

February 19, 2021

CONTINUUM OF CARE / WITS MEETING

ALCOHOL & DRUG ABUSE DIVISION



- ❖ ADAD Announcement
 - ❖ Prevention Billing
 - ❖ Disaster Response Grant Client Identification and National Outcome Measures (NOMs)
- ❖ WITS Fiscal & Clinical Update
 - ❖ Treatment Plan Architecture
- ❖ Hawaii CARES Update

New Prevention Contracts Reminder: Billing Process



WITS

Submit monthly billings via WITS.



MONTHLY SERVICE FORM

Complete and email the Monthly Service Form to your Contract Manager and Cc DOH.ADAD.PREVENTION@doh.hawaii.gov.



ADAD REVIEW

Contract Manager will review the Monthly Service Form for accuracy (e.g. maximum service units, quarterly allotment, etc.)



PAYMENT REMITTANCE

Providers will receive contract payments via mail.



NOTES

When billing in WITS, you are only allowed to bill for one month at a time.

Submit Monthly Service Forms in pdf and separated by month.

COMMON ISSUES WHEN SUBMITTING BATCHES FOR REVIEW AND PAYMENT

1. Submit Invoices/Batches Monthly and Timely (ALL Contracts and Agreements)
2. Incorrect Priority of Fund Selected
3. Batch and Email Notification Amounts are NOT the same
4. Batch Submitted Exceeds Authorized Amount
5. Attestation Not Included in Batches
6. HCE Not Compliant

HI-DRS Program Frequently Asked Questions 1/29/2021

Q: How shall it be documented that the client is eligible to receive DRS-funded services?

There are three ways to document a client’s eligibility for DRS-funded services in WITS:

1. Universal Screening and Intake Form. For new clients/consumers, one way is to use the USIS and WITS Client Profile, which has a Presenting Problem field. Clinicians should then ask the following questions:

- “Have you been impacted by a natural disaster within the last two years?”
- “Can you tell me how it impacted you?”

The amended USIS that included the two questions above is available via [this link](#).

2. WITS Encounter Notes. For current clients/consumers, clinicians should also ask the questions above as part of client checkup, and document using WITS encounter notes. Please note that encounter notes are only effective if an accurate health & wellness plan (HWP) is also in place.

3. Health and Wellness Plans. The best way (and easy to find in an audit or monitoring) is to document the trigger event and the effects of the disaster in the HWP, which will also include the interventions to be used.

Supplemental Screening Tools. If clinicians choose to probe further for new clients at intake or for current clients during encounters/HWP updates, they may use the [Individual/Family Crisis Counseling Services Encounter Log](#) (OMB NO. 0930-0270). Use the “Event Reactions” section (see below) to cut-and-paste into WITS.

EVENT REACTIONS (select all that apply)

Please indicate the total # of participants experiencing event reactions.

- 1*
- 2*
- 3*
- 4*
- 5*
- 6 or more*

BEHAVIORAL

- extreme change in activity level*
- excessive drug or alcohol use*
- isolation/withdrawal*
- on guard/hypervigilant*
- agitated/jittery/shaky*
- violent or dangerous behavior*
- acts younger than age (children or youth)*

EMOTIONAL

- o sadness, tearful*
- o irritable, angry*
- o anxious, fearful*
- o despair, hopeless*
- o feelings of guilt/shame*
- o numb, disconnected*

PHYSICAL

- o headaches*
- o stomach problems*
- o difficulty falling or staying asleep*
- o eating problems*
- o worsening of health problems*
- o fatigue, exhaustion*

COGNITIVE

- o distressing dreams, nightmares*
 - o intrusive thoughts, images*
 - o difficulty concentrating*
 - o difficulty remembering things*
 - o difficulty making decisions*
 - o preoccupied with death/destruction*
- o COPING WELL: NONE OF THE ABOVE APPLY (If there are no participants experiencing the above event reactions, please check this box)*

For Further Reading.

- [Warning Signs and Risk Factors for Emotional Distress | SAMHSA](#)
- [Tips for Survivors of a Disaster or Other Traumatic Event Managing Stress](#) (see “Possible Reactions to a Disaster or Other Traumatic Event”)
- [SAMHSA Disaster Technical Assistance Center \(DTAC\) resources](#)
 - 1) [DTAC CCP Toolkit & Data Forms Trainings](#)
 - 2) [DTAC CCP Toolkit Data Forms Training Video](#)
 - 3) [Train Your CCP Staff](#)
- Red Cross Screening Process – Home Displacement due to Natural Disaster
 - 1) VERIFY EVENT OCCURRED:
 - Press Release on the event
 - Verification by Fire or Police to include name, badge #, and phone #
 - 2) VERIFY CLIENT'S AFFECTED:
 - Client must provide a form of i.d. (state i.d. or Hawaii license)
 - Driver's license or State ID - must have client's name and address that was impacted
 - other sources of verification: utility bill, landlord verification, First Responder verification
 - 3) VERIFY DAMAGE ASSESSMENT for financial assistance and support services:
 - Verified by Red Cross responder, Fire or Police

Q: Are NOMs assessments part of the billable services?

A: NOMs are billable services for Hawaii CARES providers. Baseline NOMs are billable using the Assessment Tier 1 Initial rate (\$90/report), whereas Reassessment and Discharge NOMs are billable using the Assessment Tier 2 Follow up rate (\$75/report).

Q: How to record the consumer's consent for the NOMs interviews?

A: Providers may write GPRA/NOMs Interview in the Other" box, see current consent form: https://health.hawaii.gov/substance-abuse/files/2019/09/ADAD_CARES_Consent_Form.pdf

Q: Is it okay to use the first four characters of the UCN (Client ID in WITS) on the HIDP data platform?

A: It's okay because the HIDP does not use any part of the UCN to generate the DRS consumer ID and the UCN will not be submitted to SAMHSA.

CONFIDENTIAL

HAWAI'I CARES INTAKE FORM

Added to WITS: YES NO

Name _____ Date: ____/____/____ Time: ____:____ AM/PM

To whom are you speaking with (if not client): _____

Do you give consent for Hawai'i CARES to contact any agency within our network for an assessment/treatment?

YES NO

Do you have any current/immediate medical or psychiatric concerns?

Have you been impacted by a natural disaster within the last two years? If yes can you tell me how it impacted you?

Current living arrangement:

____ Houseless/Homeless ____ Living in others home ____ Living in my own home ____ Jail/Incarcerated

Address: _____

City/Island: _____ Zip Code: _____

Contact number: _____ Alternate Phone: _____

of children living with you _____ Age(s): _____ Pregnant: YES NO

	Name	Relationship	Phone number
Referral Contact			() -
Personal Contact			() -
Emergency Contact			() -

Do you give consent for Hawai'i CARES to contact (list collateral contacts) if we are unable to get in contact with you? YES NO

Other Reference No. (A#, Adolescent Judiciary #, etc.): _____

Gender: _____ Date of Birth: ____/____/____ Marital Status: _____

Ethnicity: _____

Race: _____ Citizenship: _____ Veteran: YES NO

Presenting Problem (s) ("In Client's Own Words"):

CAGE-AID

- 1. Have you ever felt you should cut down on your drinking or drug use? YES NO
- 2. Have people annoyed you by criticizing your drinking or drug use? YES NO
- 3. Have you ever felt bad or guilty about your drinking or drug use? YES NO
- 4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye opener)? YES NO

In the last 30 days have you misused alcohol or other drugs? YES NO LDOU: _____

Are you an Injection Drug User? YES NO

Do you consume tobacco products? YES NO

Have you been in a controlled environment in the past 30 days (e.g. jail)? YES NO

If so, where: _____

Do you have a history of causing physical harm to others? YES NO

If yes, current risk action: _____

Do you have a history of causing physical harm to yourself? YES NO

If yes, current risk action: _____

Describe current legal status:

Current medical problem(s):

List medications currently using (OTC and prescribed):

Health Insurance: _____ Membership #: _____

Employment Status: _____

Is transportation a challenge for you? YES NO

Have you received treatment in the past? If so, where: _____

What services are you interested in?

Counseling Sober Living Outpatient Residential Other: _____

REFERRAL

Was the referral made? YES NO

If not, please explain:

Notes:

Staff initials: _____

Project #

OMB NO. 0930-0270
Expiration Date 07/31/2022

Individual/Family Crisis Counseling Services Encounter Log

Provider Name

Provider #

Date of Service (mm/dd/yyyy)

County of Service

1st Employee #

2nd Employee #

ZIP Code of Service

VISIT TYPE (please check the appropriate box)

Number of participants in this encounter (either Individual or Family or Household)

Individual = 1 Family or Household (2 or more individuals) = 2 3 4 5 6 or more

VISIT NUMBER First Visit Second visit Third visit Fourth visit Fifth visit or later

DURATION 15-29 minutes 30-44 minutes 45-59 minutes 60 minutes or more

DEMOGRAPHIC INFORMATION

Number of MALES per age category in this encounter (indicate # in box)

preschool (0-5 years) child (6-11 years) adolescent (12-17 years) adult (18-39 years) adult (40-64 years) older adult (65 years or older)

Number of FEMALES per age category in this encounter (indicate # in box)

preschool (0-5 years) child (6-11 years) adolescent (12-17 years) adult (18-39 years) adult (40-64 years) older adult (65 years or older)

Number of TRANSGENDER individuals per age category in this encounter (indicate # in box)

preschool (0-5 years) child (6-11 years) adolescent (12-17 years) adult (18-39 years) adult (40-64 years) older adult (65 years or older)

Race/ethnicity of participants in this encounter (select all that apply)

- American Indian/Alaska Native Asian Black or African American
 Native Hawaiian/Other Pacific Islander White Hispanic or Latino

Primary language spoken during encounter (select one)

- English Spanish Other (specify in box)

If any of the participants has a disability, or other access or functional need, indicate the type (select all that apply)

- Physical (mobility, visual, hearing, medical, etc.) Intellectual/Cognitive (learning disability, developmental delay, etc.) Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

LOCATION OF SERVICE (select one)

- school and child care (all ages through college) temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings)
 community center (e.g., recreation club) IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
 provider site/mental health agency (agency involved with Crisis Counseling Assistance and Training Program [CCP]) permanent home
 workplace (workplace of the disaster survivor and/or first responder) IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
 disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross) phone counseling (15 minutes or longer)
 place of worship (e.g., church, synagogue, mosque) retail (e.g., restaurant, mall, shopping center, store) If HOTLINE, HELPLINE, or CRISIS LINE, please **check here**.
 public place/event (e.g., street, sidewalk, town square, fair, festival, sports) medical center (e.g., doctor, dentist, hospital, mental health, or substance abuse specialty center)
 other (specify in box)

RISK CATEGORIES (select all that apply)

- family missing/dead
- friend missing/dead
- pet missing/dead
- home damaged or destroyed
- vehicle or major property loss
- other financial loss
- disaster unemployed (self or household member)
- injured or physically harmed (self or household member)
- life was threatened (self or household member)
- witnessed death/injury (self or household member)
- assisted with rescue/recovery (self or household member)
- had to change schools
- prolonged separation from family
- evacuated quickly with no time to prepare
- displaced from home 1 week or more
- sheltered in place or sought shelter due to immediate threat of danger
- past substance use/mental health problem
- preexisting physical disability
- past trauma

EVENT REACTIONS (select all that apply)

Please indicate the total # of participants experiencing event reactions. 1 2 3 4 5 6 or more

BEHAVIORAL

EMOTIONAL

PHYSICAL

COGNITIVE

- extreme change in activity level
- excessive drug or alcohol use
- isolation/withdrawal
- on guard/hypervigilant
- agitated/jittery/shaky
- violent or dangerous behavior
- acts younger than age (children or youth)
- sadness, tearful
- irritable, angry
- anxious, fearful
- despair, hopeless
- feelings of guilt/shame
- numb, disconnected
- COPING WELL: NONE OF THE ABOVE APPLY
- headaches
- stomach problems
- difficulty falling or staying asleep
- eating problems
- worsening of health problems
- fatigue, exhaustion
- distressing dreams, nightmares
- intrusive thoughts, images
- difficulty concentrating
- difficulty remembering things
- difficulty making decisions
- preoccupied with death/destruction

(If there are no participants experiencing the above event reactions, please check this box)

FOCUS OF ENCOUNTER (select all that apply)

INFORMATION/EDUCATION ABOUT: reactions to disaster community resources this crisis counseling program

TIPS FOR:

- reducing negative thoughts
- managing physical and emotional reactions (e.g., breathing techniques)
- doing positive things
- problem solving

HEALTHY CONNECTIONS:

- mutual support/building social networks
- participating in community action

other (specify in box)

FOCUS OF GROUP SESSION (select all that apply)

Were flyers, brochures, handouts, or other materials provided to this/these participant(s)? YES NO

REFERRAL (select all that were communicated)

- crisis counseling program services (e.g., group counseling, referral to team leader, follow-up visit)
- mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)
- substance abuse services (e.g., professional, behavioral or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous)
- community services (e.g., FEMA, loans, housing, employment, social services)
- resources for those with disabilities, or other access or functional needs
- other (specify in box)

NO REFERRAL PROVIDED

Reviewer Name

Signature

Date of Review

**INSTRUCTIONS:
INDIVIDUAL/FAMILY CRISIS COUNSELING SERVICES ENCOUNTER LOG**

When to Use This Form:

Complete this form immediately **after** the individual or family/household crisis counseling service is provided.

1. Complete this form for each individual or family/household that receives crisis counseling services of 15 minutes or more.
2. An individual or family/household crisis counseling encounter is defined as a contact where the discussion goes beyond education and assists understand of current situations and reactions, involves review of options, or addresses emotional support or referral needs.
3. This form is not intended to be used as a survey. Do not ask the individual for any of the information on this form. Complete all items on the form based on your best observations and information you received during the encounter.

PROJECT #—FEMA disaster declaration number, e.g., DR-XXX-State

PROVIDER NAME—The name of the program/agency.

PROVIDER NUMBER—The unique number under which your program/agency is providing services.

DATE OF SERVICE—The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2012.

COUNTY OF SERVICE—The county where the service occurred.

1st EMPLOYEE #—YOUR employee number (must be numeric and no more than 6 digits).

2nd EMPLOYEE #—Employee number of your teammate during this encounter (must be numeric and no more than 6 digits).

ZIP CODE OF SERVICE—The ZIP code of the location where the service occurred.

VISIT TYPE—Was this encounter with one person (individual) or with two or more individuals living as a family or household (family or household)?

VISIT NUMBER—Based on your conversation, is this the first, second, third, fourth, fifth, or later visit for this person, family, or household to your program? All visits did not have to be with you. **SELECT ONLY ONE.**

DURATION—How long did your encounter last? **SELECT ONLY ONE.** If the encounter was under 15 minutes, use the Weekly Tally Sheet.

DEMOGRAPHIC INFORMATION—For each variable.

NUMBER OF MALES IN THIS ENCOUNTER—Please indicate the number of males for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)

NUMBER OF FEMALES IN THIS ENCOUNTER—Please indicate the number of females for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)

NUMBER OF TRANSGENDER INDIVIDUALS IN THIS ENCOUNTER—Please indicate the number of transgender individuals for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)

RACE/ETHNICITY—Based on your observations and your conversation with the participants, what race/ethnicity do you think the participant(s) would identify as being? **SELECT ALL THAT APPLY.** If participant(s) are of more than one race/ethnicity, you should indicate all race/ethnicities that you believe to be represented. For a family encounter, if more than one race/ethnicity is represented, you should indicate all races/ethnicities that you believe to be represented.

PRIMARY LANGUAGE SPOKEN DURING ENCOUNTER(S)—Which language did you actually and primarily use to speak with this individual during the encounter? This may be different than the preferred language. If "OTHER" (not English or Spanish, may include sign language), fill in the other language that the person used. (**SELECT ONLY ONE.**)

PERSONS WITH DISABILITIES OR OTHER ACCESS OR FUNCTIONAL NEED(S)—Based on your observations and your conversation with the participants, does anyone have a physical, intellectual/cognitive, or mental health/substance abuse disability? **SELECT ALL THAT APPLY.**

- Physical: includes disorders that impair mobility, seeing, or hearing, as well as medical conditions, such as diabetes, lupus, Parkinson's, AIDS, or multiple sclerosis (MS).
- Intellectual/Cognitive: includes a learning disability, birth defects, neurological disorders, developmental disabilities, or traumatic brain injuries, (e.g., Down syndrome).
- Mental Health/Substance Abuse: includes psychiatric disorders, such as bipolar disorder, depression, posttraumatic stress disorder (PTSD), schizophrenia, and substance dependence.

LOCATION OF SERVICE—Where did the encounter occur? **SELECT ONLY ONE.**

RISK CATEGORIES—These are the factors that participants may have experienced or may have present in their lives that could increase their need for services. **MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.**

EVENT REACTIONS—Do not use this as a checklist during the encounter. Complete this based on your observations and the conversation **AFTER** the service is complete. **SELECT ALL THAT APPLY.** If the participants have no observable or reported problems, check "coping well: none of the above apply."

FOCUS OF INDIVIDUAL, FAMILY, OR HOUSEHOLD ENCOUNTER—What is the focus of the encounter? **SELECT ALL THAT APPLY.** If the focus is different from the categories listed, please select "OTHER," and fill in the blank with the primary purpose.

MATERIALS PROVIDED IN THIS ENCOUNTER—Did you leave any materials with the participant, family, or household? This refers to printed materials such as a brochure, flyers, tip sheets, or other printed information. **SELECT ONLY ONE.**

REFERRAL—Based on your conversations, you may have referred the participants for other services. In the **REFERRAL** box, select all of the types of services to which you referred participants. If you made a referral to a service not listed, please check the box labeled "other" and write in the specific type of referral.

REVIEWER—Team lead or direct supervisor to review completed form for accuracy and then sign and date (date of review).

Please submit the completed form to the designated person in your agency who will review the form.

Thank you for taking the time to complete this form accurately and fully!

Paperwork Reduction Act Statement This information is being collected to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) with program monitoring of FEMA's Crisis Counseling Assistance and Training Program. Crisis counselors are required to complete this form following the delivery of crisis counseling services to disaster survivors (44 CFR 206.171 [F][3]). Information collected through this form will be used at an aggregate level to determine the reach, consistency, and quality of the Crisis Counseling Assistance and Training Program. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 8 minutes per encounter, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Ln, Room 15E57B, Rockville, MD 20857.

Hawai'i CARES Substance Use Gateway Utilization Monthly Report

January 1-31, 2021

Data Last Updated: February 18, 2021



Table of Contents

I. Call Center (Substance Use)

A. Calls In/Out

II. Referrals

A. Referrals In/Out

B. Referrals In/Out By Agency

C. Referrals In: Accepted vs. Rejected

III. USIS & Criminal Justice

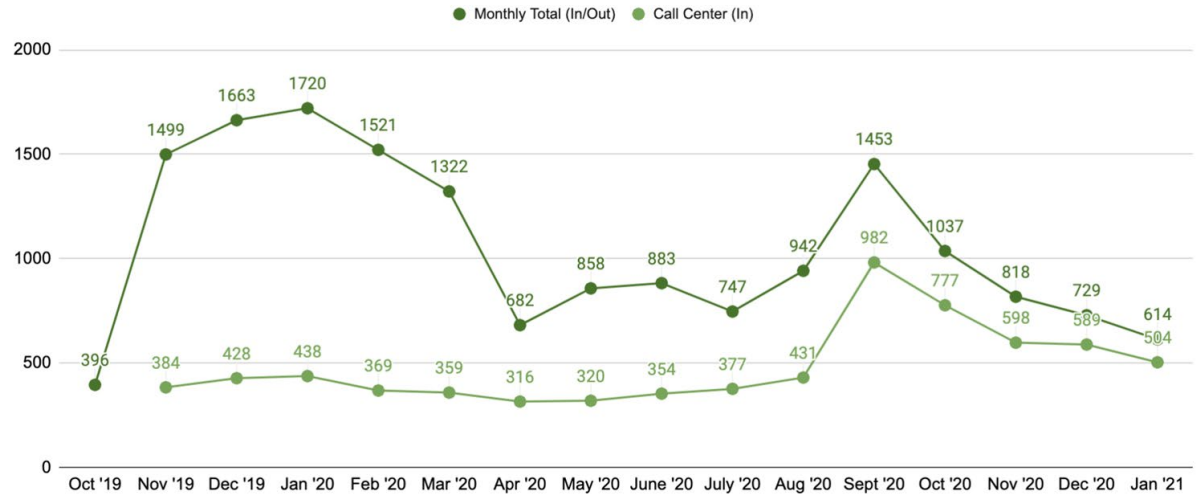
IV. Benefit Exceptions



Substance Use Gateway: Number of Calls In/Out

	Monthly Total (In/Out)	Call Center (In)
Oct '19	396	
Nov '19	1499	384
Dec '19	1663	428
Jan '20	1720	438
Feb '20	1521	369
Mar '20	1322	359
Apr '20	682	316
May '20	858	320
June '20	883	354
July '20	747	377
Aug '20	942	431
Sept '20	1453	982
Oct '20	1037	777
Nov '20	818	598
Dec '20	729	589
Jan '21	614	504

Number of Call-Center Calls In/Out



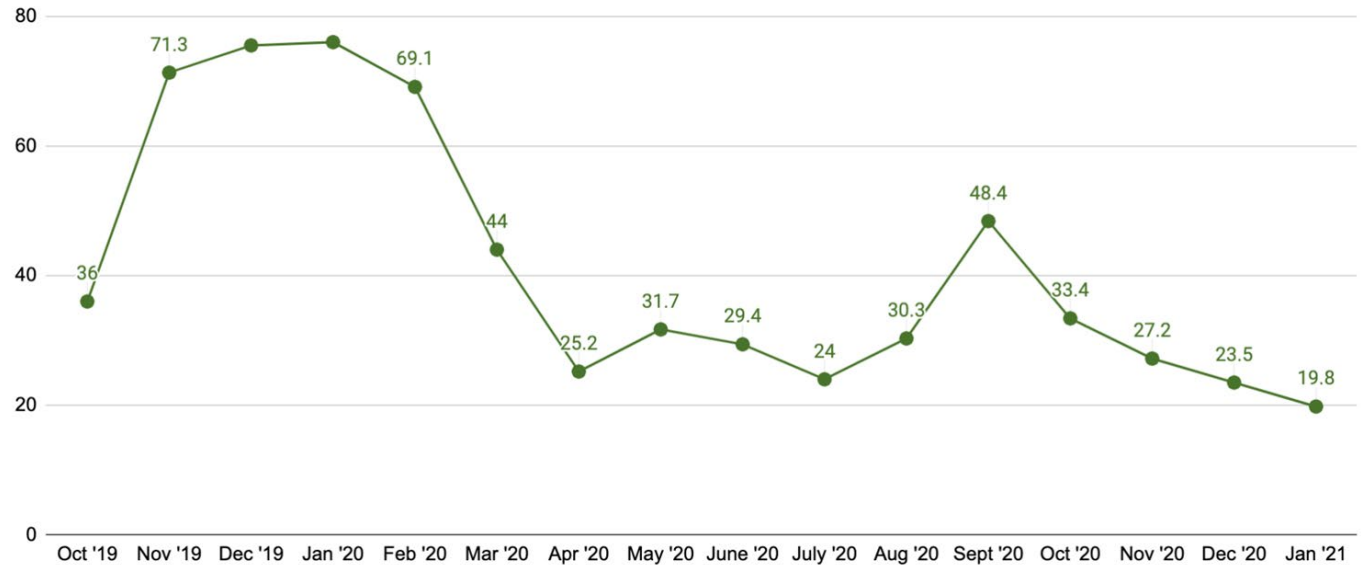
Notes: Hawaii CARES Go Live date was Oct 1, 2019. COVID-19 pandemic from Mar 2020 affected call volume and changed operations. The call volume numbers presented from Mar 2020 are an underestimate.



Substance Use Gateway: Average Number of Calls In/Out Per Day

	Average Calls Per Day
Oct '19	36
Nov '19	71.3
Dec '19	75.5
Jan '20	76
Feb '20	69.1
Mar '20	44
Apr '20	25.2
May '20	31.7
June '20	29.4
July '20	24
Aug '20	30.3
Sept '20	48.4
Oct '20	33.4
Nov '20	27.2
Dec '20	23.5
Jan '21	19.8

Average Number of Calls In/Out Per Day



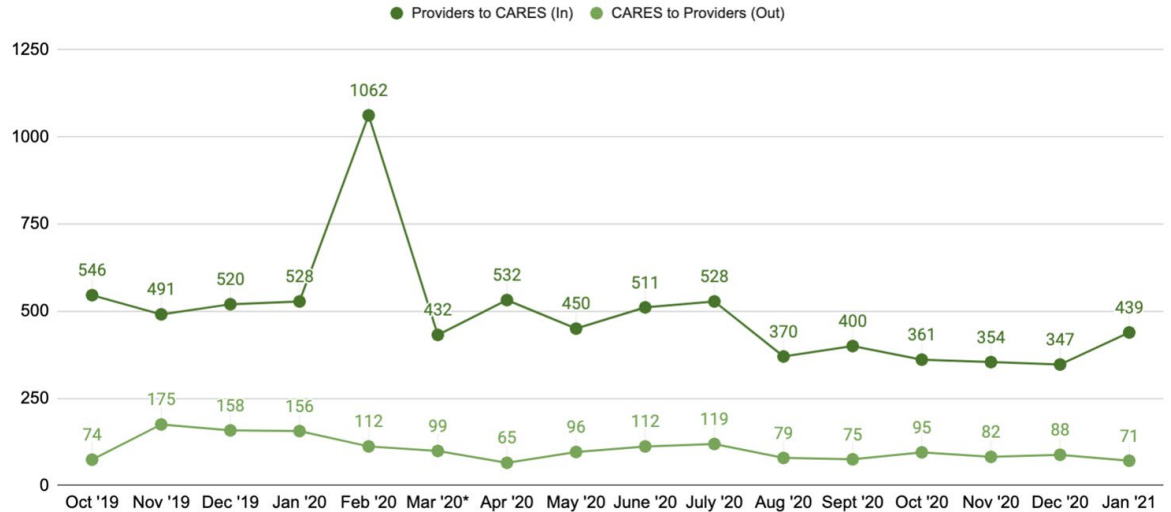
Notes: Hawaii CARES Go Live date was Oct 1, 2019. COVID-19 pandemic from Mar 2020 affected call volume and changed operations. The call volume numbers presented from Mar 2020 are an underestimate.



Substance Use Gateway: Referrals In/Out

	Providers to CARES (In)	CARES to Providers (Out)
Oct '19	546	74
Nov '19	491	175
Dec '19	520	158
Jan '20	528	156
Feb '20	1062	112
Mar '20*	432	99
Apr '20	532	65
May '20	450	96
June '20	511	112
July '20	528	119
Aug '20	370	79
Sept '20	400	75
Oct '20	361	95
Nov '20	354	82
Dec '20	347	88
Jan '21	439	71

Referrals In/Out Summary



Notes: Hawaii CARES Go Live date was Oct 1, 2019. COVID-19 pandemic from Mar 2020 affected call volume and subsequent referrals, and changed operations.



Substance Use Gateway: Referrals In By Agency

Agency Referred by	# Placed/Accepted	# Referral Terminated	# Refused Treatment	# Rejected by Program	# Placed on the Waitinglist	Total Referred	% Referred by this Agency
Action with Aloha, LLC	4	0	0	0	1	5	1.10%
Alcoholic Rehabilitation Services of Hawaii, Inc	155	0	0	7	1	163	37.00%
Aloha House, Inc.	2	0	0	2	0	4	0.90%
Big Island Substance Abuse Council	29	0	0	7	0	36	8.20%
Bobby Benson Center							
Bridge House, Inc	4	0	0	1	0	5	1.10%
CARE Hawaii, Inc.	41	0	0	9	4	54	12.30%
Child and Family Service	16	0	0	5	3	24	5.50%
Coalition for a Drug-Free Hawaii							
Hawai'i Health & Harm Reduction Center	0	0	0	0	2	2	0.50%
Ho'omau Ke Ola							
Hope Treatment Services	7	0	0	11	0	18	4.10%
IHS, The Institute for Human Services, Inc.	1	0	0	0	1	2	0.50%
Ka Hale Pomaika'i	0	0	0	1	1	2	0.50%
Kline-Welsh Behavioral Foundation	39	0	0	2	0	41	9.30%
Kokua Support Services	1	0	0	1	0	2	0.50%
Ku Aloha Ola Mau							
Malama Na Makua A Keiki	6	0	0	7	2	15	3.40%
Maui Youth and Family Services, Inc	2	0	0	1	0	3	0.70%
North Shore Mental Health, Inc	6	11	0	0	4	21	4.80%
Ohana Makamae							
Oxford House							
Po'ailani, Inc	12	0	0	2	0	14	3.20%
Salvation Army	1	0	0	0	0	1	0.20%
The Queen's Medical Center	4	0	0	0	0	4	0.90%
The Salvation Army							
Waianae Coast Comprehensive Health Center	1	0	0	0	0	1	0.20%
Waikiki Health Center							
Women In Need							
Young Men's Christian Association of Honolulu	19	0	0	3	0	22	5.00%
[Totals]	350	11	0	59	19	439	100%

- Jan 1 - Jan 31
- 21 out of 30 agencies were utilized



Substance Use Gateway: Referrals Out By Agency

Agency Referred To	Total Referred Prior to TX	% Referred Prior to TX	Total Referred During TX	% Referred During TX	Total Referred	% of All Referred to this Agency
Action with Aloha, LLC	0	0.00%	1	100.00%	1	1.40%
Alcoholic Rehabilitation Services of Hawaii, Inc	1	6.70%	14	93.30%	15	20.80%
Aloha House, Inc.	0	0.00%	2	100.00%	2	2.80%
Big Island Substance Abuse Council	0	0.00%	2	100.00%	2	2.80%
Bobby Benson Center						
Bridge House, Inc						
CARE Hawaii, Inc.	1	4.50%	21	95.50%	22	30.60%
Child and Family Service	0	0.00%	1	100.00%	1	1.40%
Coalition for a Drug-Free Hawaii						
Hawai'i Health & Harm Reduction Center						
Ho'omau Ke Ola						
Hope Treatment Services	0	0.00%	1	100.00%	1	1.40%
IHS, The Institute for Human Services, Inc.	2	50.00%	2	50.00%	4	5.60%
Ka Hale Pomaika'i						
Kline-Welsh Behavioral Foundation	0	0.00%	2	100.00%	2	2.80%
Kokua Support Services	0	0.00%	1	100.00%	1	1.40%
Ku Aloha Ola Mau	0	0.00%	1	100.00%	1	1.40%
Malama Na Makua A Keiki						
Maui Youth and Family Services, Inc						
North Shore Mental Health, Inc	2	18.20%	9	81.80%	11	15.30%
Ohana Makamae						
Oxford House						
Po'aialani, Inc						
Salvation Army						
The Queen's Medical Center	0	0.00%	1	100.00%	1	1.40%
The Salvation Army	0	0.00%	3	100.00%	3	4.20%
Waianae Coast Comprehensive Health Center						
Waikiki Health Center						
Women In Need	0	0.00%	4	100.00%	4	5.60%
Young Men's Christian Association of Honolulu						
[Totals]	6	8.30%	65	91.70%	71	100%

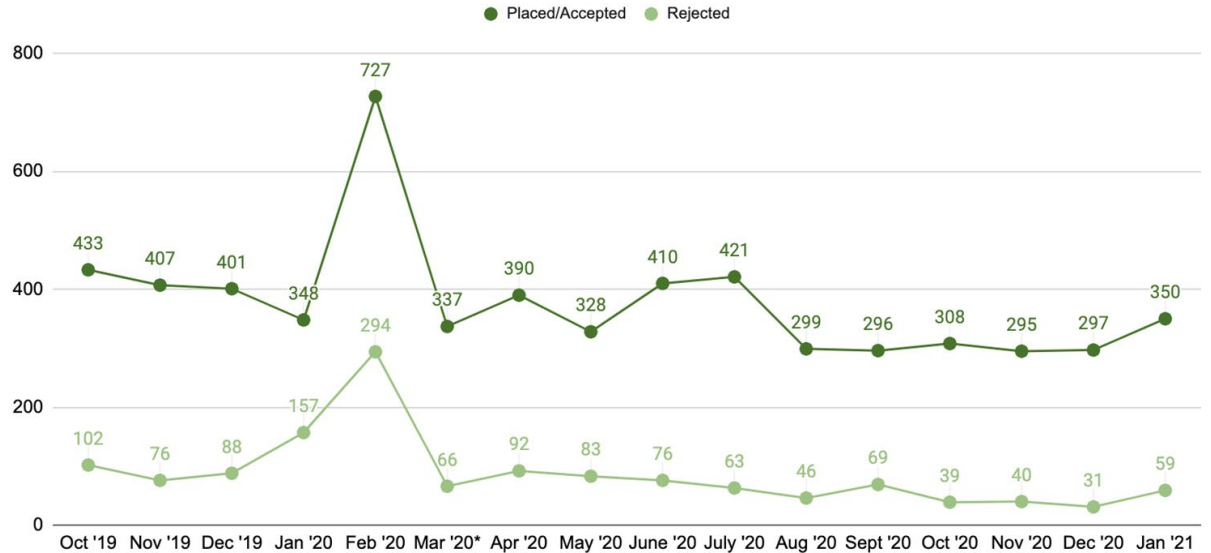
- Jan 1 - Jan 31
- 15 out of 30 agencies were utilized



Substance Use Gateway: Referrals In: Accepted vs. Rejected

	Placed / Accepted	Rejected
Oct '19	433	102
Nov '19	407	76
Dec '19	401	88
Jan '20	348	157
Feb '20	727	294
Mar '20*	337	66
Apr '20	390	92
May '20	328	83
June '20	410	76
July '20	421	63
Aug '20	299	46
Sept '20	296	69
Oct '20	308	39
Nov '20	295	40
Dec '20	297	31
Jan '21	350	59

Referrals In: Placed/Accepted vs. Rejected



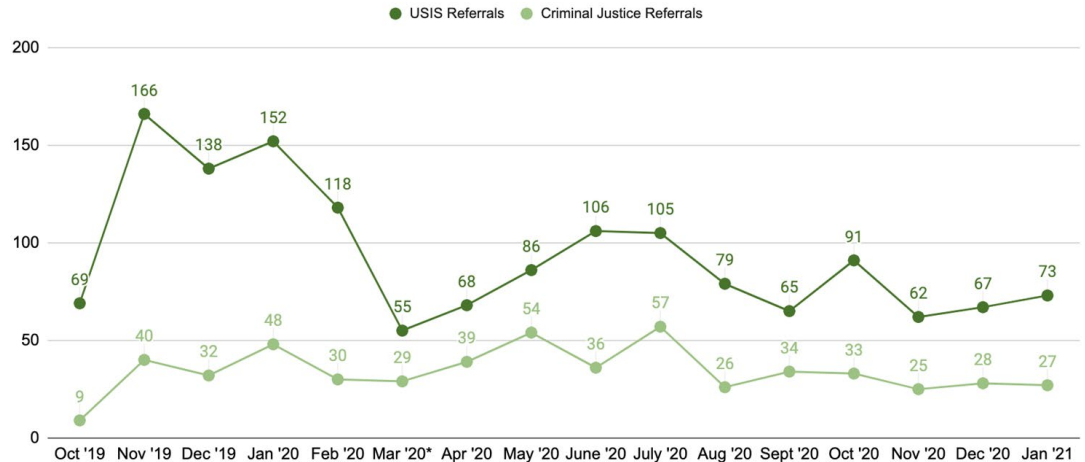
Notes: Hawaii CARES Go Live date was Oct 1, 2019. COVID-19 pandemic from Mar 2020 affected call volume and subsequent referrals, and changed operations.



Substance Use Gateway: USIS Forms and Criminal Justice Referrals

	USIS Referrals	Criminal Justice Referrals	% of Referrals
Oct '19	69	9	13.04%
Nov '19	166	40	24.10%
Dec '19	138	32	23.19%
Jan '20	152	48	31.58%
Feb '20	118	30	25.42%
Mar '20*	55	29	52.73%
Apr '20	68	39	57.35%
May '20	86	54	63.53%
June '20	106	36	33.96%
July '20	105	57	53.92%
Aug '20	79	26	32.91%
Sept '20	65	34	52.30%
Oct '20	91	33	36.26%
Nov '20	62	25	40.32%
Dec '20	67	28	41.79%
Jan '21	73	27	36.98%

USIS & Criminal Justice Referrals



Notes: Hawaii CARES Go Live date was Oct 1, 2019. COVID-19 pandemic from Mar 2020 affected call volume and subsequent referrals, and changed operations.



Substance Use Gateway: Benefit Exceptions

		BE Requests			
		January 2021			
Month	Received	Approved	Rejected	% Rejected	
January 2021	24	13	11	45.8	

BEs by Agency			
		January 2021	
Agency	Received	Approved	Rejected
Bridge House, Inc.	2	1	1
Malama Na Makua A Keiki	11	5	6
Salvation Army	9	5	4
Young Men's Christian Association of Honolulu	2	2	0



Questions?

