

ADVISORY COMMISSION ON DRUG ABUSE AND CONTROLLED SUBSTANCES (HACDACs)

Alcohol and Drug Abuse Division (ADAD), Department of Health (DOH), State of Hawai'i

Kākuhihewa Building, 601 Kamokila Boulevard, Room 360, Kapolei, Hawai'i

September 23, 2025

9:00 am – 11:00 am

Members Present: Lilinoe Kauahikaua, MSW, Co-Chair; Dave Fields, Co-Chair; John Paul Moses III, Vice-Chair; Emily Andrade, Jon Fujii; ARPR-R; Jawanna Ready, MD.

Members Absent: Kunane Drier, Ku ulei Salzer-Vitale, MSW

Staff Present: John Valera, AICP; Robyn Loudermilk, AICP; Brenda Wong; Michaella Abitz

Guests Present: Dr. Miki Kiyokawa

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/ CONCLUSIONS	PERSON(S) RESPONSIBLE	DUE DATE
1. Call to Order:	The meeting was called to order at 9:06 a.m.			
2. Consideration and approval of meeting minutes of August 26, 2025.	Motion by Commissioner Andrade, seconded by Co-Chair Kauahikaua to adopt minutes from the August 26, 2025, meeting. Motion approved.	Motion unanimously approved.		
3. Community Input: [Pursuant to section 92-3, Hawaii Revised Statutes, all interested persons will have three (3) minutes to speak, i.e., per person, per item, or written testimony can be submitted on agenda items]	<ul style="list-style-type: none"> No community input provided. 			
4. Alcohol and Drug Abuse Division (ADAD) Report <ul style="list-style-type: none"> Update on Zoom bombing incident at the August 26, 2025, meeting. Shared the Substance Use and Mental Health Services Administration (SAMHSA) recently release strategic priorities. 	<p>Mr. Valera provided an update on the Zoom bombing incident at the August 26, 2025, meeting and shared SAMHSAs recently released strategic priorities.</p> <ul style="list-style-type: none"> Reports on the Zoom bombing incident were filed with Zoom as well as with the DOH. <p>Meeting recessed.</p> <p>Meeting reconvened.</p> <ul style="list-style-type: none"> SAMHSAs recently released strategic priorities reflects the current administrations priorities and 			

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	<p>are consistent with Make America Healthy Again. The strategic priorities were sent with every federal Notice of Award received by ADAD.</p> <ul style="list-style-type: none"> • Mental illness, mental health, and substance use crisis is more complicated, more toxic, unpredictable than ever before. Also, more dangerous than ever due to poly substance use, the emergence of substances like xylazine, medetomidine and illicit benzodiazepines, including potent synthetic opioids such as nitazones. • Key outcomes identified to track impact of work being done including but not limited to: decreasing overdose and suicide deaths, decreasing rates in substance misuse and substance use disorders, as well as increasing rates of individuals in treatment and recovery. • SAMHSA to end the following: crime and disorders on America’s streets, subsidization of illegal immigration, and DEI. Also combating gender ideology and protecting health and safety of children as well as protecting parental rights. • Currently no direct impact to our funded programs, however, will continue to monitor. Will be updating our data to better describe who needs to be reached and who needs services but currently not receiving them. • Also, the Center for Disease Control and Prevention (CDC) just recently sent out their list of priorities. However, has not have an opportunity to review. <p>Co-Chair Fields led the discussion on the ADAD report.</p> <p>In response to questions Mr. Valera noted that ADAD currently does not see any impact on how language is used in relation to cultural programs and services. Are</p>			

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	<p>working with our project officers on language used in federal reports. Ms. Loudermilk is currently working on ADAD’s current application and is aware of language that would raise the flag. It does not affect ADAD’s ability to service ethnicities and other groups.</p> <p>ADAD has a number of initiatives to increase recovery services. September is Recovery Month and ADAD has issued a number of trainings and conferences. There was an all-day event at Windward Community College for peer recovery specialist and other interested professionals. Typically, ADAD’s training events are not just opened to substance use professionals, but to any interested member of the community. Also invite those in mental health.</p> <p>Currently working on an RFP to increase clean and sober homes. A few months ago, had an opportunity to meet the CEO of Oxford House at a conference in Washington D.C. who shared that they are looking to have homes on the neighbor islands. Informed the CEO about the RFP.</p> <p>Updating administrative rules to include peer recovery specialist. Finalizing draft rules to obtain Governor’s approval to conduct public hearings. In the meantime, training has occurred for those interested in becoming a peer recovery specialist for substance use. Training has been completed for two cohorts while another two cohorts are currently being trained. Number of participants in each cohort range from 20 – 30. Once the administrative rules has been finalized and signed by the Governor’s those training participants would automatically be certified as a peer recovery specialist.</p>			

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	ADAD is always interested in hearing ideas for projects.			
<p>5. Update on meeting topics and presentations for HACDACS meetings in:</p> <ul style="list-style-type: none"> • October 2025 • November 2025 • December 2025 • January 2026 <p>Potential topics include Medical Cannabis Safety and Testing Policies; Harm Reduction Review based on substance use; Status of Residential Treatment Programs and their trends and needs, Prevention Initiatives, Medication Assisted Treatment for Methamphetamine Use Disorder, the intersection of substance use treatment and the criminal justice system. New topic ideas are encouraged.</p>	<p>Co-Chair Fields led the discussion on upcoming meeting topics.</p> <p>No presentations scheduled for the October 2025 and November 2025 meetings. Focus is on the annual report.</p>			
<p>6. Identification of Areas of Focus for the Next Twelve Months</p>	<p>Co-Chair Fields led the discussion on areas of focus.</p> <p>Co-Chair Kauahikaua mentioned coordination of services was suggested as a theme during the last meeting. With discussion identifying potential topics to tie in with theme. Recall Commissioner Moses identifying states providing state-level coordination of services</p> <p>Co-chair Field and Commissioner Moses commented that coordination of services is a priority.</p> <p>Commissioner Andrade noted that part of the conversation last month on coordination of services</p>			

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	included recommending that the state hire a person to do state level coordination of all substance use related efforts. That coordination of services could eliminate some of the confusion. If she is confused, then can only imagine the confusion for those persons needing services. Advocating for a state-wide role is also advocating for the those who need access to services.			
7. Discussion on HACDACS annual report to the Legislature including subject matter areas to be included in the report and writing assignments. Topics may include harm reduction and the Veterans Administrations Pacific Islands Health Care Substance Treatment and Recovery Program.	<p>Co-Chair Fields led the discussion on the annual report.</p> <p>Ms. Loudermilk to email list of meeting topics along with links to recordings. Prior to next meeting, Commissioners to review list and identify sections that they are interested in taking the lead.</p>			
8. Presentation: Addition Medicine – Psychological Needs of Substance Use Disorder Patients in Inpatient Settings	<p>Dr. Miki Kiyokawa is an Addiction Medicine Fellowship Program Director at the University of Hawaii John A. Burns School of Medicine as well as an Addiction Medicine Physician at Queens Medical Center (QMC). Data analysis provided by Treena Becker, Assistance Professor at the UH Thompson School of Social Work and Public Health. Does impatient addiction medicine consultation at QMC, Manamana/Punchbowl campus twice a week. Only see patients when consulted by the primary team. Also provides consultation to community physicians via phone call.</p> <ul style="list-style-type: none"> • March 2024 to February 2025: 366 new consultations ranging in ages from 18 to 87. Approximately one out of four consultations were curbside in which demographics may be “unknown”. Curbside consultations includes phone consultation with community physicians and calls from QMC on days that she is not there. • Most patients were male (66%). A majority of the consultations were for patients aged 30-69 years old. With one out of three patients aged 55 years or older and almost one in five patients being 65 years or older. Elder substance use disorder (SUD) patients are more complex as they may have more co-morbidities/medical problems. Many in the older population need physical assistance after acute care in the hospital, however, not able to enter a skilled nursing facility (SNF) or an intermediate care facility (ICF). • More than half of patients consulted self-identified as Caucasian (53.8%), followed by Asian (15.30%), Unknown (13.66%), Hawaiian/Part Hawaiian (9.29%), Other Pacific Islanders (3.56%), Latino (2.46%), and Others (1.91%). Houseless persons accounted for one in four consultations ,while six patients were incarcerated. • Primary SUD diagnosis is alcohol use disorder (AUD) followed by opioid use disorder (OUD). Primary diagnosis for patients 55 years or older is OUD, followed by AUD. This is also true for patients 65 years or older. There is a higher proportion of patients 55 years and older having OUD than those younger than 55 years. Further breakdown shows that methamphetamine use is more prominent in patients between 55 to 64 years old, benzo use is more prominent is patients 65 years or older, and AUD is more prominent in patients 70 years or older. 			

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	<ul style="list-style-type: none"> • One out of three patients have symptoms of withdrawal during hospitalization with alcohol (67.5%) the major substance causing withdrawals. Due to lack of detox facilities acute beds are being used for detox. Approximately 17% of AUD patients admitted at QMC for withdrawal symptoms had no other medical problems. This is increasing as in August 2025, 24% of patients were admitted only for alcohol withdrawal symptoms. • About half the time able to connect with patient’s outpatient provider. Approximately 62% of warm handoffs were with non-ADAD providers and approximately 38% with ADAD providers. Most of the patients were seen by the community prior to going to the hospital or preferred to be referred to a community provider due to a patients’ treatment preference. • About half of the patients were interested in referral to treatment. Approximately 63% of patients were referred to non-ADAD providers while approximately 37% were referred to ADAD providers. Referred to Hawaii CARES when there was absolutely no time to refer to a specific entity. Many patients are interested in one-to-one therapy. There are also many patients that also have dual diagnosis. More than one out of four AUD patients were interested in medication assisted treatment (MAT), however were not able to start in the hospital. Several reasons are that they were on certain medications that might interact with medications used for AUD. Or their lab results are not completely back to normal. Approximately 72% of OUD patients were placed on or continued MAT. • Identified a number of potential gaps in treatment. 1. There is a lack of a detox center that can handle complicated alcohol/sedative withdrawal. 2. There is a lack of SNF and/or ICF beds for older adults needing physical assistance after acute care. 3. There is a lack of dual-diagnosis long-term care as well as one-to one therapy. • Would be nice to provide daily addiction medicine services. It will also increase educational opportunities for medical students, residents, fellows, and equip future doctors to treat SUD. <p>Co-Chair Fields led the discussion on questions about Queens Care Coalition that serve Native Hawaiian high utilizers of the emergency room; ethnicity data, insurance, assistance from Medicaid, liaison with the VA on veteran patients as well as thoughts on group therapy, and AUD detox and treatment.</p> <p>There is overlap with the Queens Care Coalition that serve Native Hawaiians. However, many patients do not want to talk with her because they are not ready to change. This is reflected in the low percentage of Native Hawaiians shown in the data. Does not want to speak on behalf of Queens, but does know that they have referral and monitoring, however, not aware of specific mechanism Will obtain and forward that information. Also does a lot of phone advice with population, as patients are interested in treatment but do not want to talk to her.</p> <p>The data collected is skewed. There are specific situations in which consultation with patients can occur and it is up to the patient whether they want to talk to her. Did not cross reference ethnicities with the different disorders, however, this can be done and will be provided. Not aware of reasons for the high percentage of Caucasians in the data. However, has observed cultural differences in patients. Some populations and ethnicities feel entitled to treatment while others are reluctant to ask for treatment because of shame. Have not been collecting medical diagnosis data as there are so many diagnoses; using whatever diagnosis provided. In the future will try to categorize diagnosis to see what kind of medical problems are occupying the acute beds.</p>			

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	<p>Does not have specific breakdown on insurance type. Most of the patients seen are insured through QUEST and some are on Medicaid. It is quite rare to have a patient with private insurance. Medicaid could provide some assistance with medications. Certain medications may not be covered by a specific QUEST plan. Also, certain medications were not started in hospital as prior authorization for medications required for inpatient and again as an outpatient. Thus, potential gaps in treatment. Does see some veterans and try to connect them with the VA. There is interest in group therapy, but the preference is one to one as they feel safer and feel like they can share better. Her experience is that many veterans do not like the VA group therapy as they are not ready to share their stories and do not have the bandwidth to hear other people's stories. May have to do with their recent experience and being in an inpatient setting. Does not have information on percentage of those going through alcohol detox in acute beds meeting hospitalization criteria. QMC recently changed the AUD protocol in which patients are treated upfront even without symptoms. There are two protocols used as Queen's: one for benzodiazepine and another for phenobarbital. With the benzodiazepine protocol, treatment is with diazepam upfront regardless of symptoms.</p> <p>Co-Chair Kauahikaua commented that the cross-reference of ethnicity data with different disorders would provide a story for folks. Especially as there is limited data for native clients.</p> <p>Commissioner Andrade commented that this was an excellent presentation and appreciated everything that went into it.</p> <p>Commissioner Fujii shared that he is with Medicaid and appreciated the good information. He commented that medications are plan specific, however, he would be interested in what medications plans are not authorizing but rather authorizing another medication. He can then pass this information on to his team to think about and try to understand why. Newly approved 1115 Waiver includes a medical respite benefit which includes short-term post hospitalization benefit for short term housing and limited support to continue recovery for physical, psychiatric and or substance use conditions. Targeting issuance of Policy memo during the first week of October. Hopeful that this will provide some relief for difficult placements.</p> <p>Dr. Kiyokawa commented that after doing the data analysis she wants to collect additional data on insurance, where are patients from, additional medical diagnosis.</p>			
<p>9. Open Forum:</p> <p>Public comments on issued not on the agenda, for consideration for Commissions agenda at its next meeting.</p>	<p>No community comments provided.</p>			
<p>10. Adjournment</p>	<p>10:45 a.m.</p>			

**Next Meeting: October 28, 2025
9:00 am to 11:00 am**

Zoom Meeting