treatment providers and MH providers has created an expansion to access of Multi-Systemic Therapy (MST). Another activity is the creation of a residential crisis shelter for youth; this is another collaboration between ADAD, CAMHD, Office of Youth Services, and the State’s Adolescent Drug Court.

The State Targeted Response to the Opioid Crisis Grant (Opioid STR) and the State Opioid Response Grant (SOR) combine 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. With support from Governor Ige and collaboration with over 100 stakeholders and community representatives, ADAD has implemented the Hawaii Opioid Initiative (the HOI). The HOI initiates activities in seven (7) focus areas all targeted to reduce risk factors and increase protective factors throughout the state for opioid and other substance misuse. The HOI is in its second year of implementation and has achieved several objectives which include expanded registration in the Patient-Driven Payment Model (PDPM), broadened naloxone training and distribution, and coordination of state-wide installation of medication drop boxes.

Funded through the State General Funds and in collaboration with the Governor’s Office on Homelessness, ADAD has implemented a state-wide Law Enforcement Assisted Diversion System (LEAD). The result is the creation of four (4) individual, county level LEAD programs; the State has implemented LEAD on Maui, Hawaii Island, Oahu, and Kauai. Each county program is made up of three (3) components: a SUD treatment provider, a mental health (MH) provider, and a housing service provider offering temporary and permanent supportive housing. Each LEAD program also coordinates with the county’s prosecuror’s office and the county police department. ADAD oversees contract administration, coordination and evaluation.

**Substance Use Disorder Prevention Services**

The goal of the substance use disorder prevention service system is to reduce the prevalence,
incidence and consequences of alcohol, tobacco and other drugs (ATOD) by addressing community conditions that promote alcohol and other substance use and by enhancing community conditions that buffer individuals from the consequences of substance use disorders. ADAD supports the implementation of the Strategic Prevention Framework (SPF), a cost-effective, structured planning process that can be applied to prevention systems at both the state and local level. Focused on systems development, the SPF reflects a public health, or community-based, data-driven approach to selecting and delivering effective prevention interventions appropriate for the community. The SPF has been used effectively by community-based organizations and community coalitions to mobilize and create community-level change. Mobilization has included the implementation of evidence-based environmental strategies which establish or change written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population. Partnership for Success (PFS) grant funds from the Center for Substance Abuse Prevention (CSAP) have contributed further to enhancing the prevention system infrastructure and supporting efforts to implement the SPF and building the capacity of community coalitions and organizations to address alcohol and other substances. (Please see https://spfhawaii.org)

Guided by the SPF process, ADAD awards available resources to align prevention priorities, leverage resources, build capacity and enhance community-level infrastructure to reduce and prevent the use of ATOD among at risk persons in high need areas. Federal and State dollars are allocated through service contracts with community-based non-profit organizations and public agencies to provide an effective, accessible 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. Funded prevention programs primarily focus on the provision of evidence-based curricula and practices categorized in at least one of the six the CSAP strategies for youth and their families. Prevention interventions are comprehensive and culturally appropriate for universal, selected and/or indicated populations and strive to produce sustainable positive outcomes.

Prior to making decisions regarding funding allocations, ADAD requests public agencies and non-profit community-based organizations provide feedback related to definitions of community, available community level data, identified priorities, and the current capacity of communities to address the components of SPF and to implement the CSAP strategies and evidence-based programs, practices and policies to address the prevention of substance use disorder and related issues and priorities. Additionally, ADAD considers analysis and recommendations made by the State Epidemiology Outcomes Workgroup (SEOW) and statewide and county profiles using available data related to youth and adult use of alcohol and other drugs substance use (http://health.hawaii.gov/substance-abuse/survey/2018-hawaii-state-epi-profiles/)

During this application planning period of July 1, 2019 to June 30, 2021, ADAD is using the FFY 2018 SAPT Block Grant along with State dollars to fund the fourth and final budget year of prevention service contracts which started on July 1 2016 and end on June 30, 2020. The contracted prevention services continue 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 use disorder prevention system
based on data driven decision-making process. The contracted providers utilize data to develop logic models and 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 are at-risk youth, ages 9-17 and young adults ages 18-24 and their families, schools and communities. Additionally, depending on the geographic area or community where prevention services are delivered, providers may target and include for prevention services populations identified below:

- Children and youth whose parents are experiencing substance use disorders;
- Children and youth who have experienced academic difficulties or chronic failure in school;
- 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;
- Youth at risk for suicide;
- Lesbian, Gay, Bisexual, Transgender, Questioning, and In transition individuals (LGBTQI);
- Homeless children, youth and families;
- Military personnel and dependents; and
- Native Hawaiian.

The lengthy procurement process is underway for primary prevention services to begin July 1, 2020 to further support community efforts to prevent and reduce the use of alcohol, tobacco, and other drugs among children, youth, families, and other at-risk populations and expand prevention approaches to prevent substance use through the implementation of evidence-based prevention programs and strategies. Prevention service contracts are awarded based on the best configuration of services to promote a statewide, culturally appropriate, comprehensive substance use disorder prevention system of services to meet the needs of Hawaii’s communities. Considerations for the allocation of funds to the applicants include, but are 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 community stakeholders including children and youth, and Native Hawaiian organizations; and cost effectiveness as determined by estimated per participant costs.

ADAD promotes the coordination of resources to further support and strengthen the prevention service system. State and local government agencies and community-based organizations coordinate to leverage resources and services to address risk factors, increase protective factors, expand innovative prevention approaches, and improve the quality of comprehensive community-based prevention efforts to prevent substance use disorder and its related issues. ADAD funds the Hawaii Prevention Resource Center (HI-PRC) 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, as well as the website: http://www.hiprc808.org. Further, ADAD collaborates with other Department of Health programs, the Hawaii Department of Education, and consultants from the University of Hawaii to develop and administer an integrated Hawaii Student Health Survey in selected public high and middle school classrooms across the State. The analyzed survey data is instrumental in guiding ADAD planning activities for prevention services.

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 maintains a cost-reimbursement 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.

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 M/SUD 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 M/SUD 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.

A data-driven process must support the state's priorities and goals. 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, 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 disorder prevention, 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.

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, 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.


Footnotes:
Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

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 Mental and Substance Use Disorder (M/SUD) health care. The transportation issue limits or prohibits islands from 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 in the Honolulu area.

According to a 2015 study by the Pew Charitable Trusts, the national service provider average is 32 providers per 1,000 people with drug or alcohol addiction; Hawaii has approximately 20 providers per 1,000 adults with addictions. Hawaii’s ranking among the states, which includes Washington D.C., is 44th; thus, Hawaii’s ratio average is lower compared to most other states.

Second, the stigma associated with substance misuse remains a 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. To decrease this negative impact, ADAD’s substance abuse treatment contracts are named “health and wellness plans.”

Third, a lack of coordinated entry among Hawaii treatment providers continues to result in fragmented collaboration among providers. This fragmented collaboration has resulted in continued barriers of client access to a full continuum of care (COC) for substance use disorder (SUD) treatment services. 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. With FY 2019-2021 treatment contracts, the State plans to implement the Community Addiction Resource Entry System (CARES), with the objectives of reducing treatment access barriers and creating a system that provides a COC to deliver SUD treatment modeled after the American Society of Medicine (ASAM) criteria for SUD services.

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 state 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 issues Request for Information (RFI) to obtain community input from stakeholders and substance abuse treatment providers 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 currently approximately two 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, 2019, ADAD will start the first year of its two-year contract period for treatment and recovery support services from October 1, 2019 to September 30, 2021, with the possibility of extensions for two more years ending September 30, 2023. The SABG application planning period of July 1, 2019 to June 30, 2021, covers the first and second year of ADAD’s new two-year contracts for treatment and recovery support services. The federal fiscal year (FFY) 2019 SABG award is being utilized to support the first year of ADAD’s new two-year contracts. The FFY 2020 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., October 1, 2020 to September 30, 2021. 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 two-year contract period followed State procurement requirements and procedures which preceded the first year of the contract period. Planning
activities for ADAD’s two-year contract period included publishing four (4) electronic RFIs throughout calendar year 2018. ADAD utilized information from the RFIs 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 two-year contact period (with the possibility of extensions) from October 1, 2019 to September 30, 2021.

**Adult Population:** In planning for substance abuse treatment and recovery support services for the adult population, ADAD reviewed state fiscal year (SFY) 2018 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, 16.8% received treatment for alcohol as the primary substance while 54.7% received treatment for methamphetamines and 10.9% for marijuana. Another 7.4% received treatment for heroin. Other opiates as primary substance accounted for 6.9% for adults. 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 released the “Alcohol and Drug Treatment Services in Hawai`i, 2018” report produced by the University of Hawaii Center on the Family under a contract with ADAD. The report focuses on substance use disorder treatment services provided by agencies that were funded by ADAD during State fiscal years 2015, 2016 and 2017. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes. The report is available on the ADAD website at https://health.hawaii.gov/substance-abuse/files/2018/12/TREATMENT_2018_WEB.pdf.

**Pregnant Women and Women with Dependent Children:** In planning for specialized substance abuse treatment and recovery support services for pregnant women and women with dependent children, ADAD reviewed the 2017 National Survey on Drug Use and Health (NSDUH) data, the Treatment Episode Data Set (TEDS) Report of April 2017, ADAD’s SFY 2018 WITS data, and the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) Trend Report, 2009-2015 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 2017 data for the U.S., 11.5% of pregnant women aged 15 to 44 drank alcohol in the past month. The 2017 TEDS data, Admissions to and Discharges from Publicly-Funded Substance Abuse, indicates that female admissions aged 18 years and older reported alcohol (10.6%) as their primary substance use at admission. Additionally, the 2017 TEDS data indicates that female admissions, aged 18 years and older, reported methamphetamine/amphetamines (16.0%) as their primary substance use at admission. For opiates (heroin and other opiates), as the primary substance use upon admission, 39.2% of females aged 12 years and older reported this substance. Thus, the highest proportion of opiate and
methamphetamine/amphetamines usage reported as the primary substance upon admission was by females aged 18 and older. According to the PRAMS Trend Report of 2009-2015 in 2015 an estimated 8.7% of mothers reported alcohol use during pregnancy; and an estimated 4.9% reported cigarette smoking during pregnancy. From 2012 – 2015 there was an average annual estimate of 18,400 resident births. Approximately 76% of those births occurred to women age 20-34 years of age; 18% was to women 35 years of age and older and 5% 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 7.4% of treatment admissions for adults, up from 6.4% of in SFY 2017. Other opiates as primary substance accounted for 6.9% for individuals age 18 and older, up from 6.2% in SFY 2017. Based on WITS data for SFY 2018, ADAD’s contracted providers reported total admissions of 5,187 ADAD-funded clients of which 4.5% had a primary substance use of heroin.

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. Now adopted as the Hawaii Opioid Initiative (the HOI) the State moves towards its third year of implementation. The second version (HOI 2.0) are available at: [https://health.hawaii.gov/substance-abuse/files/2019/01/The-Hawaii-Opioid-Initiative_2.pdf](https://health.hawaii.gov/substance-abuse/files/2019/01/The-Hawaii-Opioid-Initiative_2.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 substance use treatment 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 SFY 2018 treatment program admissions data, the PRAMS Trend Report for 2009-2015, information from the Hawaii State Judiciary, the Hawaii State Department of Public Safety, and the Hawaii Paroling Authority.

Another way ADAD supports services for substance use disorders is through recovery housing. The 2019 Homeless Point in Time Count for the State of Hawaii, conducted by Partners In Care (PIC), found of 6,530 homeless individuals of which 3,638 were unsheltered. 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 2020 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, 2019 to June 30, 2021 also covers the planning period for ADAD’s upcoming two-year contract period for treatment and recovery support services from October 1, 2019 to September 30, 2021, with the possibility of a two-year extension ending September 30, 2023. Planning and information gathering activities were completed throughout 2018 for development of the 2019 RFP for adult and adolescent substance abuse treatment services. RFI were published during CY 2018 to obtain community input on services needed. ADAD published the next RFP in January 2019 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 Use Disorder Prevention Services

National and local data sources are used to inform the process to identify service needs and develop priorities and goals for the substance use disorder prevention services in Hawaii.

ADAD relies heavily on community-based service providers, contracted consultants and experts, trained epidemiologists for assessments, data collection, and data analysis to identify primary prevention program needs and gaps. Representatives from community-based organizations and other stakeholders participate in formal and informal discussions and meetings to provide insights and feedback regarding local conditions, behaviors and trends related to substance use disorder issues. The implementation of prevention program services funded by SABG and State general funds is documented and tracked in the Hawaii-Web Infrastructure for Treatment Services (HI-WITS). ADAD recognizes that the local information gathered and reported through HI-WITS may be flawed or biased relative to the contracted service providers’ depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation. The University of Hawaii is contracted to provide technical assistance and training to contracted service providers to ensure more effective reliable primary prevention program data collection and reporting.

The State Epidemiologic Outcomes Workgroup (SEOW) led by the University of Hawaii Office of Public Health Studies Epidemiology Team has been instrumental in assisting ADAD in making data informed decisions regarding plans and resource allocations to enhance the prevention system. The functions and membership of the SEOW have been sustained through the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) five-year grants awarded by CSAP to ADAD in 2013 and 2018. The workgroup is comprised of voluntary members, primarily directors, epidemiologists or data managers, from government, educational and community agencies involved in research or data collection. The SEOW provides additional support to sustain SPF efforts, fill knowledge gaps, and develop a platform for data sharing and a data sharing protocol that enables timely and efficient sharing of epidemiological data relating substance use disorder and its consequences. Quarterly meetings, training workshops and conferences are organized by the SEOW to share and review different data sources and reports in efforts to apply the lessons learned in substance use disorder data collection and reporting to broader behavioral health issues.

Compiling and analyzing various data sources, the SEOW created and periodically updates community profiles that provide an insight and basis for potential prevention program design and direction. Please see (http://health.hawaii.gov/substance-abuse/survey/2018-hawaii-state-epi-profiles/) for the updated profiles. The original data sources for the profiles include the Hawaii Youth Risk Behavior Survey (Hawaii YRBS), the National Survey on Drug Use and Health (NSDUH), the Behavioral Risk Factor Surveillance System (BRFSS), Uniform Crime Report (UCR) data, Fatality Analysis Reporting System (FARS) data, and the Pregnancy Risk Assessment Monitoring System (PRAMS). To address the issues of substance use disorder on a broader scale, all substances, age groups and indicators are 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:

- 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 use disorder or dependence (alcohol, any illicit drug)
- Adult substance use disorder 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

As first identified during the State Incentive Grant (SIG) period and further supported by more recent survey results and data analysis of the SEOW, alcohol use is more prevalent among youth ages 9-17 and young adults ages 18-20 than any other substance, so therefore, underage drinking (UAD) remains a prevention priority focus statewide. Although the prevalence of UAD has been in decline for Hawaii overall, neighbor islands, Native Hawaiians, sexual and gender minorities, and homeless and runaway youth are disproportionately impacted. The most recent Youth Risk Behavior Survey (YRBS 2017) data shows that youth living in counties outside of the highly urbanized City and County of Honolulu are more likely to consume alcohol. Hawaii, Maui and Kauai Counties have higher prevalence rates in alcohol indicators for middle and high school students. These indicators include: ever having a drink of alcohol; current drinkers; first drink before the age of 13, and; binge drinking for both girls and boys. Hawaii County ranks the highest for all indicators except binge drinking.

Data also shows that Native Hawaiian youth have a greater risk of alcohol use compared to other racial groups. Among the major racial groups where data were available, Native Hawaiian high school students consistently showed the highest prevalence in all alcohol-use indicators: 54.8% reported they had ever used alcohol, 29.6% were current drinkers, 15.3% of boys and 18.7% of girls participated in binge drinking and 21.4% of alcohol users had their first drink before 13 years of age. (http://ibis.hhdw.org/ibispview/query/selection/yrbs/_YRBSSelection.html). UAD also disproportionately affects gender and sexual minority youth. According to the Hawaii State Department of Health (DOH) Hawaii Sexual and Gender Minority Health Report (2017), over 1 in 10 high school students self-identified as lesbian, gay, bisexual and questioning (LGBQ). Using YRBS multi-year high school data (2011 – 2015), the report found that 45% of LGBQ youth were current alcohol users, compared to 25% of heterosexual youth. Moreover, LGBQ youth were twice as likely to participate in binge drinking compared to heterosexual youth (20% versus 10%).

Homelessness is another major public health problem within the State. The 2018 Street Youth Study, released by the University of Hawaii, surveyed 151 homeless and runaway youth aged 12-24 in the City and County of Honolulu. The study found that street youth are about five times more likely to report “fair” or “poor” overall health compared to the general population. When looking specifically at youth drinking, 53% of youth in the study reported using within the 30 days prior to the interview; among younger youth (aged 12-17) the prevalence of current drinkers
was 44.4%.

Needs and gaps related to readiness, capacity, and resources to provide services to identified high need areas and special populations to sustain an effective prevention service system for Hawaii continue to exist. Often community-based organizations are challenged to select and deliver effective programs for specific populations such as the homeless adolescent, LGBTQI, and Native Hawaiian populations. Though a commitment continues to incorporate cultural values and traditions without compromising the integrity of identified evidence-based programs, there is a lack of locally developed and evaluated evidenced-based, culturally appropriate substance use disorder prevention programs and curricula. Additionally, the limited capacity and financial resources of community-based organizations to manage and maintain compliance with the fiscal reporting, management requirements and special conditions of state and federal contract agreements, provide challenges for the substance use disorder prevention system at the community level. Even though prevention services may be delivered more effectively by local, small agencies or individuals in certain communities or for specific populations, the smaller organizations often lack the business plan and infrastructure necessary for billing and reporting processes. A related gap to be addressed is the workforce capacity, expertise and staff required to conduct the financial or programmatic aspects of government contracts and sustain operations. Communities have expressed the need for attention to workforce development and further support for increasing the skills and numbers of certified prevention specialists.

According to the Hawaii SEOW, Hawaii has data limitations and gaps in the substance use disorder and mental health areas, specifically prescription drug misuse, substance use disorder by ethnic sub-groups, specific populations, and mental health related comorbidities. The following list of data gaps, identified by the SEOW, if addressed could expand the knowledge base of specific populations, substances, risk, and protective factors and assist in effective allocation of substance use disorder prevention resources.

- **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.).

- **Special populations**

  Current data sources do not identify current college enrollment, resulting in the need to collect data specifically for college students and individuals above and individuals below 21 years of age. Limited data available for youth drug use indicate that sexual minority youth may be using certain substances at higher rates than their heterosexual peers. Based on the few findings regarding ethnic differences, groups with consistently higher use, specifically Native Hawaiian and Caucasian youth, have been seen over several years.
• **Consistent indicators**

A consistent set of indicators to measure each substance is useful in comparing the priorities by substance; however, certain substances, such as alcohol are thoroughly measured whereas others, such as heroin, are not. Further, certain indicators for alcohol use are not available consistently for every year. For example, the indicators for youth disapproval of alcohol use, youth driving while under the influence of alcohol, family communication around substance use, and percentage of youth seeing a prevention message were canvassed in previous years’ questionnaires but are no longer available. Continued data collection for all indicators would allow for better cross-year comparisons.

• **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 use disorder association.

• **Additional Substances**

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

Under the lead of the SEOW, community partners, and other stakeholders, ADAD plans to address the needs and gaps identified above and enhance the substance use disorder prevention system and services in Hawaii during the SFY20 and SFY21. The ADAD will allocate available resources to community-based agencies to implement evidence-based programs, practices and policies that will impact the highest need communities and special populations. Funded prevention strategies and programs will be culturally appropriate and tailored to target populations and behaviors. Evaluation practices will be used to understand whether and how programs should be altered for specific ages or population characteristics. ADAD also plans to focus technical assistance efforts toward building capacity at the local level to enhance the potential for agencies to diversify funding to sustain substance use disorder prevention efforts and promote healthy communities across Hawaii.
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, 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.
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 1,100 users (logons) for both the treatment and prevention fields. WITS has 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.

As of August 1, 2017, WITS was enhanced to include substance use prevention plan development, prevention data collection and reporting. The prevention enhancement to WITS serves about 25-50 active users in field substance abuse 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 use disorder treatment and prevention services. Data are collected from ADAD-contracted service providers.

ADAD in 2018 developed 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. Currently the Department of Health is using such data sharing agreements to adopt department-wide data governance procedures for data-sharing and information use across multiple DOH programs. Currently the Data Governance project encompasses the Behavioral Health Administration and the Health Resources Administration. Besides consistent practices for data-sharing as well as data quality standards, other main goals of the Data Governance project include the maintenance of privacy and compliance, and to enable data-driven decision-making.

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 posed 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 were in negotiations as of December 2017. Since then, the federal grant funding for the APCD from the Centers for Medicare and Medicaid Services’ Center for Consumer Information and
Insurance Oversight expired in March 2019. To continue operating the All-Payer Claims Database beyond the federal grant expiration, management and operating funds were placed in the new Department of Human Services’ Med-QUEST Division’s Health Analytics Program established by Act 55, Session Laws of Hawaii 2018.

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

Using the WITS systems, 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).

Based on a review of the proposed client measures for the previous FFY18-19 SABG Application & Plan, SAMHSA's proposed measures for primary prevention are not 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).

The FFY20-21 SABG Application instructions state, “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](http://www.samhsa.gov/data/quality-metrics/block-grant-measures).” However, the link to the CBHSQ website in the instructions is broken.

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

In order to be able to collect and report on client-level measures not currently collected, additional resources and sufficient time will be needed to conduct internal business process review to design technical requirements and then implement changes to the WITS system. 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.*

No technical assistance (TA) is requested at this time.
Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area:</td>
<td>1</td>
</tr>
<tr>
<td>Priority Type:</td>
<td>SAT</td>
</tr>
<tr>
<td>Population(s):</td>
<td>PWWDC</td>
</tr>
</tbody>
</table>

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, 2019 - September 30, 2021) 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 October 1, 2018, 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 FFY 2020. |
| 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 FFY 2021. |

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)- Providers Acknowledgment
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
Data issues/caveats that affect outcome measures:

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

Priority #: 2
Priority Area: 2
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, 2019 - September 30, 2021) 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 October 1, 2018, 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 FFY 2020.

Second-year target/outcome measurement: Maintain a minimum of one (1) contract to provide enhanced services for IDUs in FFY 2021.

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)- Providers Acknowledgment
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 Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when Applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Lia

Data issues/caveats that affect outcome measures:

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

Priority #: 3
Priority Area: 3
Priority Type: SAT
Population(s): Other (Recovery Support Services)

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, 2019 - September 30, 2021 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 October 1, 2018, 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 FFY 2020.

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 FFY 2021.

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)- Providers Acknowledgment
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 Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when Applicable) (Comptroller’s Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any anticipated delay may affect the timely execution of contracts and contract modification.

Priority #: 4
Priority Area: 4
Priority Type: SAP
Population(s): PP
Goal of the priority area:

To prevent and reduce the use and abuse of alcohol, tobacco and tobacco products, marijuana, and other drugs by youth and young adults in communities statewide.

Objective:

To fund community-based prevention efforts to implement culturally appropriate, evidence-based prevention programs, practices and policies to prevent and reduce substance use and misuse by youth and young adults.

Strategies to attain the objective:

a. Provide communities with resources, technical assistance and specific training directed to build capacity for data collection and the use of data, planning, evaluation, cultural competence, and other prevention topics identified to support the implementation of the Strategic Prevention Framework (SPF) to sustain local prevention efforts.

b. Allocate available resources to community organizations and coalitions to implement individual and/or community-based prevention strategies to reduce risk factors and address local conditions associated with substance use by youth, young adults 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. Allocate available resources to support programs that increase knowledge about tobacco and tobacco products, alcohol, prescription drug misuse, marijuana use and other drug problems as well as to establish 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

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Percent of contracted community-based organizations utilizing data driven decision making, capacity building and planning (SPF) to address local conditions and prevent substance use disorders in their communities as demonstrated by completed, or in progress, logic models, Comprehensive Strategic Plans, and evaluation reports.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>60% 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 (SFY2019)</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>65% of the funded community organizations, have completed, or have in progress, assessment, comprehensive strategic plans, and evaluation of prevention programs and interventions by end of SFY 2020.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>70% of the funded community organizations have evaluated the implementation of prevention programs to determine effectiveness and plan for sustainability of outcomes by end of SFY 2021.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Program Quarterly Reports; Program Monitoring Reports; Comprehensive Strategic Plans and evaluation reports submitted by contracted agencies; Surveys and questionnaires completed by contracted agencies.</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Review of status and evaluation progress as provided through written program reports and updated comprehensive strategic plans submitted by contracted organizations; Dates and content details of training and technical assistance provided to contracted agencies to enhance SPF implementation efforts.</td>
</tr>
</tbody>
</table>
| Data issues/caveats that affect outcome measures: | Delayed implementation of the various components of the SPF due to inability of the state to provide sufficient training and technical assistance to communities; Delays in procurement process and procedures may shorten time for services to proceed; development of the consistent evaluation tool for prevention organizations may affect the degree of increased capacity to utilize the tool; 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; inadequate resources and capacity to engage assistance and services of evaluators.

| Indicator #: | 2 |
| 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 9-17 years old and young adults ages 18-24. |
| Baseline Measurement: | 60% of funded prevention interventions are evidence-based in SFY2019. |
| First-year target/outcome measurement: | 65% of funded prevention interventions are evidence-based by end of SFY2020. |
| Second-year target/outcome measurement: | 75% of funded prevention interventions are evidence-based by end of SFY 2021. |
| Data Source: | (1) Prevention Data Collection System; (2) Comprehensive Strategic Plans, including logic models and data reporting template submitted by contracted agency; (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; (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 #: | 3 |
| Indicator: | Number of technical assistance and training opportunities related to implementing the SPF, including identifying, implementing and evaluating evidence-based prevention programs and strategies, information on alcohol, tobacco, marijuana, and other substance use, and related topics provided to prevention specialists and community organizations. |
| Baseline Measurement: | Five (5) opportunities provided during SFY2019 |
| First-year target/outcome measurement: | Seven (7) opportunities for TA and training by end of 2020. |
| Second-year target/outcome measurement: | Ten (10) opportunities for technical assistance and training by end of 2021. |
| Data Source: | Registration flyers, Agendas, Sign In Sheets, Handouts and materials distributed, Participant Evaluation/Comment Forms; Number of certification units (CEs); Assessment 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; 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. |

Priority #: 5  
Priority Area: 5  
Priority Type: SAT
Population(s): TB

Goal of the priority area:
To make available tuberculosis (TB) services for individuals receiving substance use disorder (SUD) treatment services.

Objective:
To maintain service contracts that make available TB services for individuals receiving substance use disorder treatment 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.

Strategies to attain the objective:
Scope of services for SUD contracts the next two-year (October 1, 2019 - September 30, 2021) contract period to include availability of TB services for individuals receiving substance use disorder (SUD) treatment services.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Execution of SUD contracts with a Scope of Work to include provision for the availability of TB services for individuals receiving substance use disorder (SUD) treatment services.</td>
<td>Effective October 1, 2018, there was at least one (1) contract executed in each of Hawaii’s four counties Oahu, Maui, Kauai, and Hawaii to make available TB services for individuals receiving substance use disorder (SUD) treatment services.</td>
<td>Maintain a minimum of one (1) contract per county in each of Hawaii’s four counties (Oahu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving substance use disorder (SUD) treatment services in FYF 2020.</td>
<td>Maintain a minimum of one (1) contract per county in each of Hawaii’s four counties (Oahu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving substance use disorder (SUD) treatment services in FYF 2021.</td>
</tr>
</tbody>
</table>

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)- Providers Acknowledgment
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)
Data issues/caveats that affect outcome measures:

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

Footnotes:

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 tuberculosis (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 use disorders. 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 2020 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.
## Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019     Planning Period End Date: 6/30/2021

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity (See instructions for using Row 1.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.Substance Abuse Block Grant</td>
<td>B.Mental Health Block Grant</td>
<td>C.Medicaid (Federal, State, and Local)</td>
<td>D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</td>
<td>E.State Funds</td>
<td>F.Local Funds (excluding local Medicaid)</td>
<td>G.Other</td>
</tr>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$5,973,910</td>
<td>$0</td>
<td>$1,492,537</td>
<td>$16,400,688</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td>$1,600,000</td>
<td>$0</td>
<td>$0</td>
<td>$1,838,100</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. All Other</td>
<td>$4,373,910</td>
<td>$0</td>
<td>$1,492,537</td>
<td>$14,562,588</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$2,189,476</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$2,532,276</td>
<td>$0</td>
<td>$0</td>
<td>$2,338,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$8,506,186</td>
<td>$0</td>
<td>$3,682,013</td>
<td>$18,738,688</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

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Footnotes:

Printed: 9/26/2019 9:03 PM - Hawaii - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022
1. Amounts in Column A are based on the Federal Fiscal Year (FFY) 2020 SABG estimated allotment for Hawaii which is planned to be spent during State Fiscal Year (SFY) 2021 (July 1, 2020 to June 30, 2021). Amounts for SFY 2022 (July 1, 2021 to June 30, 2022) will be reported to SAMHSA in the FFY 2021 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 2020 SABG, Hawaii is not a “designated state” whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SABG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.
### Planning Tables

#### Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th>Description</th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>506</td>
<td>61</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>5160</td>
<td>281</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>7980</td>
<td>426</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>2123</td>
<td>313</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>1729</td>
<td>536</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the state does not have a data source.

Not applicable. Each data cell has a data source.

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Footnotes:
## Planning Tables

### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment*</td>
<td>$5,928,910</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$2,577,276</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV**</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$75,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$8,581,186</strong></td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention

** 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 2020 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.
## Table 5a SABG Primary Prevention Planned Expenditures

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FFY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td>SA Block Grant Award</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td></td>
</tr>
<tr>
<td>2. Education</td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td></td>
</tr>
<tr>
<td>3. Alternatives</td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td></td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td></td>
</tr>
<tr>
<td>5. Community-Based Process</td>
<td>Selective</td>
<td>Indicated</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Environmental</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Section 1926 Tobacco</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$110,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Other</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

| Total Prevention Expenditures | $110,000 |
| Total SABG Award* | $8,581,186 |
| Planned Primary Prevention Percentage | 1.28 % |

*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 2020-2021 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.
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019  Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$904,140</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$678,058</td>
</tr>
<tr>
<td>Selective</td>
<td>$71,838</td>
</tr>
<tr>
<td>Indicated</td>
<td>$16,400</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,670,436</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$8,581,186</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>19.47 %</strong></td>
</tr>
</tbody>
</table>

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

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**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): $906,840.
Table 5c SABG Planned Primary Prevention Targeted Priorities
States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019       Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Targeted Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
</tr>
<tr>
<td>Military Families</td>
</tr>
<tr>
<td>LGBTQ</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
</tr>
</tbody>
</table>
Footnotes:
1. Aside from the Native Hawaiian target population, please note that ADAD does not track prevention funds allocated to or expected for specific substances or populations.
## Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. SABG Treatment</td>
</tr>
<tr>
<td>1. Information Systems</td>
<td>$470,000</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$335,482</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$2,500</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$955,882</strong></td>
</tr>
</tbody>
</table>

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

OMB No. 0930-0168 Approved: 06/07/2017 Expires: 06/30/2022
Footnotes:
1. Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B = $906,840.

2. Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Combined, Column C = $15,493.
Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.\(^{22}\) 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.\(^{23}\) It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.\(^{24}\)

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.\(^{25}\) SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.\(^{26}\) 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.\(^{27}\)

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.\(^{28}\)

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.\(^{29}\) 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 M/SUD include: developing models for inclusion of M/SUD 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.\(^{30}\) 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 M/SUD 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\(^{31}\) and ACOs\(^{32}\) may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD 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.\(^{33}\) Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.\(^{34}\)

One key population of concern is persons who are dually eligible for Medicare and Medicaid.\(^{35}\) 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.\(^{36}\) 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.\(^{37}\) Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.\(^{38}\) SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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. 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 M/SUD 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. 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. 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.


26 http://www.samhsa.gov/health-disparities/strategic-initiatives


32 New financing models, [https://www.integration.samhsa.gov/financing](https://www.integration.samhsa.gov/financing)


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, 2019, 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 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 well-being. 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 significant individuals who are stakeholders in the treatment and/recovery support process and vital to positive outcomes of episode care.

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

ADAD is also meeting 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 discretionary 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 connections 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. Collaboration between the State Department of Health and the Department of Human Services for the broader implementation of SBIRT is also underway. 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.

In 2017, with the endorsement of the State Governor, the Hawaii Department of Health launched the Hawaii Opioid Initiative (HOI). Through collaboration with over 100 stakeholders, the HOI focuses on seven (7) areas for the overarching goal to develop and implement a proactive coordinated statewide action plan on opioid and other substance misuse issues. A copy of the latest Hawaii Opioid Action Plan is available here: https://health.hawaii.gov/substance-abuse/files/2019/01/The-Hawaii-Opioid-Initiative_2.pdf.

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 continues it’s collaboration with the MedQuest Division (MQD) of the Department of Human Services, towards standardization of billing policies and procedures for statewide substance use disorder (SUD) continuum of care (COC) treatment services. The goal is to crosswalk services and rates to improve coordination of service delivery.

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

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?

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education  
   b) Health risks such as  
      i) heart disease  
      ii) hypertension  
      iii) high cholesterol  
      iv) diabetes  
   c) Recovery supports

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

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
   No technical assistance is requested at this time.

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[^42], Healthy People, 2020[^43], National Stakeholder Strategy for Achieving Health Equity[^44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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).[^45]

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.”[^46]

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[^47]. 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[^48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.


[^44]: https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

[^45]: http://www.ThinkCulturalHealth.hhs.gov
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, sexual orientation, gender identity, 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 M/SUD 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) Standards?
   
   Yes ☐ No ☐

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD 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 use disorder 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 shared with ADAD’s substance use disorder prevention staff at a State Epidemiological Outcomes Workgroup quarterly meeting, and is found here: http://health.hawaii.gov/surveillance/files/2017/05/HawaiiSexualandGenderMinorityHealthReport.pdf. No update to this report has been produced.

   ADAD released the “Alcohol and Drug Treatment Services in Hawai`i, 2018” report produced by the University of Hawaii Center on the Family under a contract with ADAD. The report focuses on substance use disorder treatment services provided by agencies that were funded by ADAD during State fiscal years 2015, 2016 and 2017. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes. The report is available on the ADAD website at https://health.hawaii.gov/substance-abuse/files/2018/12/TREATMENT_2018_WEB.pdf:

   Enrollment in substance use disorder 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 use disorder 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 use disorder 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 use disorder 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 substance use disorder treatment and recovery services contracts, the contracts’ scope of work now includes translation or interpreter services as a reimbursable recovery support 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 makes available translation or interpreter services as a reimbursable recovery support service provided by ADAD’s contracted substance use disorder treatment and recovery providers.

Please indicate areas of technical assistance needed related to this section

No technical assistance is requested at this time.

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question
While there are different ways to define value-based purchasing, its 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, \( V = \frac{Q}{C} \)

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 M/SUD 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 M/SUD 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. SAMHSA’s Evidence Based Practices Resource Center 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. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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, The New Freedom Commission on Mental Health, the IOM, NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). 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.” 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 M/SUD 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) are best practice guidelines for the SUD treatment. SAMHSA 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) was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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.


53 http://psychiatryonline.org/
54 http://store.samhsa.gov
55 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) ☐ Leadership support, including investment of human and financial resources.
   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ 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.

3. 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.

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Footnotes:
1. The Hawaii SSA provided no response because the Innovation in Purchasing Decisions section is not required for SABG per the FFY20-21 SABG Application instructions.
Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards?  
   - Yes  
   - No

3. Does the state have any activities related to this section that you would like to highlight?
   - Yes  
   - No

   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: 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-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/.

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 related to this section

No technical assistance is requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

7. 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 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.

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?
3. 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. No federally recognized tribes or tribal lands exist within Hawaii’s borders.

56 https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf
Environmental Factors and Plan

8. 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:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

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
   a) Data on consequences of substance-using behaviors
   b) Substance-using behaviors
   c) Intervening variables (including risk and protective factors)
   d) Other (please list)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
   - Cultural/ethnic minorities
   - Sexual/gender minorities
   - Rural communities
   - Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)

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

Uniform Crime Reporting (UCR)
Fatality Analysis Reporting System (FARS)
Pregnancy Risk Assessment Monitoring System (PRAMS)

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?

☐ Yes ☐ No

If yes, (please explain)

Based on the analysis of needs assessment data and community profiles developed by the State Epidemiological Outcomes Workgroup (SEOW), priority populations and communities are identified for prevention services. Comments and feedback regarding the data and priorities is provided by the community-based service providers and stakeholders to also inform decisions regarding allocation of SABG primary prevention funds.

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

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;
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5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

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

### 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
   
   Pursuant to State law (HRS §321-193(10) and regulations (Hawaii Administrative Rules, Title 11, Dept. of Health, Chapter 177.1), ADAD approves credentials for Certified Prevention Specialist (CPS). 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. Information on the certification process and requirements is available at [http://health.hawaii.gov/substance-abuse/counselorcertification/](http://health.hawaii.gov/substance-abuse/counselorcertification/)

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
   
   Existing service contracts and collaborative partnerships facilitate the logistics of utilizing consultants, trainers, and venues to conduct relevant training workshops and courses approved for continuing education/contact hours (CEs) that may be applied toward meeting the education requirements for certification and/or renewal of certification. Additionally, ADAD continues to allocate SABG funds to maintain the Hawaii Prevention Resource Center to ensure prevention practitioners and the general public have access to up-to-date research, substance use disorder treatment and prevention resources, and evidence-based curriculum models. The [https://www.drugfreehawaii.org/hawaii-prevention-resource-center](https://www.drugfreehawaii.org/hawaii-prevention-resource-center) links to a lending library, resource clearinghouse, and technical assistance services. A website specific to the Strategic Prevention Framework and prevention efforts is available for the workforce and prevention system at [https://www.spfhawaii.org/](https://www.spfhawaii.org/).

3. **Does your state have a formal mechanism to assess community readiness to implement prevention strategies?**  
   - Yes  
   - No
   
   If yes, please describe mechanism used
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:

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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):
   - Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - Timelines
   - Roles and responsibilities
   - Process indicators
   - Outcome indicators
   - Cultural competence component
   - Sustainability component
   - Other (please list):
   - 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.

   The EBW has established criteria and is consulted for implementation of programs and policies but not specific to SABG funds. The intent is to utilize the EBW for assistance in evaluating locally developed, culturally appropriate programs and innovative interventions to determine effectiveness.
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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### 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:**
      - Health Fairs
      - Media Ready
      - Drug-free Awareness Community Events
      - School Presentations
   b) **Education:**
      - LifeSkills Training
      - Positive Action Curriculum
      - Project Alert Curriculum
      - STARS for Families
      - Project Venture Curriculum
      - Second Step Curriculum
   c) **Alternatives:**
      - Project Venture Camps
      - Family Strengthening Activities
Positive Action Alternative Activities
Project Alert Alternative Activities
Parenting and Family Management
Media Ready
Drug-Free Alternative Activities/Events

d) Problem Identification and Referral:
   STARS for Families - psychoeducation

e) Community-Based Processes:
   Prevention Resource Center
   Coalition and interagency collaboration
   Prevention Workforce Training

f) Environmental:
   Synar Activities
   Coalition involvement and interagency collaboration to address local conditions, attitudes and 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

   Applicants for funding provide information related to agency-wide budget and sources of funds, planned expenditures and actual expenditures for program services. Budgets and expenditures are approved and tracked by State fiscal and program staff.
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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**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):
   - Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - Includes evaluation information from sub-recipients
   - Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - Establishes a process for providing timely evaluation information to stakeholders
   - Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - Other (please list:)
   - Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - Numbers served
   - Implementation fidelity
   - Participant satisfaction
   - Number of evidence based programs/practices/policies implemented
   - Attendance
   - Demographic information
   - Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - 30-day use of alcohol, tobacco, prescription drugs, etc
   - Heavy use
   - Binge use
   - Perception of harm
   - Disapproval of use
Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

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.
Environmental Factors and Plan

10. 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
   ii) Education
   iii) Brief Intervention
   iv) Assessment
   v) Detox (inpatient/social)
   vi) Outpatient
   vii) Intensive Outpatient
   viii) Inpatient/Residential
   ix) Aftercare; Recovery support

b) Services for special populations:
   Targeted services for veterans?
   Adolescents?
   Other Adults?
   Medication-Assisted Treatment (MAT)?
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention - Required SABG.
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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   □ 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. Has your state identified a need for 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, and custody issues?  
      □ 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 wait-list is also generated weekly via web-based infrastructure (WITS) for Treatment Services.

   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 encumber 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. This orientation reviews the scope and 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 providers Policies and Procedure 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 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 and scope of work requirements. 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 programs 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 WITS data, for the safe 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, interview with staff, and interviews with client to verify services 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 Fiscal section, for optimal utilization review, in order to minimize lapping funds. Increasing or decreasing contract amounts require a contract modification. The Clinical Psychologist, is responsible for monitoring all clinical aspects of all 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 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

**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. Has your state identified a need for 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 (e.g., military families, veterans, adolescents, older adults)?
     - Yes ☐ No ☐

3. States are required to monitor program compliance related to activities 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. Has your state identified a need for 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.

   Additional response to 1.

   The RFP requires all providers to adopt a policy which states that it provides for TB and Hepatitis C screening, referral, and education as appropriate.

   Monitoring program compliance

   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 have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?
   - Yes ☐ No ☐

2. Has your state identified a need for 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.C § 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, please provide a brief description of the elements and the arrangement
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?

2. Has your state identified a need for any of the following:
   a) Workforce development efforts to expand service access
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   c) Establish a peer recovery support network to assist in filling the gaps
   d) Incorporate input from special populations (military families, service memers, veterans, tribal entities, older adults, sexual and gender minorities)
   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
   f) Explore expansion of services for:
      i) MAT
      ii) Tele-Health
      iii) Social Media Outreach

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?

2. Has your state identified a need for any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   b) Establish a program to provide trauma-informed care
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

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)?

2. Does your state provide any of the following:
   a) Notice to Program Beneficiaries
   b) An organized referral system to identify alternative providers?
   c) A system to maintain a list of referrals made by religious organizations?

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?

2. Has your state identified a need for any of the following:
   a) Review and update of screening and assessment instruments
   b) Review of current levels of care to determine changes or additions
   c) Identify workforce needs to expand service capabilities
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Patient Records
1. Does your state have an agreement to ensure the protection of client records?  
   - Yes ☐ No ☐

2. Has your state identified a need for 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 during the fiscal years involved.

3. Has your state identified a need for 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) Development of 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, such as the 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. Has your state identified a need for 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 opportunity 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) Performance-based accountability ☑ Yes ☐ No
   d) Data collection and reporting requirements ☑ Yes ☐ No

2. Has your state identified a need for 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

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC? ☑ Yes ☐ No
   b) Mental Health TTC? ☑ Yes ☐ No
   c) Addiction TTC? ☑ Yes ☐ No
   d) State Targeted Response TTC? ☑ 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

Please provide a link to the state administrative regulations that 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 2020-2021 MHBG Application Plan for information on this section.


Hawaii Revised Statutes, Sections 321-191 to 198:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0195.htm

Hawaii Revised Statutes, Sections 329-1 to 4:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0004.htm
Environmental Factors and Plan

11. 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 2018-FFY 2019?  
   □ Yes  □ No

   Please indicate areas of technical assistance needed related to this section.
   No technical assistance is requested at this time.

Footnotes:
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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 Trauma58 paper.

57 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. 58 Ibid

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

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers?  
   Yes ☐  No ☐

3. Does the state have a plan to build the capacity of M/SUD 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 Adult Mental Health Division in supporting peer support services (see Hawaii 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;
healing the offender; Medication Assistance Treatment; opioid overdose prevention and response; integrating viral hepatitis; HIV & STDs info counseling; effecting change through the use of MI; positive re-framing and stress reduction; compassion fatigue for trauma-impacted providers; issues and barriers faced by gay, 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, the DOH Adult Mental Health Division, University of Hawaii: School of Social Work, the Judiciary State System, the Department of Transportation, and the Department of Human Services.

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

No technical assistance is requested at this time.

Footnotes:
Environmental Factors and Plan

13. 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.

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.

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 the Health Insurance 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.


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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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 13, 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 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;
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 parents involvement
in substance abuse and who have open cases with the Child and 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 inter-agency collaboration in the treatment of
substance, 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 of 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 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 in the State.

ADAD receives $800,000 general fund appropriation as part of its annual base budget from the Hawaii State Legislature to work
with the Governor’s Coordinator on Homeless to continue to implement 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.hhhrc.org/lead.

With respect to Section 13, item 2, ADAD still works with law enforcement to implement LEAD on the island of Oahu, and since
February 12, 2019, ADAD has secured additional contracts to expand LEAD services to Hawaii, Maui and Kauai counties. 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 13, 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. Training center emphasis is
on: cognitive behavioral therapy; suicide intervention and response, medication assisted treatment, opioid crisis, trauma-based
care techniques and recidivism.

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

No technical assistance is requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
14. Medication Assisted Treatment - Requested (SABG only)

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) ☑ Methadone
   b) ☑ Buprenorphine, 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 provide 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, First Responders, Pharmacy, Primary Care providers, and the University of Hawaii, as well as community-based organizations like the Hawaii Health & Harm Reduction Center to sponsor and promote training sessions in evidence-based practices, naloxone, and overdose prevention.

ADAD has also received the two-year, $2,000,000 State Targeted Response to the Opioid Crisis grant (HI-STR), and the two-year State Opioid Response Grant (SOR), both 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, 2019. 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.

*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

15. 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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.61 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 M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises, "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 M/SUD 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:

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) Peer Support/Peer Bridgers
   b) Follow-up Outreach and Support
   c) Family-to-Family Engagement
   d) Connection to care coordination and follow-up clinical care for individuals in crisis
   e) Follow-up crisis engagement with families and involved community members
4. 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 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 2020-2021 MHBG Application Plan for information on this section.
Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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?  
   - Yes  - 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 are provided through 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 2020-2021 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 recovery 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 service and Childcare.

5. Does the state have any activities that it would like to highlight?  
   1. 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 (http://health.hawaii.gov/amhd/consumer/hcps/). The plan is to review the current support services and structure specificity that incorporates SUD. ADAD has collaborated with providers in approving educational credits for peer recovery training.

   2. With respect to Section 17, item 1.b., regarding peer accreditation or certification, through the support of the State Targeted Response to Opioids grant (STR), ADAD has begun developing a Peer Recovery Support Specialist certification (PRSS). This certification is modeled after the Peer Specialist certification from the Adult Mental Health Division. The PRSS is also written into ADAD’s 2019 RFP for SUD COC treatment services. The PRSS certification will be administered by ADAD.

   3. 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. The plan is to review the current support services and structure specificity that incorporates SUD. ADAD has collaborated with providers in approving educational credits for peer recovery training.

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

   5. Cultural activities: Treatment providers were encouraged during the RFP process, resulting in the new contracts starting October 1, 2019, 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 (TIP) 59: Improving Cultural Competence for guidance.

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

   No technical assistance is requested at this time.

Footnotes:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

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

**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?

   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 2020-2021 MHBG Application Plan for information on this section.
Environmental Factors and Plan

18. Children and Adolescents M/SUD 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. 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. 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.

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. 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.

According to data from the 2015 Report to Congress 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 M/SUD 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).

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 M/SUD 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 M/SUD 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, 2019 to September 30, 2021 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

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

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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.

No technical assistance is requested at this time.

Footnotes:
Environmental Factors and Plan

Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020  End Year: 2021

<table>
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<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
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</tbody>
</table>

*Council members should be listed only once by type of membership and Agency/organization represented.

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 2020-2021 MHBG Application Plan.
## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2020  End Year: 2021

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
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<td>Individuals in Recovery* (to include adults with SMI who are receiving, or</td>
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<td>have received, mental health services)</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults</td>
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<tr>
<td>with SMI)</td>
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<tr>
<td>Parents of children with SED/SUD*</td>
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<tr>
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<tr>
<td>Others (Advocates who are not State employees or providers)</td>
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<td>Persons in recovery from or providing treatment for or advocating for SUD</td>
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<tr>
<td>services</td>
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<td>Representatives from Federally Recognized Tribes</td>
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<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td>Vacancies</td>
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<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td>Youth/adolescent representative (or member from an organization serving young</td>
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<tr>
<td>people)</td>
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</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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**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 2020-2021 MHBG Application Plan.
Environmental Factors and Plan

22. 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 2020-2021 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:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
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 for substance use prevention contracts and two years for substance use treatment contracts. 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 2019 SABG award is currently being utilized to support the first year of the next contract period, i.e., State fiscal year (SFY) 2020 (July 1, 2019-June 30, 2020) for treatment and recovery support services and the fourth year of the contract period for prevention service contracts awarded in accordance with State procurement procedures and requirements. The FFY 2020 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 first year of the next contract period 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 2020-2021 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.