STATE COUNCIL ON MENTAL HEALTH (SCMH) MEETING

December 10, 2024 9:00 a.m. – 12:00 p.m.
Remote meeting via Zoom with
in-person site at Hale F Conference Room, 2201 Waimano Home Road, Pearl City 96782

DRAFT MINUTES

Members Present: Katherine Aumer, John Betlach, Tianna Celis-Webster, Lea Dias, Jon Fujii, Heidi Ilyavi, Jackie Jackson, Kathleen Merriam, Christine Montague-Hicks, Ray Rice, Mary Pat Waterhouse, Forrest Wells, Kristin Will, Marian Tsuji (ex-officio)
Members Absent: Asianna Saragosa-Torres
Members Excused: Naomi Crozier

AMHD and CAMHD Staff: Chanel Daluddung, Madeleine Hiraga-Nuccio, Jocelyn Nazareno, Richalle Patague, Darryl Tanaka, Carolyn Weygan-Hildebrand, Valerie Yin.

Guests: Andre Fraticelli (R.Y.S.E), Christopher Knightsbridge, David Litman, Christopher Au (S24Ultra), Dr. Dang.

I. Call to Order

Katherine Aumer, chairperson, called the meeting to order at 9:03 am and quorum was established.

II. Announcements

K. Aumer warmly welcomed members and guess.

Meeting protocol:

- In case of communication technology-related interruption that could not be restored in 30 minutes, the meeting will automatically be terminated and resume on December 17th, at 9 am using the same zoom links used of this meeting.
- Community input will be received in the designated part of the agenda as well as throughout the meeting.
- Meeting is recorded and will be releases through the Council's website and will be publicly available.

Announcement:

- 2025 Legislature Calendar is out.
- LRB Room (Legislature Access Room) is available.
- Reminder for Council Members to check membership status for those who need to reapply.
- The Office of Information Practices (OIP) recommended that the Council table members reports today. The OIP deem that the public notice and the agenda should be clear on what each report will be about. Chairperson Aumer requested staff to look for the old Council report template to address this.

Ex-officio message:

Marian Tsuji shared that the assistant secretary for SAMHSA, Dr. Miriam E. Delphin-Rittmon, was here last week. While she won't continue with the new administration, she was able to look at how DOH was responding to the Maui fires. DOH received funding from several different sources

within SAMHSA in addition to the large 17-million-dollar SAMHSA emergency response grant (SERG). She was impressed with all the work that has been done by the community – the integration of cultural practices and the variety of ways that we are reaching out into the community that is not necessarily with therapist but with talk stories groups and other alternative trusted listening groups. The approach could be the model of how future responses would be done in other disasters, but there are things to rethink about. Hawaii is headed in the right direction even though there will be some rocky roads ahead.

III. Approval of Minutes

John Betlach moved to approve the August 13, 2024 minutes as drafted. Lea Dias seconded. Motion passed.

J. Betlach moved to approve the November 12, 2024 minutes subject to two changes -removing the web links and using L. Dias PowerPoint slides in place of the text in the draft. Forrest Wells and L. Dias seconded. Motion passed.

The October 8, 2024 minutes was tabled.

IV. Community Input

J. Betlach expressed a community member's concern about the fate of insurance in the State, and pursuing instead the single payer model. He brought up also the idea of the Council supporting such.

Jon Fujii commented that there will be a lot of questions because of transitions at the federal level. He offered that the State has experienced this with the previous Trump administration. One of those things that was floating back than was block granting the Medicare Program, which will limit the funds for each state to some fixed amount rate. While there are concerns, there is nothing concrete yet so there is monitoring, watching, and weekly meetings with the Medicaid Director Association. He also noted that every year, there is a proposal for a single payer system in Hawaii, so testimonies (not the Council's) have been prepared in the past.

V. New Business

A. **"***Observations on the Impact of the Lahaina Wildfires have Had on Individuals and Community Mental Health***"**
Christopher Knightsbridge, Hawaii Community Mental Health

Dr. Knightsbridge shared his observations from working in collaboration with the University of Hawaii Maui Wildfire Exposure Study. He said that a big part of the study was on the toxic exposure, and while researchers were collecting data for the mental health and trauma impact, there was no one there offering support, referring out to services, and getting the community help. He stepped in as part of the nonprofit mainly on pro bono basis. He has been flying out to Maui for the past 3 ½ months. To date, he was able to speak to some 400 people and families directly in a longer form of conversation at the end of their testing for toxic exposure. He shared the following based on his observations:

1. Mixture of distrust. The project is more than just a study. It is more about trying to identify problems that are going around, reaching out and informing study participants that they are more than just data, and if they need help with anything that said help will be sought.

The biggest thing that he noted are the mixture of distrust in the system. People on Maui that he has talked to feel disgusted and abandoned by the system, including the State and Federal Government.

2. Not sharing about their trauma. Some 90% to 95% that he has talked to have never talked to anybody about their trauma. About 30% to 40% of the people break down in tears when asked "How are you doing? How have you been this past year?"
3. Navigating the system. Most of the people he has talked to have no clue how to navigate the system and most of them qualify for Medicaid, Medicare, and others. When he is in Oahu, he calls back/email the people he has talked to and refer them to a network of trusted providers to get the people services they need. there is a need to get funding to hire more case managers, social workers, and others.
4. Disproportionate hospitalization per capita. He noticed even before the wildfire, the mental health crisis on Maui was disproportionate, and there are more hospitalization per capita than all of the other islands.
5. Children. When they talk to children, the children were open about their feelings and started to tear up.
6. Barrier to treatment. There is a large Mexican ethnicity population on Maui that is undocumented. It is a huge barrier to treatment because there are not enough Spanish speaking providers in Hawaii. On top of the wildfires, worries about deportation are additional stress to families.
7. More of a crisis than we thought it was. Most people impacted open only if it an authentic conversation, revealing that the crisis is more than the crisis we thought it was. There are some agencies helping, and his goal is to guarantee that every single participant in the study and their friends and their family members can be treated if they want, and we will find them a provider within two weeks of the consultation.

He concluded that leads are need to therapists who are Spanish-speaking and Marshallese-speaking who can take in some of those needing help. He is also seeking a letter in support to get grants to grant the work.

Q&A, comments

Q. With the difficulties of accessing mental health care, do you have any suggestions on how to help people reach out to that? We have a therapist who goes to the Lahaina Behavioral Health Center once a week. We've been trying to recruit people to be seen there, going with the talk story approach. We have only 19 people that we are serving so far, and we want a lot more. So, is there anything you see that might be leading to the disconnect?

A. Yes, we are committed to warm hand off and the follow up. It is never enough to just give information and say contact these people because they won't. Also, to let them know if that it is fine to say if they do not want their therapists but they not give up on therapy. I ask them to just email me back and we will try to find somebody else. So, letting them know all this in advance combined with the warm hand off is what has been effective for us.

Q. With the warm hand off, would you think it would be better if they go to their PCP and they can do a warm hand off that way or are there other organizations around in the community who can facilitate such.

A. There probably is but I don't know them. That's why with this group, the Hawaii Community Health Hui, are asking the same questions. So we do it ourselves. The only problem is that we are unfunded volunteers and there is only so much we can do. But you can always email me

chris@hawaiicommunityhealth.org and I will help everybody find somebody and pass it on to our Hui group or you can join the Hui group just let me know.

K. Aumer clarified that the letter of support must be in the Council's agenda first for discussion. Also, that is normal for support letters to follow grant deadlines.

B. *"The Medicaid Perspective: Care Coordination Services"*
Jon Fujii, Health Care Services Branch Administrator, Med-QUEST Division

"Care coordination" can mean many things but for Medicaid it has a specific meaning. They are called health coordinators and do the health coordination services. What happens is that certain Medicaid patients qualify for health coordination services. There is a threshold for making this available.

- The first group are for folks who are at a nursing home level of care. There is a form and assessment that happens to qualify for a level of care called the 1147 form. This form must be signed by a Clinician and there is a standard on how folks get into level of care which can turn the switch on for their health coordination services.
- There second group is called" at risk" of level of care. These are folks that when 1147 is completed, they don't quite score at that level required. They are determined to be" at-risk population" and basically at risk of needing the level of care or at risk of decompensating to required level of care. So, Medicaid wants to get to these folks earlier so that we can provide them with a few services that they can continue to live more independently and not move to the nursing level of care situation."
- There is a third group, the special health care needs. Special health care needs could be various things. It could be folks with multiple health comorbidities including behavioral and medical health comorbidities. It could be often times be that have multiple needs because of things that happened early in their life. So special health care needs is a third population that qualify for health coordination services. So that's kind of folks in our Medicaid Program that health coordination is available to.

Depending on the population, it might be the health plan who has health coordinators. It might be the health plan that provide those services. It also might be, if they are in the foster care system, what's called CCFFH Community Care Foster Family Homes.This is in the state regulations. If they are in nursing level of care in a foster home, they are going through the health plan but what's called CCMAs case management agencies. Basically , the agencies are called out in our state laws as well. So, if you are in a foster home the health carrier is going to be supported not by the health plan health coordinators but the CCMAs. There are like 19 different CCMAs in the state. They are statewide. Other than that population, all of the health coordination is provided by our health plans and their staffs. The staff that provide these services typically are RNs or Licensed Social Workers (LCSW).

So, what happens is that when you qualify for health coordination, either through SCM level of care or you are identified as special health care population, there's like a couple things that happen. The first thing is an assessment occurs called a health and functional assessment. This is a comprehensive evaluation, an assessment on what's going on with the member and what their needs are, where they are struggling. Results from that Health and Functional Assessment the HAP is a Health Action Plan. Health and Functional Assessment leads to a Health Action Plan. Health Action Plan is the Care Plan. And one follows the other based on how they are

assessed they develop a plan of action for the member --from anything, the need for some personal care services to the need of transportation to go to places. So this is like the connectivity. This is like plugging them into and closing gaps for when they might have a difficult time to do those things that they need to do to keep themselves healthy. And part of the Health Action Plan is to there is a person center aspect to it as well. There are questions like what is your vision? how you want to live your best life? They have questions around what does the member want? Just large picture right.

So, it takes a person center approach and also consider sort of Ohana center approach so a person is not all by themselves. And then the member can choose who they want included. They just want themselves or they want aunty and neighbor to be part of this discussion in creating a health action plan.

And when the health action plan is developed it turns into sort of authorization services right. The action plan is basically a driver for ok we need to have xx amount of hours of personal care, we need to have xx amount nursing support in home, we need to have them go to adult day care……So it outlines basically want needs to happen that drives authorization.

So, this is sort of just a general picture for our health coordination for our Quest Integrated Program. We started this I think in 2009 and developed further iteratively. We have a vision of sort of the best way it should happen. Our vision involves sort of the community level/provider level. So, health coordination should be by someone the members are comfortable with. We have ideas in our contract. Our vision of health coordination is its best delivered at the community or at the community level not necessarily at the health plan level.

We are looking at how we want to align better. So the health coordination doesn't technically provide the behavioral health services but it does connect the person to where if they are showing a need for behavioral health services.

Q&A, Comments
Q. Does Medicaid/MedQuest have a community resource guide?
A. I can look on our webpage for links. The information maybe more underground. Medicare Program don't have a resource guide, but I can check with our health plans.

Q. What is the percentage of health care coordinators that are source out through PCP or the primary care system and other systems?
A. I said that at the end. That's sort of like what we want to happen but that's not happening now. We see that as sort of the better model if you will. There is something I forgot to mention. There's a health care coordinator but the health care coordinator drives the team, it's not a single person, it's a team of folks that work on the health coordination.

Q. On the Big Island, some of the directors mention that there is a shortage of people who do those assessments. I was wondering if you have looked at that at all, career track and preliminary licensed case workers to be able to do that.
A. When you say assessments you are talking about the 1147 for them to be assessed at the level. The 1147 can be done by anyone. If you are saying that the member doesn't have clinician that they are working with then that's a different problem, right? For me l like to hear

about those specific situation and which health plans you are talking about. I wish to hear about the members who are not getting the care they need.

Q. The shortage is true in the Big Island. For example, Hawaii Island Community Health Center is one of the only places where consumers can go to get assessed initially before they can get treatment. And they are so backed up that you are looking at 30, 40 or even 65 days out before you can get an assessment done. Providers are limited to them, and they are the only ones that will start anybody with or without insurance so that's usually where they start.
According to Steve Pavao, CMHC, they were wanting to get some people that were licensed to do assessments.
A. Steve Pavao would be DOH. The issue came up and the issue of cost of living/rentals came up as an issue for workers. At least in the Kona area, there is a shortage of applicants, and all the positions are open for case workers. So, issues like rentals involves more agencies.
The other part (of getting workers) is going through the civic service system, where candidates trying to get into the system will have to go through a process of complying for positions and multiple departments will be vying for them. We have been trying to work with DHRD to quicken the process, but it is not quick enough, and we lose the candidates. The other part is not having competitive salaries. So DOH is trying different things and the bill we are proposing is asking that all behavioral health positions be exempt from civil service at the time of hiring with the understanding that the qualified applicant will get on the civil service list and be processed within a year or lose their position.

Q. Christopher Au commented that there is another option, but insurance won't pay for it. In other states they have these positions called peer support services. I ran a substance abuse program and I've been trying for years get HMSA to pay for this where I would have a client who's been clean for a 1-1/2 years than go through the training. Hawaii has only 1 training per year, which makes it hard to get in. So, I would pay somebody from the mainland to come out to do the exact same training, but HMSA won't pay for it. Even though it's a Medicare billing code, HMSA just say there is no need for it. HMSA have said the same thing with a couple of different things like day treatment. They say that there's already enough providers but there are all on Maui and Oahu, and so what are the people on the Big Island supposed to do or people on Kauai supposed to do. And we keep running into these roadblocks but they are not case managers but they are certainly help like a lot. The reimbursement rate is pretty good, you could pay somebody $25 to $30 an hour but has a high school diploma.

A. I think we should look into that because peer support services are reimbursable. I think we can talk offline about how to expand. CAMHD does its own peer support training from an CAMHD perspective and I think in our state plan we talk about national standards or through one of the partners we have at DOH. A law was passed last year for the Office of Wellness and Resilience to look at all the different peer specialist program-CAMHD, AMHD, ADAD, Department of Corrections, and some rehabilitation, Veterans, DHS. I know that's been convened but I don't know what the status of that is we can check on that and report back to the Council.

Christopher Au commented that the focus has to be getting these people paid and there has to be more billable codes.

Q. Just to clarify we are talking about Med-Quest and Medicare is there anything you can say about other health plans not providing any of or not honoring certain service codes that apparently supposed to be service full but not being covered?
A. From a Medicaid perspective we don't differentiate in terms of one plan can pay for this, one plan can't for this, it's a single program. We don't have a different contract in terms of service scope between our health plans for Quest Immigration. I'll go look more into that.

A. State Council on Mental Health 2025 Report to the Governor

See handout on draft report which is last year's. Carolyn Weygan-Hildebrand went over the key points on where the changes will be for the 2025 report. Mary Pat Waterhouse suggested that the Council can report that it had Hawaii State Hospital updates through M. Tsuji and Katherine Merriam. M. Tsuji reported that Hawaii State Hospital got its accreditation and that Dr. Mark Linscott is the new administrator for the State Hospital.

J. Betlach move to create a negotiating Permitted Interaction Group to work with staff in finalizing the 2025 Report. Jackie Jackson and F. Wells seconded. Motion passed.
The following volunteered to be members of the PIG: K. Aumer, Tianna Celis-Webster, and J. Jackson.

VI. Old Business

A. Presentation in November

J. Betlach moved to approve the Thank You Letter and bring to attention that I like the line "We are eager to support you and the State in implementing the statewide targeted violence prevention plan". F. Wells seconded. Motion passed.

B. 2025 Legislation Council Agenda

Please refer to the Meeting Minutes of the Ad Hoc Committee on 2025 Legislation. K. Aumer moved to approve the themes that the Council will have as criteria for reviewing a bill or not. The themes will be as listed in the committee meeting draft minutes, adding disaster and supportive housing, themes from last year, and correcting the last line that should state that Council will stay out of controversial bills (e.g., prescriptive authority by psychologists). J. Fujii seconded. The motion passed.

Summarizing the themes that the Council approved:

- workforce development
- family and youth
- crisis services, including ACT/AOT but to stay away from controversial ones
- AMHD and CAMHD bills
- forensic-related
- Mental Health Task Force themes but 2025 themes will not be out until January next year
- general policy (e.g., Sunshine Law-related)
- employment of clients as part of recovery services (clubhouse, vocrehab)
- other themes from last year's bill tracking -mental health code, forensic-related bills
- disaster-related
- supportive housing

The Ad Hoc Committee also recommended that the Council consider a resolution to address the faster hiring of public mental health workers. M. Tsuji reported that a bill that seeks to facilitate hiring is in the works and has good chances of being in the Governor's package. The M. P. Waterhouse suggested that the resolution be put on hold for now. K. Aumer recommended that it be put in the agenda for next meeting depending on what happens to the proposed bill.

Christopher Au asked that the Council support a bill that he is working on around public auction or single payer system if it is taken up at the next legislative session. K. Aumer recommended that this be put on the agenda next meeting if needed.

VII. Informational Reports by Council Members

Tabled because of OIP recommendation but please see written reports submitted by L. Dias and K. Merriam.

H. Ilyavi commented that the Mental Health Kokua does not have a contract with AMHD and its contract expired October 27, 2024.

VIII. Adjournment

The meeting was adjourned at 12:10 p.m.

Handouts

01_SCMH 121024 Public Notice and Agenda.pdf
02_SCMH Attendance Log SFY2025 (070124 to 063025) as of 111224.pdf
03_SCMH-081324 Draft Minutes with Attachments.pdf
05_SCMH_2024-11-12 Meeting Minutes Draft with Attachments.pdf
06_SCMH_112524 Meeting Minutes of the Ad Hoc Committee on 2025 Legislation.pdf
07_SCMH_121024 Thank You Letter to Ms. Taketa DRAFT.pdf
08_SCMH - DVR-VRA Report 12.2.24.pdf
09_SCMH-DOH Report.12.10.24.pdf
10_2023 Planning Reference _Behavioral Health Services in Hawaii Landscape Report FINAL.pdf
11_2023 Performance Targeting Reference_ Hawaii Only Uniform Reporting System Output Table.pdf
12_2023 Planning Reference_State by State SMI SED Prevalence Estimates.pdf
13_2025 HACDACS Annual Report -DRAFT.pdf