STATE COUNCIL ON MENTAL HEALTH (SCMH) MEETING

August 8, 2023, 9:00 a.m. – 12:00 p.m.
Hybrid meeting via Zoom and
in-person at Hale F Conference Room, 2201 Waimano Home Road, Pearl City 96782

APPROVED MINUTES

Members Present: Katherine Aumer, John Betlach, Naomi Crozier, Lea Dias, Heidi Ilyavi, Jackie Jackson, Kathleen Merriam, Eileen Lau-James, Ray Rice, Richard Ries, Mary Pat Waterhouse, Marian Tsuji (ex-officio)

Members Absent: Antonino Beninato, Jean Okudara, Kau`i Seguancia

Members Excused: Jon Fujii, Kristin Will

Guests: Dr. Jared Yurow, John Valera, Dr. Christopher Au, Kathi Fujii

AMHD Staff Present: Jocelyn Nazareno, Carolyn Weygan-Hildebrand, Amy Curtis
CAMHD Staff Present: Madeleine Hiraga-Nuccio, Scott Shimabukuro, Valerie Yin

I. Call to Order

Katherine Aumer, chairperson, called the meeting to order at 9:04 am. Eileen Lau-James, secretary, declared quorum at 9:06 a.m.

II. Announcements

K. Aumer warmly welcomed members and guests. For meeting protocol, she announced that in case of a communication technology-related interruption that could not be restored in 30 minutes, the meeting will automatically be terminated and resume on August 15 at 9 a.m. using the same zoom link used in this meeting. She also announced that public input will be received during the designated part of the agenda and also solicited throughout the meeting.

III. Consideration and Approval of Meeting Minutes – July 11, 2023

Action: Richard Ries moved to approve the minutes. Lea Dias seconded. The minutes were approved unanimously.

IV. Community Input

Dr. Christopher Au testified on the absence of facility for substance abuse on the Big Island and there is a desperate need for beds. He asked if Block Grant can support. He said that he runs Access Capabilities, a small for-profit substance abuse facility on the Big Island. He said that in the last 14 years, he has been trying to create a residential program for the Big Island that accepts QUEST. He pointed out that the main issue that he has

been running into is the difficulty of meeting the requirements of the Office of Healthcare Assurance. He is trying to make a facility that is specifically for individuals who have QUEST to take some of the load off the Judiciary. He said, "I know there is enough money for all the programs if only somebody at the state regulatory level would assist in having the insurance companies pay what they should be paying for. For instance, substance abuse, I can get IOP and LIOP paid through HMSA but cannot get any of the other services such as individual sessions, any kind of interaction with people involved or with their probation officers going to court, anything like that isn't reimbursed. We can't bill for any kind of charting, treatment planning, etc. These are services that are paid for through Medicare. HMSA refuses to pay for these services for QUEST but will pay for these services for commercial. What we need help for is, we can't bill for any kind of live-in program, such as a clean and sober house. I have a contract with HMSA to provide residential services but don't have the piece of paper from the state. We are Joint Commission-accredited for residential, but don't have a piece of paper from the state. Every time I try and build up steam to try and do that something else or some other expense comes up. I have to prioritize and play triage and it just gets lost in the mix. And so, we were wondering if part of the grant could be used as a bridge, especially for neighbor islands. Because I get calls from Kauai constantly begging me to come up there and start a residential. But I can't leave Kona to do that until I have enough staff to be able to leave the island and not get emergency calls 24/7. So that's the kind of funding that would be really great for us."

Discussions and Comments

- Marian Tsuji requested that Dr. Au reach out to her to figure out why he is having trouble getting licensed by OHCA. Dr. Au informed further that he has an office in Pahoa Village and an office in Kailua-Kona and a group home in Kealakekua. He offers dual diagnosis and substance abuse services.
- K. Aumer thanked Dr. Au for his testimony. She explained that the Mental Health Block Grant Plan is due September 1st. To see whether or not the Council can recommend, strongly recommend, or not recommend what goes into that block grant would mean that the Council see it beforehand, or at least be able to know what the draft is that's being proposed.

V. New Business

A. Presentation: *Current Alcohol and Drug Abuse Division (ADAD) Priorities*

John Valera, ADAD Administrator, shared that he has been with the DOH for over 20 years. He was with environmental bealth before coming over to behavioral health. He did a lot of policy development type of work, contracts, and procurements which proved to really be valuable experience when he joined ADAD as a planner in 2016. He introduced two other members of the ADAD team -ADAD's chief psychologist, Dr. Jared Yurow, and ADAD's new Public Health Treatment Recovery Branch Manager, Ms. Kathi Fujii.

Because the current substance use issues are too big for any one division or any one department or any product or even all of us together to handle, he said that ADAD need allies, partners, not just in government, but also in the community. To build those collaborations and partnerships, he subscribes to the Whole Public Health 3.0 model that the DOH is moving towards. Over 76,000 individuals were needing but not receiving treatment for substance use in the pass year. (See presentation slides for the rest of the presentation).

Discussions and Comments

Q. As mentioned Hawaii has one of the second lowest in terms of opioid fatalities but I believe we have the seventh highest in terms of meths, is that correct? Is there any initiatives for meth?

A. We were looking at our current funding sources. Our state Opioid Response Grant has an emphasis on the stimulant use disorders, which includes meth and cocaine. Meth requires a more intensive sort of residential type program. This is one thing we will continue conversation with Adult Mental Health Division and how we can work together for it. I also highlighted was working with AMHD on the substance use services of patients, whether they're in custody at HSH or whether they go to the CMHC's on an outpatient basis. I think it is not just the services but it's having to find those connections so that when they are released in the in the community that they have someone to go and they're not all by themselves, because if they're released and on their own, it's likely they're going to either recidivate or relapse or both.

Q. You talked about starting a study with UH to identify what programs? Do you have any current preventative public health programs? Many states have chronic disease prevention, tobacco control, immunization campaigns, maternal child health, sexual, health ED, etc., is that in the works or are we still in the pre identifying stage of what would be helpful for Hawaii?

A. We have about 14 different contracts with different providers in the community that do school based and community based. Many of them have already have MOAs, whether in the complex level or at the school level, to be co located at the school, and they serve the population of that school. As far as the prevention activities that other DOH programs and other community programs do, we want to try to expand those connections as much as possible and learn about them.

Q. We work with people who have disabilities, including those who are recovering from substance abuse disorders, and many of them are interested in becoming substance abuse counselors. There is a great need in the community for people with this certification. Are employers willing to hire them or how can we get our clients in on the peer mentoring, employment opportunities that you have?

A. We should definitely start to have more conversations on how we can make those connections and find ways to place them with organizations and employers.

K. Aumer thanked John Valera, Jared Yurrow, and Kathi Fujii for coming, and sharing a very informative presentation.

IV. Old Business

A. July 11 Presentation by Tia Hartsock – Thank You Letter

Action: M.P. Waterhouse moved to approve the draft thank yu Letter to Tia Hartsock. Heide Ilyavi seconded. The letter as drafted was approved unanimously.

B. 2023 Mental Health Block Grant (MHBG) Planning Update

M. P. Waterhouse reported that the committee met on August 7, 2023 and there was both public and committee member at said meeting. She requested Carolyn Weygan-Hildebrand to give an update. C. Weygan-Hildebrand said that the update of the MHBG Plan draft (aka application) that the committee members have seen is not ready to be released for public comments. The draft for public comment is projected to be ready by August 10 or 11. She offered an update of the presentation to the committee (see attached slide presentation) and added that the committee's comments were around addressing homelessness, diversity and equity, and workforce issues.

Discussion and Comments

- The MHBG is a DOH plan, and the Council is only reviewing and commenting on it.
- As explained at the July 12 SAMHSA webinar, the full grant application requires a letter from the Council Chairperson stating that the Council has reviewed the State Plan. Supporting documentation is required.
- The September 1 deadline for submitting the Plan to SAMHSA is required by law. If the Council have substantial comments after the September 1 submission deadline, a request for revision is a mechanism for a Plan change. In the past, request for revision have taken place because of changes in the budget or proposed expenditures.
- The conflict of issue was raised over C. Weygan-Hildebrand's dual role as lead drafter of the MHBG Plan and drafter of the letter to the DOH and SAMHSA. C. Weygan-Hildebrand responded that she is clear about her role as a planner and is guided by planner's ethics. As a planner, she is a facilitator of the process and ties information and data together. For Council letters, like the one sent to SAMHSA last year, contents are from meeting minutes. A suggestion was made to look into involving the Council in the (DOH MHBG) planning process.
- AMHD administrator, Dr. Amy Curtis, shared the following in response to Council member questions:
    - In response to the question about neighbor island services and pay rates, AMHD is working on changes in some of the pay rates and bed day rates, gone through matching with MRO (Medicaid Rehabilitation Option) rates, and looked at putting increases through change in procurement and contracts. These have been painstaking and slow.

- On workforce, AMHD has been looking at pay, having trainings, and credentials.
- For housing, AMHD is considering how to have a Kauhale solution at HSH grounds for individuals who cannot be get out because of housing reasons.
- On use of MHBG funds, conversations with SAMHSA clarified that it was really important that monies were applied, more or less, directly to services. So, taking a substantial one for recruitment efforts and fill positions will not be allowed (as it will be administrative cost). Funds for the crisis part is directly to providers, the funds are paying providers and the service they are providing. What is more important for AMHD to have is the data part to know what we are doing and can tell others, like the Legislature and Council. Currently, AMHD is also trying to ensure that we continue to put out contracts, which is part of the budget, for care and doing services for folks.
- On community-based group housing for social workers or psychologists, her suggestion is for the Council to help AMHD maybe set up some kind of bill or work with the Legislature.
- Regarding PR effort to recruit workers, the AANHPI Ohana Center for Excellence has been helpful, primarily for Maui. There has been a turnover in PR personnel at AMHD. Leaders have mentioned the need for more communication, internally and externally.

- CAMHD former administrator, Scott Shimabukuro, discussed where MHBG funds will be used through a brief slide presentation (see slide presentation).

V. Information Reports

All reports were tabled due to time constraints.

VI. Meeting Evaluation/ Future Agenda Items

No further discussion

VII. Adjournment

The meeting adjourned at 12:13 p.m.

Meeting Handouts

1. Public Notice and Agenda August 8, 2023 Meeting
2. Attendance Log SF2023 July Attendance
3. Meeting Minutes draft– July 2023 meeting
4. Draft Thank you letter to Tia Hartsock
5. MHBG FY2024-2025 Application SAMHSA Webinar
6. MHBG Planning Presentation August 8, 2023

STATE COUNCIL ON MENTAL HEALTH

ADAD Presentation
8/8/23

ABOUT

Hawaii Single State Agency (SSA), Kapolei, Hawaii

Non-direct services thru community providers using a variety of federal and state funds

4,400 adult & adolescent clients received treatment services in FY22

19,000 youth and adults participated in prevention services in FY22

Workforce FY22: 1,500 CSACs, 900 in training; 40 CPSs, 14 in training

SITUATION

- DOH role in the community is as a "public health strategist"[1]
- Hawaii has the 2nd lowest opioid fatality rate in the nation (4.6 per 100,000), however has the 7th highest fatality rate for meth (11.4 per 100,000)[2]
- Since 2016 fatal poisonings due to opioid Rx pain relievers have decreased but deaths due to synthetic opioids (assumed to be fentanyl) have increased, possibly due to decreased availability of Rx opioids[3]

[1] www.healthypeople.gov/ph3 The goal of Public Health 3.0 (PH 3.0) is to engage multiple sectors and community partners to generate collective impact and improve social determinants of health. An early example of a PH 3.0 response is the Hawaii Opioid Initiative, launched July 2017.

[2] https://health.hawaii.gov/opppd/files/2023/01/2023-ADAD-Leg-Report_.pdf Report on Unintentional Opioid-Related Drug Overdose, Figures 2 and 4, pp. 44-45.

[3] Ibid, Figure 5, p. 46.

SITUATION

- Over 76,100 individuals were needing but not receiving treatment for substance use in the past year.[4]
- Service gaps continue both in SU treatment and prevention especially for rural communities (outside Oahu) and different service populations (e.g., injection drug users, pregnant/parenting women, criminal justice clients, homeless)
- Current electronic health records system does not map or collect data addressing social, environmental, or economic determinants of health
- SU workforce reduced in the last few years likely due to the public health emergency

[4] https://health.hawaii.gov/opppd/files/2023/01/2023-ADAD-Leg-Report_.pdf Appendix D, Table D1, pp. 36-37.

CURRENT PRIORITIES - VACANCIES

Fill our remaining vacancies by December 2023

- Success: was 50%, now under 40%
- New Treatment/Recovery Branch Manager: Kathi Fujii
- Fill three (3) positions for opioid settlement project by June 2023 (2/3 filled)
- OD2A-S Grant (successor to AMHD OD2A Grant)
- 3rd UH Center on the Family EHR Project Specialist filled

CURRENT PRIORITIES – OPIOID RELATED PROJECTS

Establish the Opioid Settlement Project

- Role of advisory committee
- How projects are selected
- How projects are evaluated
- Reporting requirements

MOUD mobile medication units

- Establish at least one mobile medications unit for opioid use disorders (MOUD) on Oahu and another mobile unit on a neighbor island by the end of 2024
- Expand medication-assisted treatment (MAT) capacity in rural areas
- Over 23,700 adults statewide need but do not receive SU treatment for illicit drug use in the past year

Integration with Hawaii Opioid Initiative and State Opioid Grant activities

- Update annual HOI Evaluation and annual HOI Action Plan
- Recruit new workgroup membership, including new one for lived experiences
- Re-prioritize goals/objectives marked “in progress”

CURRENT PRIORITIES – WORKFORCE DEV

Challenge: need to add to workforce individuals with lived experience (i.e., Peer Recovery Coaches)

- Takeaways: (1) Develop more outreach to/connections between SU professionals and organizations that need them* and (2) set a SMART goal

Challenge: Competitive salaries, fair wages.

- Takeaway: Commence a rate study* for SU professionals that looks at both fee-for-service and value-based purchasing rates

**HACDACS recommendation*

CURRENT PRIORITIES – WORKFORCE DEV

Finish development of peer credential (ICRC)

Develop a “paperless” credentialing system for SU counselor applicants and other supported credentials (HAR 11-177.1)

Develop partnership with a community college to coordinate course offerings for emerging SU professionals so they can be trained on-island

Explore features resources such as SAMHSA's Recruitment and Retention Toolkit with local university workforce “brain trust”

CURRENT PRIORITIES – AMHD PARTNERSHIPS

Partnership opportunities with AMHD

- Continue Hawaii CARES 988
  - Care Hawaii – MH, Crisis
  - AUW 211 – SU
- Buildout of Maui CCBHC
- SU services at HSH and CMHCs
- COD Workgroup
- Integrated jail diversion
  - LEAD (pre-arrest)
  - AMHD jail diversion (post-arrest)
- BHA data sharing across divisions for improved care coordination, case mgmt

THANK YOU

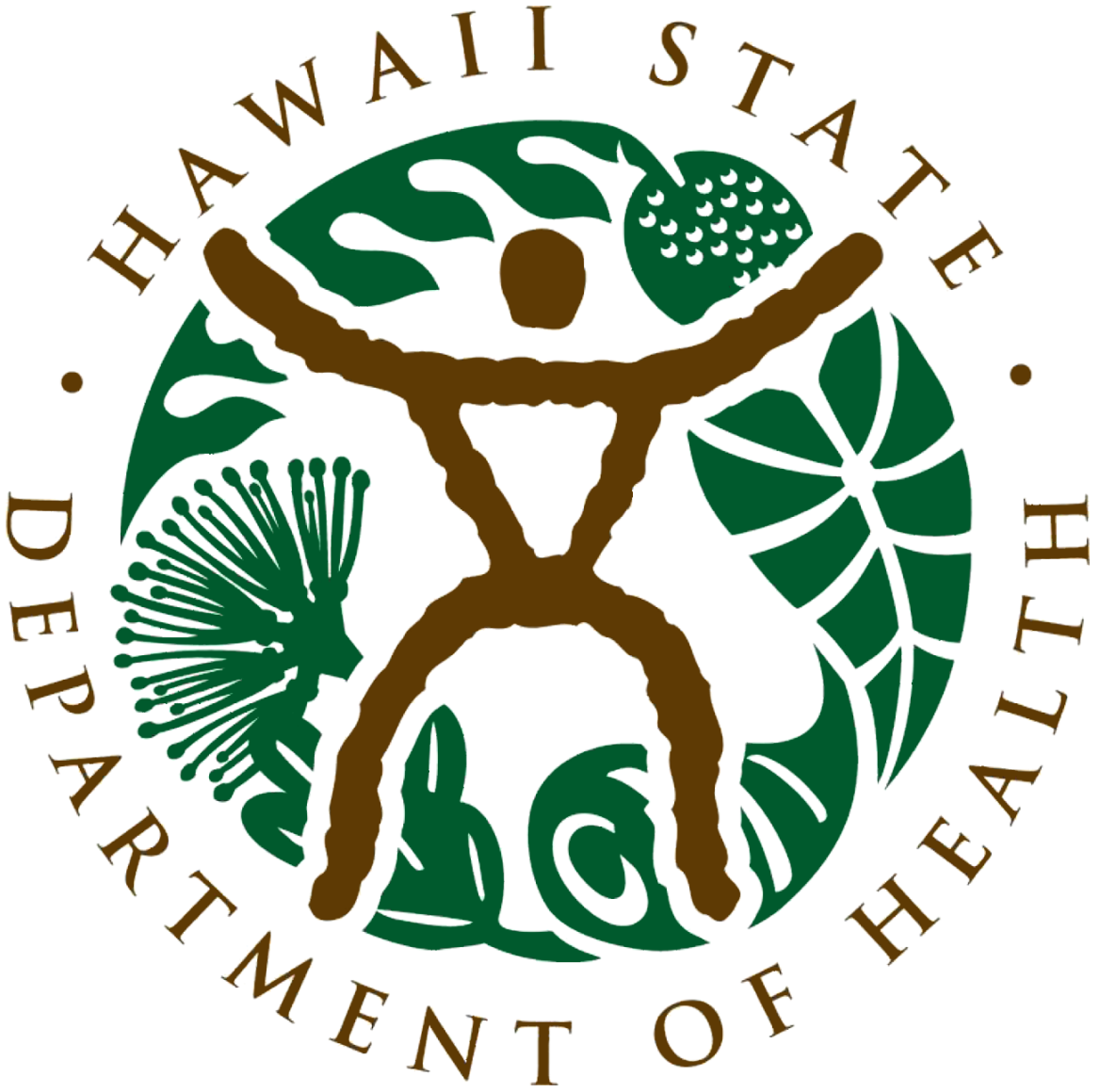
John Valera, Administrator
Alcohol and Drug Abuse Division
Hawaii Department of Health
john.valera@doh.hawaii.gov

Mental Health Block Grant Plan FY 24-25
State of Hawaii
Due September 1, 2023

State Council on Mental Health Review:
Ad Hoc Committee- August 7, 2023
Full Council – August 8, 2023

Suggested Public Comment Period:
August 11 to August 25, 2023

DRAFT – FOR DISCUSSION ONLY



TWO FORMATS

Community Format

To be posted in

https://health.hawaii.gov/amhd/

for public comment and communication purposes

Note: Minnesota and Massachusetts set examples

Submission Format

To be posted in

https://bgas.samhsa.gov/

Include

Fill up forms in report entitled

Hawaii - FY 2024-2025 MHBG Only Application/Behavioral Health Assessment and Plan

Role of SCMH as an MHBG planning council

- **Review State Plans** and submit to the State any recommendation or modifications
- **Serve as advocates** for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems.
- **Monitor, review and evaluate**, not less than once a year, the allocation of mental health services within the state.

The Law: 42 USC 300x-3: State mental health planning council

	Remaining Timeline
June 30	*-Official release of planning guidelines by SAMHSA*
July 12	*-SAMHSA technical assistance webinar*
August 7	-SCMH ad hoc committee on mental hel
August 8	-SCMH meeting
Aug 10 – 24	-Public comment period
TBA	-SCMH ad hoc committee on MHBG planning meeting
August 25	-DOH BHA administrators review and approval
Sept. 1	DEADLINE PLAN SUBMISSION via WebGAS
Sept. 12	-Schedule of next SCMH meeting

Attach a letter from the Council Chairperson *that the Council has reviewed the State Plan and previous year's report with supporting documentation (meeting minutes, letters of support, etc.)*

Attach comments *received from the Planning Council, including any comment concerning the annual report.*

Step 3. Prioritize State Planning Activities

SAMHSA *Priority Types*

Mental Health Services for individuals with Serious Mental Illness or Serious Emotional Disorder

Early Serious Mental Illness

Behavioral health crisis services

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION priority themes

Promote resilience and well-being in children & families

Advocate for mental health acceptance

Provide quality and accessible mental health services

ADULT MENTAL HEALTH DIVISION themes

Telehealth

Integrated care

Evidence-based practices

Special populations (forensic, co-occurring substance use disorder and/or chronic physical conditions)

Step 3. Prioritize State Planning Activities

SAMHSA STRATEGIC PLAN *goals*

-Improve quality and accessibility of the crisis system

- Increase program integration and expand pediatric behavioral health capacity

- Support dissemination and implementation of evidence-based and culturally-appropriate services

- Advance bi-directional integration of health care across systems for people with behavioral health conditions

- Support active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce

- Support professional development initiatives to improve the competencies of service providers

- Reduce barriers to the continuum of high-quality services

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION *priority activities*

-**I**ncrease access to Care and reduce health disparities

-**E**nhance mental health system by using data & research

-**P**romote primary, secondary & tertiary MH prevention

ADULT MENTAL HEALTH DIVISION* *priority activities*

-Data infrastructure improvement project (Electronic Health Records System, Data Reporting, Data for Evidence-Based Practices)

-Expansion/adapting to Certified Community Behavioral Health Clinic model

-Hawaii State Hospital rehabilitation projects

-Increase stabilization beds

-Support AMHD as a resource for providers, community (e.g., have trainers of trainings)

*By Strategic Planning Executive Group (SPEG) January 2023

Step 2. Identify the unmet needs and critical gaps of the current systems

Environmental Factors and Plan

Answer (efforts)

- Telehealth –Response to COVID19 pandemic is now a norm, Data Infrastructure Improvement project to improve Electronic Health Record system,
- Certified Community Behavioral Health Clinic (Maui),
- On-Track Hawaii as Specialty Care for Early Serious Mental Illness/First Episode Psychosis.
- New Agreement Guiding Jail Diversion in the Community.
- Hawaii State Hospital Sequential Rehabilitation of Buildings to support different levels of care.
- Accreditation of Hawaii State Hospital, Community Mental Health Centers, Clubhouses.
- Certified Peer Specialists Programs with two tracks – Hawaii Certified Peer Specialist (for children, adolescents & adults), Parental Supports and Certified Forensic Peer Specialist.
- Hawaii CARES 988 – Rebranding, continuous improvement

Step 2. Identify the unmet needs and critical gaps of the current systems

Environmental Factors and Plan

More Answers…

- Crisis Mobile Outreach (Youth) advocacy, piloting
- Trauma-Informed Care Task Force that advocated for the Office of Wellness and Resilience (now in Governor's Office)
- Iwilei Behavioral Health Urgent Care Center
- Patchwork of workforce solutions
  - *informal rate/compensation studies for services/professions*
  - *legislative advocacy for more positions*
  - *DLIR Hele Imua internship program*
  - *Mental Health Technician Certification program for entry-level positions*
  - *Training of Trainers, Training (e.g. Dialectic Behavioral Therapy,NetSMART Conference, Wellness Recovery Action Plan, and others, Trauma Focused Cognitive Behavioral Therapy, Employment Supports, Disaster Behavioral Health-related, and others)*
- New Partnerships/Collaborations/Networks
  - AANHPI Ohana Center for Excellence (San Jose State University, Papa Ola Lokahi)
  - Employment First Task Force
  - Disaster Behavioral Health Network
  - Safe Spaces Committee focusing on LGBTQ+

Step 2. Identify the unmet gaps and critical needs of the current systems

Notables from a critical review of data in previous section

- Need to treat and help more, both youth and adults.
- Newer and emerging mental health issues in the community.
- More rapid rise in substance use in Hawaii than rest of the country.
- Youth as well as households on and below ALICE thresholds have increased social or economic challenges alongside mental health issues.
- Need for better outcomes for clients who have already been diagnosed with SED or SMI and receiving treatment and support services, especially among youth clients and their families, and the forensic population.
- Little or no data reported. Need for evidence-based practices that are working for the various populations, including for specific gender and sexual minorities, but getting and accessing data, including ethnicity, are necessary conditions.
- Chronic physical health condition of populations, the clearest need among Native Hawaiian population and older population.
- Ambiguous ranking in workforce availability (25^{th}) compared to feeling of being the worst state.

Noting houselessness, ethnic diversity of population, high cost of living, island state with no interisland roads.

Step 2. Identify the unmet needs and critical gaps of the current systems

Environmental Factors and Plan

How was capacity, strengths, sense needs and gaps explored further?

- Plan requested or required answers to many questions to many subject categories and or sub-categories.
- Hawaii will answer all 12 required questions and one requested question.

Step 2. Identify the unmet needs and critical gaps of the current systems

Environmental Factors and Plan

What are the topics?

1. Access to care, integration, care coordination
2. Health disparities
3. Evidence-based practices for early intervention to address early serious mental illness
4. Person-centered planning
5. Program integrity
6. Statutory Criterion (5)
    a. Comprehensive community-based mental health service system
    b. Mental health system data epidemiology
    c. Children's services
    d. Targeted services to rural and homeless populations and to older adults
    e. Management Systems (incl. Telehealth)
7. Trauma (requested information only)
8. Crisis Services
9. Recovery
10. Children & adolescents mental health services
11. Suicide Prevention
12. Support of State Partners
13. State Planning/Advisory Council and Input on MHBG Application

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

- **A State Profile**
  - *Remote Island State*
  - *4 counties, no interisland roads*
  - *Extraordinary ethnic diversity*
  - *Most expensive state to live in*

- **The State's Mental Health Care System**
  - The Law
  - The Department of Health
  - High Level Structure
  - Payee and Providers Networks
  - Specific populations -Uninsured, Underinsured and In-Crisis

- **A Mental Health Epidemiology**
  - Prevalence
  - Data on services – Insured, Underinsured and in Crisis
  - National comparison

Ad Hoc Committee's Input: Address Homelessness, Workforce

Step 4. Develop goals. objectives, performance indicators, and strategies

SAMHSA STRATEGIC PLAN *goals*

-Improve quality and accessibility of the crisis system

- Increase program integration and expand pediatric behavioral health capacity

- Support dissemination and implementation of evidence-based and culturally-appropriate services

- Advance bi-directional integration of health care across systems for people with behavioral health conditions

- Support active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce

- Support professional development initiatives to improve the competencies of service providers

- Reduce barriers to the continuum of high-quality services

What indicators should we keep, toss, modify? What should be added?
What strategies will help meet the target? What will be the constraints?

Priority Area #2
Community-Based Services

Goal: Increase access to mental health

Performance target year 1: Increase by five percent

Data used and definition:
Percent change in the number of distinct consumers served across all Adult Mental Health Division (AMHD) service types between the baseline year and implementation year. The AMHD service types covered services provided at the Hawaii State Hospital ("HSH"), Community Mental Health Centers ("CMHCs", and Purchase of Services ("POS") or services that were contracted out.

Data Source: DOH AMHD Avatar database

Result:
The percent increase was 3.4 percent.
FY22 (Year 1 implementation) Count = 7,390
FY21 (Baseline) Count = 7,142

Story behind the result:
The target was 5 percent and the first year result was 3.4 percent, or a difference of 1.6 percent. Restrictions related to the pandemic were not lifted during the early months of the implementation period. Many consumers or target service recipients were not able to receive services due to pandemic-related reasons. On Oahu where the count decreased, Avatar data indicates the top reasons to be the change in level of case management (e.g., needing Intensive Case management+ services) and death of consumers or target service recipients.

Step 4. Develop goals. objectives, performance indicators, and strategies

SAMHSA STRATEGIC PLAN *goals*

-Improve quality and accessibility of the crisis system

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- Support professional development initiatives to improve the competencies of service providers

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Priority Area #1
Community Tenure

Goal: Decrease percentage of individuals discharged from the Hawaii State Hospital (HSH) who are readmitted within six months.

Performance target year 1: Decrease by five percent

Data used and definition:
Readmission Rate: This is based on the number of patients discharged from the HSH during the implementation period and who were admitted back within 180 days or less, excluding patients who were admitted and discharged within 14 days or less.

Notes about measure used: Due to a new law that was first implemented in November 2020, individuals with petty non-violent misdemeanors who are being assessed for fitness to stand trial can be sent to the Hawaii State Hospital for an approximately seven-day assessment. If an individual is found unfit, they are generally released to the community. The population is very different from the longer-term population receiving care at Hawaii State Hospital and were thus excluded from the analysis.

Data Source: DOH AMHD Avatar database

Result:
Readmission rate increased by 2.7 percent.
FY22 (Year 1 implementation)
Readmission rate = 17.6 percent based on 39 readmissions and 221 discharges
FY21 (Baseline)
Readmission rate = 14.9 percent based on 36 readmission and 241 discharges.

Story behind the result:
The readmission rate increased instead of decrease. The COVID-19 pandemic ("pandemic") continued during the implementation year, affecting all consumers, whether recently discharged or not. More data on adverse conditions will be examined.

Step 4. Develop goals. objectives, performance indicators, and strategies

SAMHSA STRATEGIC PLAN *goals*

-Improve quality and accessibility of the crisis system

- Increase program integration and expand pediatric behavioral health capacity

- Support dissemination and implementation of evidence-based and culturally-appropriate services

- Advance bi-directional integration of health care across systems for people with behavioral health conditions

- Support active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce

- Support professional development initiatives to improve the competencies of service providers

- Reduce barriers to the continuum of high-quality services

Priority Area #3
Crisis Stabilization

Goal: Keep individuals stable within the community

Performance target year 1: Increase by five percent

Data used and definition:
Data to *count distinct individuals* will be cleaned. A set of proxy indicators are used together to indicate performance. These capture the different services that make up AMHD's array of crisis services.

Source of data: DOH AMHD Avatar database, crisis call providers responses to data requests.

Results:

Hawaii CARES total calls (# of calls)
FY 2022 Implementation year: 107,138;
FY 2021 (Baseline): 103,955
Change: Increase by 3.1 percent

Stabilization beds available (# of beds)
FY 2022: 10,505
FY 2021: 2,002
Change: Increase by 424.7 percent
The occupancy rates are between 58 to 96 percent

Mental Health Emergency Worker (MHEW) calls (# of calls)
FY 2022: 653
FY 2021: 429
Change: increase by 52.2 percent

Crisis Mobile Outreach (CMO) services (# of services)
FY 2022: 7,987
FY 2021: 7,312
Change: Increase by 9.2 percent

Licensed Crisis Residential Services (LCRS) (# of services)
FY 2022: 11,092
FY 2021: 11,436
Change: decrease by 3 percent

Intensive Case Management (ICM) services (# of services)
FY 2022: 58,888
FY 2021: 67,086
Change: Decrease by 12.2 percent

Story behind the results:
These results were achieved by expanding crisis-related services, with tremendous increases in stabilization beds. In the context of houselessness and co-occurring conditions (houselessness, substance abuse) among those experiencing crisis, the expansion of stabilization beds was noted as a best practice by collaborators. The decrease in LCRS and ICM services can be explained by the impact of the pandemic, where infection by even one consumer necessitated shutdown and non-provision of services to others. Also, further examination may show that stabilization bed services stepped up for LCRS and ICM services.

Step 4. Develop goals. objectives, performance indicators, and strategies

SAMHSA STRATEGIC PLAN *goals*

-Improve quality and accessibility of the crisis system

- Increase program integration and expand pediatric behavioral health capacity

- Support dissemination and implementation of evidence-based and culturally-appropriate services

- Advance bi-directional integration of health care across systems for people with behavioral health conditions

- Support active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce

- Support professional development initiatives to improve the competencies of service providers

- Reduce barriers to the continuum of high-quality services

Priority Area #4
Peer Specialist and Forensic Peer Specialist

Goal:	Increase the use of peer specialists in community-based services
Performance target year 1:	Increase the number of Hawaii Certified Peer Specialist ("HCPS") by 10 percent

Data used and definition:
Number of individuals who were certified as HCPS

Source of Data: DOH AMHD Performance Information Evaluation and Research ("PIER") Branch data

Result:
FY22 (implementation year): 31 HCPS
FY21 (baseline year): 21 HCPS
Change: Increase by 47.6 percent

Story behind the result:
The DOH AMHD stepped up the HCPS Training and Internship Program by increasing the number of training and internship opportunities. This includes providing train-the-trainer certification and also Forensic Peer Specialist training and internship opportunities.

Step 4. Develop goals. objectives, performance indicators, and strategies

SAMHSA STRATEGIC PLAN *goals*

- Improve quality and accessibility of the crisis system

- Increase program integration and expand pediatric behavioral health capacity

- Support dissemination and implementation of evidence-based and culturally-appropriate services

- Advance bi-directional integration of health care across systems for people with behavioral health conditions

- Support active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce

- Support professional development initiatives to improve the competencies of service providers

- Reduce barriers to the continuum of high-quality services

Priority Area # 6
First Episode Psychosis Services

Goal: Increase number of youth and young adults who received First Episode Psychosis ("FEP") services

Performance target year 1: Increase by five percent, with 16 as baseline

Data used and definition:
Number of youth and young adults who received FEP services
Source of Data: CAMHD MAX electronic health record system

Result:
FY22 (implementation year): 18
FY21 (baseline year): 12*
Change: Increase by 12.5* percent
*Note: These are the correct values not 16 and 15 percent as previously submitted to SAMHSA.

Story behind the result:
OnTrack Hawaii is the only coordinated specialty care program for first episode psychosis (FEP) in the state. The program serves youth statewide ages 15 to 24. The program is currently funded by federal block grant money and staffed by a psychiatrist and master's level clinicians who split their time supporting other CAMHD programs. Services to youth and families throughout the pandemic have been offered via telehealth, at the OnTrack office, or in the community, wherever the youth and families felt most comfortable. No changes were made to programming or staffing during this year. Future expansion of services will likely be limited by challenges experienced with hiring, training and retention of staff (including administrative assistant, peer support, education and employment support associate) needed to run this program.

Step 4. Develop goals. objectives, performance indicators, and strategies

What were the major feedback from the ad hoc committee meetings, so far?

Homeless
Workforce
Diversity

Strategies?

-Improve quality and accessibility of the crisis system

- Increase program integration and expand pediatric behavioral health capacity

- Support dissemination and implementation of evidence-based and culturally-appropriate services

- Advance bi-directional integration of health care across systems for people with behavioral health conditions

- Support active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce

- Support professional development initiatives to improve the competencies of service providers

- Reduce barriers to the continuum of high-quality services

What funding resources do we use?

IN PROGRESS What is administered by AMHD and AMHD only

- Budgeted State funds

- Two federal formula grants
  - Mental Health Block Grant (MHBG)
  - Project for Assistance in Transition from Homelessness (PATH)

- Three emergency or supplementary funds via the MHBG grant
  - Coronavirus Aid, Relief and Economic Security Act of 2019 (CARES)
  - American Rescue Plan Act of 2021(ARPA) and
  - Bipartisan Safer Community Act of 2022 (BSCA)

- SAMHSA Competitive grants
  - Transformation Transfer Initiative (TTI)
  - Certified Community Behavioral Health Center (CCBHC) grant
  - Asian American Native Hawaii Pacific Islanders (AANHPI) Center for Excellence
  - Data to Wisdom expansion grant

- SAMHSA 988 State cooperative agreement

How will the funds be used in the next 2 years?

IN PROGRESS What is administered by AMHD and AMHD only

MHBG Table 2a									
Planning Period	From	7/1/2023		To	6/30/2025				
ACTIVITY	A. Mental Health Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS, Medicare SAMHSA)	D. State Funds	E. Local Funds (exluding local Medicaid)	F. Other	G. COVID-19 Relief Funds MHBG [a]	H. ARP Funds (MHBG)[b]	I. Bipartisan Safe Community Funds[c]
1. Mental Health Preventions[d]									
2. Evidence-Based Practices for ESMI incl FEP 10 percent of total MHBG award[e]									
3. State Hospital									
4. Other Psychiatric Inpatient Care									
5. Other 24-Hour Care (Residential Care)									
6. Ambulatory Community Non-24 Hour Care									
7. Crisis Services (5 percent set-aside)[h]									
8. Administration (exlcuding Program and Provider Level)[g]									
TOTAL									

MHBG Table b								
MHBG Planning Period	From			To				
ACTIVITY	**A. FY 24 Block Grant**	**B. FY COVID Funds**	**C. FY24 ARP Funds**	**D. FY24 BSCA Funds**	**E. FY25 Block Grant**	**F. FY25 COVID Funds[1]**	**G. FY25 ARP funds[2]**	**H. FY25 BSCA Funds[3]**
Activity								
1. Information Systems								
2. Infrastructure Support								
3. Partnership, community outreach, and needs assessment								
4. Planning Council Activities								
5. Quality assurance and improvement								
6. Research and Evaluation								
7. Training and Education								
8. TOTAL								

What service provider resources do we have?

IN PROGRESS This list has AMHD only

1. Aloha House – CBCM, CMO, CSM. Day Treatment, LCRS, SRSP
2. CARE Hawaii -CBCM, CMO, CSM, Day Treatment, Group Home, ICM+. IOH, LCRS, SRSP, ICM+ (SICM)
3. Community Empowerment Resources – CBCM, SICM services
4. HaleNa'au Pono -Group Home services
5. Hina Mauka – CBCM, Day Treatment, ICM+, SRSP services
6. Hope Services Hawaii – Representative payee services
7. Institute for Human Services Inc. – Homeless outreach, ICM services
8. Kahi Mohala- Psychiatric inpatient services
9. Kalihi-Palama Health Center – Homeless outreach services
10. Kokua Support Services – Representative payee services
11. Mental Health Kokua – CBCM, Group Home services, SRSP, Supported Housing, Therapeutic Living Program (TLP)
12. North Shore Mental Health – CBCM
13. Po'ailani Inc. – SRSP
14. The Queen's Health System – IOH, Partial hospitalization and ION, MHEW services
15. Steadfast Housing Development Corporation – Groups, Semi-independent housing, Supported housing

CRISIS and NON-CRISIS RESPONSE	TREATMENT & SUPPORT	SUPPORTED LIVING	RECOVERY SUPPORT
3-10 days **CRISIS** -DOH Hawaii CARES 988 -Avg. 7,031 calls/month -Crisis Mobile Outreach (CMO) -Avg. 250 outreaches/month -Crisis Support Management (CSM) -Mental Health Emergency Worker (MHEW) **CRISIS STABILIZATION: 93 beds** -Licensed Crisis Residential Services (LCRS) -Stabilization Intensive Case Management Plus (SICM) [redacted] **NON CRISIS*** *Court-ordered* Court Evaluation Branch Assessment *Not court-ordered* AMHD assessment	*30+ days* **Case Management** -Community-based case management (CBCM) -Intensive case management plus (ICM+) -Homeless Intensive case management plus (ICM+) ** **Treatment** -Day Treatment -Intensive Outpatient Hospitalization (IOH) -Specialized Residential Services Program (SRSP) **Community Mental Health Center outpatient services** -Psychiatric diagnostic evaluation in person or through telehealth - -Therapy services – -Individual and family; Telehealth -Therapeutic injection -Day treatment -Day treatment/co-occurring disorder -Intensive outpatient hospitalization (IOH) -Partial hospitalization **Long-Term Care Services** -Expanded Adult Residential Care Home (E-ARCH) -Skilled Nursing Facilities (SNF) **Inpatien** Psychiatric hospitalization	**Therapeutic Living Program (TLP)** -24 beds **24-hour Group Homes** -245 beds **8-16 hour Group homes** -265 beds **Semi-independent housing** -120 beds **Supported Housing**	*Ongoing* **Clubhouse Model** (Psychosocial rehabilitation; Supported Employment) **Peer Coaching (COMING SOON!)** **Certified Peer Specialist Training** **Certified Peer Specialist** **Representative Payee** **Homeless outreach **** *Listed services here are in-house and not by contracted service providers. **Specific to houseless clients.

What human resources do we have?

IN PROGRESS CAMHD and AMHD

Planner's Assessment Only

-Workforce is not fixed, stable

-AMHD, excluding Hawaii State Hospital, has a vacancy rate that hovers at 30 plus percent or 1/3. It is noted that about half of workers are social workers or human service professionals. The same percentage with the vacancy.

To be continued

Child & Adolescent Mental Health Division
MHBG Draft Budget – Summary & New* Items for FFY 2024-2025

SAMHSA Budget Categories	Summary (* = New Items)
Evidence Based Practice for Early SMI incl. FEP (10% of total award) – Funds are used primarily to support CAMHD's On-Track Hawaii (OT-Hi) program for youth with First Episode psychosis (FEP). OT-Hi is the only coordinated specialty care program for FEP in Hawaii.	<u>On-Track Hawaii (FEP) Program</u> • Increase staff to accommodate continuously increasing number of clients • Continue On-Track NY Mentoring • Neighbor island travel in-person visitations* • Peer Support Staff* • Training vocational and peer specialist to provide education/employment supports for clients to be job ready and attain competitive integrated employment*

Child & Adolescent Mental Health Division
MHBG Draft Budget – Summary & New* Items for FFY 2024-2025 continued

SAMHSA Budget Categories	Summary (* = New Items)
Other 24-hour Care	• To be determined
Ambulatory/Community Non-24-hour Care	• Mental health services for homeless youth program - Coastal Kids (Catholic Charities); increase in allotment by 5% • Kealahou program for girls who experienced trauma (i.e., trafficking); currently recruiting for two staff members to fill positions
Crisis Services (5% set-aside)	• Emergency Room (ER) Liaison to field calls from ERs regarding youth with mental health conditions* • 988 – CAMHD is funding through D2W grant • Travel for Crisis Intervention Training on the neighbor islands*
Administration (<5% of award)	• Electronics which are compatible for telehealth and telework • Covid mitigation supplies

Child & Adolescent Mental Health Division
MHBG Draft Budget – Summary & New* Items for FFY 2024-2025 continued

SAMHSA Budget Categories	Summary (*= New Items)
Information Systems	• Support of Electronic Medical Records (incl. licenses, security, etc.) • Child & Adolescent Functional Assessment Scale (CAFAS)
Infrastructure	• Child & Family Services for Family support incl. parent to parent services (Peer support other than OT-Hi paid by other funding) • Zoom
Partnerships, Community Outreach, & Needs Assessment	• Hawaii State Youth Interagency Network of Care (HiSYNC) facilitation • Outreach to Youth/Families through Website/ Social Media for mental health services • UH School of Public Health Mental Health Needs Assessment for youth 3 - 17 years*
Planning Council Activities	• Continue $5K allocation
Quality Assurance & Improvement	• Funded by D2W Grant

Child & Adolescent Mental Health Division
MHBG Draft Budget – Summary & New* Items for FFY 2024-2025 (continued)

SAMHSA Budget Categories	Summary (* = New Items)
Research & Evaluation	• Research Staff • Evidence Based Services Roundtable to research/evaluate practices • 988 Survey of Youth/Families users
Training & Education	Skill development and continuing education for • CAMHD clinical staff • CAMHD Contracted Service Provider Training* • Division-wide Training*