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In reply, please refer to:
File:

Senate Committee on Health

Senate Committee on Human Services

Mental Health Briefing

Testimony of Chiyome Leinaala Fukino, M.D.
Director of Health

March 2, 2009; 2:45 p.m.

Department's Position: Since January 2009, the Department of Health, Adult Mental Health Division limited the available units of Community Based Case Management (CBCM) to fourteen (14) units per month. This adjustment came after close review of related clinical outcome data. In the month since its inception, the AMHD has not seen a significant increase in the clinical outcome areas that we consider, such as sentinel events.

The Department of Health has been made aware of concerns surrounding the reporting of sentinel events, specifically the alleged practice that the AMHD has been denying sentinel events, resulting in lower reporting and potentially minimizing the impact of the decrease in available units of the Community Based Case Management. These allegations draw both concern and confusion to the division as our experience and practice is to encourage, rather than discourage, the reporting of these significant events, casting the broadest possible net.

First, for your consideration, we have attached the current AMHD policies and procedures (P&Ps) on sentinel events. These are the P&Ps and related forms that all providers are given upon contracting with AMHD. All AMHD providers, statewide, were also given training following the last update to these specific sentinel-related P&Ps in 2006. Providers are given support, as needed, by AMHD clinical staff.

If a sentinel event occurs:

1) When providers become aware or suspect that a sentinel event has occurred, they are required to submit the immediate notification form by fax to the AMHD. It can also be phoned in, but the report is then faxed in no later than the next business day.

2) The data is then entered into an AMHD database. Every form received is entered into the database by AMHD, along with the category of sentinel event (as a suicide, attempted suicide, etc.).
3) Once the sentinel event is recorded in the database, the database does not allow line staff to change the categorization. This element is recorded separately, ensuring that the existence of a reported sentinel event cannot be removed.
4) It should be noted that categorization of a sentinel event can change as new information emerges. Typically, this information is new information from the provider that is reported after the immediate notification, or it is new information gleaned from a review of the medical record, or it is information from the medical examiner's report.

A very important point for the committee to be aware is that, although every notification is recorded, some events do not rise to the level of a sentinel event. A typical example is the case of self-mutilation, which can be confused with an attempted suicide. A person who self-mutilates is not attempting to end his/her life. Rather, it typically occurs "during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil" (Diagnostic and Statistical Manual of Mental Disorders IV-TR, pg. 707). A typical example is a patient who makes a superficial cut on his/her body, and reports that the intent of the behavior was not suicide. While this is a key clinical element to address in treatment, it typically does not meet the AMHD definition of a sentinel event. However, if a self-mutilation behavior could potentially have caused serious injury or death, it is treated as an attempted suicide regardless of intent. With this example, we hope that the Committee can appreciate the complexity of some of the issues involved.

5) Changes to the categorization of an event are made with the consultation of AMHD's medical director or deputy medical director. Only one person, the Performance Improvement Coordinator, can remove a categorization from reporting.
6) The provider receives a notification form, in essence, a receipt. It is at this point that a provider has documentation that the sentinel had been received and entered into the AMHD database. Providers receive notification even if AMHD determines that a particular event does not meet AMHD's definition of sentinel event. If there is a question about whether an event has been received, the notification form should serve as verification.
7) Notification of the sentinel is sent to the DOH notification list, members including the AMHD medical director, deputy medical director, the DOH deputy director, the DOH director, and others. This notification is created directly from the database, so those on the receipt list can be assured that the event has been recorded.

Again, all reporting of sentinel events are submitted to AMHD in writing. This is deliberate to ensure proper documentation of these communications, that both the provider and the division have each done due diligence in reporting and receiving the reports on these event. Therefore, fairly, the AMHD respectfully requests specific information on the information that was provided to the Legislature that certain written reports were submitted and denied to assist to allow AMHD an opportunity to gain better understanding on what the circumstances surrounding these allegations are.

AMHD is aware that in a previous communication from one of our contracted providers, the term "sentinel event" was used as an umbrella term that included hospitalizations and incarcerations, which by themselves are not sentinel events by AMHD's definition. This represents another reason to examine the specific information.

With regard to the concern that the restrictions in units of CBCM have resulted in an increase of sentinel events, we respectfully suggest that the time elapsed since this restriction has only been about a month and a half. That is insufficient time to determine significant trends or patterns. If, there were gross changes realized, that would certainly be concerning for all and appropriate actions would certainly be taken.

In addition to official reporting and the immediate notification disseminated within the AMHD and DOH, AMHD produces internal monthly reports to monitor the safety of its population in a timely way. Although these reports are promulgated internally with the understanding that, with so short a time period, the data is not yet in its permanent state (due to the possibility of changes noted above), we hope it can provide some preliminary idea of the subject at hand. When we look at the report disseminated internally with AMHD/DOH on February 4, there were 14 sentinel events for December. This is juxtaposed to 18 sentinel events in January. This represents a slight increase, but there are several factors that must be considered with this raw number.

1) Clinically speaking, this is not enough time to make any sound clinical findings;
2) The data must be seen in context: in the twelve months of the calendar year 2008, seven months had a higher number of sentinel events, for an annual average of twenty-one per month; and
3) During the time period mentioned, the population AMHD serves has increased.

Therefore, we strongly recommend that conclusions cannot yet be drawn to determine if this is a result of the decrease in CBCM units. The data is presented to reassure the committee that the AMHD regularly monitors this important area and does so in multiple ways.

The Adult Mental Health Division is committed to our mental health consumers and supports providers in as much as our fiscal resources permit. Providers are aware that full access to our team is

available, including the Performance Improvement Coordinator and the Medical and Deputy Medical Directors to respond to questions on possible sentinel events.

Thank you for the opportunity to present information in this area.

Sentinel Events
Activities

Sentinel Events	Provider Actions							AMHD Actions			
	Immediate Notification Report	Investigation	Debriefing	10 Days Conference Report	30 Days Root Cause Report	JPOI	Report to QI/Risk Mgmt Comm	ET Notification	Internal Review	Summary	JPOI
CATEGORY A											
• Suicide of a consumer	x	x	x	x	x	x	x	x	x	x	x
• Homicide of a consumer	x	x	x	x	x	x	x	x	x	x	x
• Homicide by a consumer	x	x	x	x	x	x	x	x	x	x	x
• Medication error: any consumer death, paralysis, coma, or a permanent loss of function associated with a provider medication error.	x	x	x	x	x	x	x	x	x	x	x
• Serious consumer injury resulting in permanent loss of limb or function or risk thereof.	x	x	x	x	x	x	x	x	x	x	x
• Suspected abuse/sexual/neglect of a consumer.	x	x	x	x	x	x	x	x	x	x	x
CATEGORY B											
• Attempted suicide of a consumer	x	x		x			x	x	x	TBD	
• Attempted homicide of or by a consumer	x	x		x			x	x	x	TBD	
• Elopement from a crisis shelter, residential treatment facility or group home and that poses significant personal/public safety risk.	x	x		x			x	x	x	TBD	
• Physical Assault of Staff/Citizen by a consumer resulting in permanent loss of limb or function or risk thereof.	x	x		x			x	x	x	TBD	
• Unknown Death of a consumer	x	x		x			x	x	x	TBD	
• Accidental Death of a consumer	x	x		x			x	x	x	TBD	
• Medical Death of a consumer, unanticipated, may have resulted from lack of treatment or otherwise not clearly and primarily related to the natural course of the consumer's medical illness.	x	x		x			x	x	x	TBD	
• Elopment from HSH/AMHD contracted inpatient bed.	x	x		x			x	x	x	TBD	
• Non-adherence to HSH discharge plan, whereabouts unknown within 30 days of discharge from HSH/AMHD contracted inpatient.	x	x		x			x	x	x	TBD	
• Revocation of Conditional Release within 30 days of discharge from HSH/AMHD contracted inpatient bed.	x	x		x			x	x	x	TBD	
• Homelessness of a consumer, I.e. living in a temporary shelter; living on streets/beach within 30 days of discharge from HSH/AMHD contracted inpatient bed.	x	x		x			x	x	x	TBD	
• Readmission to HSH/AMHD contracted inpatient facility within 30 days of discharge from HSH/AMHD contracted bed.	x	x		x			x	x	x	TBD	

Note:
Incidents: Provider shall conduct an investigation, track and trend the information. A report of this investigation shall be included in the Provider Quarterly and Annual Reports which are submittted to AMHD.

[Attachment D to AMHD P/P #60.105]
[December 1, 2006]

TBD=To be determined by AMHD Medical Director

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.105**
AMHD Administration	Effective Date: 10/01/00 History: Replaces Incidents/Significant Events and Review of Deaths Rev: 5/02; 7/03; 10/04, 10/05, 12/06
SUBJECT: Consumer Sentinel Events and Incidents	
REFERENCE: Plan for Community Mental Health Services IV, B, 1, a, ii (d); JCAHO; HRS 346-222	Page: 1 of 11
Interdisciplinary Exceptional Case Review Policy and Procedure	APPROVED: Title: Chief, AMHD
Joint Plan of Improvement Policy and Procedure	

PURPOSE

To promote the safety of Adult Mental Health Division (AMHD) registered consumers and to improve the system of care and treatment, uniform processes shall be established and implemented to identify, report, analyze and investigate consumer sentinel events and incidents.

POLICY

AMHD providers shall report all consumer sentinel events and incidents to AMHD as described.

AMHD providers shall develop the internal capacity to identify and analyze consumer sentinel events and incidents including root cause analysis and implement risk-reduction strategies as appropriate.

Provider documentation concerning sentinel events and incidents shall be maintained in administrative files separate and apart from clinical records.

There are two (2) categories of sentinel events that must be reported to AMHD:

Category A

1. Suicide of a consumer.
2. Homicide of a consumer.
3. Homicide by a consumer.

4. Medication Error – any consumer death, paralysis, coma, or a permanent loss of function associated with a provider medication error.

5. Serious Consumer Injury resulting in permanent loss of limb or function or risk thereof.

6. Suspected abuse/sexual/neglect of a consumer.

Category B

1. Attempted suicide of a consumer.

2. Attempted homicide of or by a consumer.

3. Elopement from a crisis shelter, residential treatment facility or group home and that poses significant personal/public safety risk.

4. Physical Assault of Staff/Citizen by a consumer resulting in permanent loss of limb or function or risk thereof.

5. Unknown Death of a consumer.

6. Accidental Death of a consumer.

7. Medical Death of a consumer, unanticipated, may have resulted from lack of treatment or otherwise not clearly and primarily related to the natural course of the consumer's medical illness.

8. Elopement from a Hawaii State Hospital (HSH)/AMHD contracted inpatient bed.

9. Non-adherence to HSH discharge plan, whereabouts unknown within thirty (30) days of discharge from a HSH/AMHD contracted inpatient bed.

10. Revocation of Conditional Release within thirty (30) days of discharge from a HSH/AMHD contracted inpatient bed.

11. Homelessness of a consumer, i.e. living in a temporary shelter; living on streets/beach within thirty (30) days of discharge from a HSH/AMHD contracted inpatient bed.

12. Readmission to HSH/AMHD contracted inpatient facility within thirty (30) days of discharge from a HSH/AMHD contracted inpatient bed.

Incidents

1. Incarceration of a consumer within ninety (90) days of discharge from a HSH/AMHD contracted inpatient bed.

2. Readmission to HSH/AMHD contracted inpatient within thirty-one to ninety (31-90) days of discharge from a HSH/AMHD contracted inpatient bed.

3. Serious Adverse Drug Reaction of a consumer.

4. Medical Death of a consumer, anticipated, related to natural course of the consumer's medical illness.

5. Non-adherence to HSH discharge plan, whereabouts unknown, within thirty-one to ninety (31-90) days of discharge from a HSH/AMHD contracted inpatient bed.

6. Homelessness of a consumer, i.e. living in a temporary shelter; living on streets/beach within thirty-one to ninety (31-90) days of discharge from a HSH/AMHD contracted inpatient bed.

DEFINITIONS

AMHD Contracted Inpatient beds refers to hospitals contracted by AMHD for behavioral health services.

An AMHD Provider is any organization in a contractual relationship with AMHD or an entity that provides services for AMHD. The following are AMHD providers:

- HSH/AMHD contracted inpatient beds
- Community Mental Health Centers (CMHC)
- Purchase of service (POS) providers
- Sole source contract providers

Around the clock setting refers to settings where there is staffing around the clock. These settings would include hospitals, nursing facilities, licensed crisis residential facilities, E-ARCH, specialized residential facilities, interim housing, and 24-hour group homes.

Being treated refers to a consumer receiving services from an AMHD funded provider at the time of a sentinel event or incident.

Immediate jeopardy is defined as a situation with potential to place a consumer in immediate risk to life/health if not resolved within 24-72 hours.

An **incident** is defined as those occurrences with a high likelihood of producing real or potential harm to the health and well-being of the person or persons served, but are not at the same critical level as sentinel events.

Permanent loss of function means sensory, motor, physiologic, or intellectual impairment not present previously that requires continued treatment or life-style change. When permanent loss of function cannot be immediately determined, it is determined when either the consumer is discharged from an around the clock care setting or two (2) weeks have elapsed with persistent loss of function, whichever occurs first.

Risk thereof includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

A **root cause analysis** focuses primarily on systems and processes, not individual performance. The analysis progresses from special causes in clinical processes to common causes in organizational processes. The analysis repeatedly digs deeper by asking "Why?" repeatedly. The analysis identifies changes that could be made in systems and processes either through redesign or development of new systems or processes that would reduce the risk of such events occurring in the future. The analysis is thorough and credible. The analysis shall be internally consistent, provide an explanation for all findings of "not applicable" or "no problem" and refer to relevant best practices. The analysis does not blame the consumer and is recovery focused.

A **sentinel event** is any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

Serious physical injury includes permanent loss of sight, loss of limb, or loss of function or the risk thereof.

Serious psychological injury is evidenced by symptoms that require ongoing therapeutic intervention as a result of the event.

Sexual assault is defined as unconsented sexual contact involving a consumer and another consumer, staff member, or unknown perpetrator while being treated or on the premises of the health care organization, including oral, vaginal or anal penetration or fondling of the consumer's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine reporting:

- Any staff or another individual witnessed sexual contact as described above.
- Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact.
- Admission by the perpetrator that sexual contact, as described above, occurred while being treated or on the premises of the health care organization.

Suspected abuse/neglect is defined by AMHD per chapter Hawaii Revised Statutes (HRS) 346-222 is physical injury, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment or maltreatment which is suspected to have occurred or is imminent. Neglect is subsumed under the abuse definition. In addition to the definition under chapter HRS 346-222, consented sexual contact between a consumer and staff is reported under this category.

Unanticipated death includes death by suicide, homicide of or by a consumer, death as a result of an accident, death as a result of a suspected drug-overdose, and untimely death for medical reasons.

GENERAL PROCEDURES

Provider Responsibilities:

1. All AMHD funded providers whose annual contract or estimated reimbursements will be more than $100,000 or whose staff number six (6) or more shall have an internal quality management/risk management committee. The committee shall include the medical/clinical director (if one is contractually required), a program representative, and the quality management coordinator.

2. The provider shall report all sentinel events and incidents to their internal quality management/risk management committee and to AMHD. Providers are not limited to AMHD sentinel event and incident types to initiate their internal quality management program process. The AMHD Sentinel Event and Incident process is a minimum requirement. Providers are encouraged to include additional sentinel event and incident

types within their own quality management program to support attainment of their quality improvement goals.

3. Sentinel event reports will be required from all case managers and Assertive Community Treatment (ACT) team members for their clients. In addition, a staffed around the clock setting will be required to send in sentinel events involving their residents. If a sentinel event occurs at a health care facility or during treatment, that provider shall also be required to send in a sentinel event report.

4. The provider's quality management/risk management committee will meet as necessary to review and act on sentinel event and incident reports. (See specific procedures below.) Members of the committee are expected to have read all relevant sections of the clinical record. The committee's actions and deliberations shall be maintained in written form at the facility by the provider.

5. The provider shall maintain a record of all consumer sentinel events and incidents, noting consumer's name, date of occurrence, types of sentinel event and incident investigations, analysis of causative factors, risk reduction plan or action plan, and monitoring as appropriate. They will also maintain copies of the Report Forms as required below.

6. Providers shall submit quarterly Sentinel Event and Incident reports to AMHD Performance Improvement as indicated in the AMHD Provider Quality Management Program Report Directive. The reports will allow AMHD Performance Improvement to monitor provider implementation of risk reduction plans or action plans.

AMHD Responsibilities:

1. The AMHD Medical Director, or designee shall review the notifications of a sentinel event, the "*Consumer Sentinel Event Report Form*", the "*Provider/Consumer Ten Day Sentinel Event Conference Report*", and the "*Steps for Root Cause Analysis In Response to a Sentinel Event Form*" for all deaths, immediate jeopardy events, and any other sentinel event as deemed necessary.

2. AMHD Performance Improvement staff shall review all provider submissions and shall determine whether AMHD agrees with the findings and the plan for risk reduction if required. A risk reduction plan or action plan will be considered acceptable if:

    - Identifies changes that can be implemented to reduce risk, or formulates a rationale for not undertaking such changes; and

- Where improvement actions are planned, identifies who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated.

- AMHD's determination shall be communicated to the provider and may include a request for a response, additional data, and/or a plan of corrective action, as deemed necessary.

3. AMHD Performance Improvement staff will prepare a Summary Report as indicated. Summary reports are for internal use only.

4. The AMHD Quality Review Committee will ensure all areas of the organization with responsibility for quality of care and oversight are involved in the review of critical cases.

5. The AMHD Statewide Medical Executive Committee (SMEC) will conduct peer review and exceptional case review of selected critical cases. Other areas of AMHD will be asked to review selected cases as needed, such as consumers on Conditional Release, and those with Mental Illness and Co-occurring Substance Abuse or Developmentally Disabilities.

6. Aggregate quarterly and annual reports on sentinel events shall be submitted by AMHD Performance Improvement to the AMHD Quality Improvement Committee and AMHD Quality Council for review and determination of additional actions to be taken to improve the system of care.

7. AMHD Performance Improvement will review Provider Sentinel Events and Incidents processes and selected cases during the annual Provider monitoring activity. AMHD Performance Improvement may, additionally, review provider implementation through on-site visits, requests for progress reports, or other means as indicated.

IMMEDIATE JEOPARDY PROCEDURES

1. AMHD Performance Improvement shall review all notifications of sentinel events to determine if a situation exists with potential to place a consumer in immediate risk to life/health if not resolved within 24-72 hours.

2. Potential immediate jeopardy cases shall be referred to the AMHD Medical Director, AMHD Quality Improvement Administrator, and AMHD Chief of Clinical Operations. The appropriate AMHD Service Area Administrator will be notified based on the

consumer's current placement. The AMHD Service Area Administrator shall conduct an Immediate Jeopardy Assessment, and assemble an intervention team if immediate jeopardy is determined.

3. The AMHD Chief of Clinical Operations assigns the case to the appropriate AMHD Service Director who then calls the agency or CMHC to assess support needs, selects an Emergency Response Team, develops an Emergency Response Plan which includes:

   a) Short term needs,
   b) Long-term needs,
   c) Support to key community agencies, and
   d) Access to AMHD support services.

4. The AMHD Service Director will report their findings to the AMHD Chief of Clinical Operations who then informs the AMHD Service Area Administrator, AMHD Performance Improvement, and the AMHD Executive Team of progress and outcome. A brief written report is provided to AMHD Performance Improvement and the AMHD Executive Team.

5. The AMHD Quality Review Committee shall review all Immediate Jeopardy cases to identify opportunities for improvement of the process and outcome. These findings shall be included in the quarterly Sentinel Events reports to the AMHD Quality Improvement Committee and the AMHD Quality Council.

SENTINEL EVENT CATEGORY-SPECIFIC PROCEDURES

Category A Sentinel Events

1. During State working hours, the provider shall verbally report the event immediately to AMHD Performance Improvement at (808) 733-4489. After hours, the provider shall verbally report the event immediately to the AMHD Access Line at 832-3100 or toll free 1-800-753-6879. The AMHD Medical Director will be immediately notified by AMHD Performance Improvement or ACCESS based on where the call was taken. The provider shall fax the "*Consumer Sentinel Event Report Form*" to AMHD Performance Improvement at (808) 733-9277 within the same day of the event.

2. AMHD Performance Improvement shall send an event notification by e-mail to all Executive Team members immediately upon receipt during State working hours.

3. The provider shall conduct and document a debriefing for the involved staff, within two (2) working days of the sentinel event. The purpose of this is to provide support to staff and should be kept clearly separate from the other procedures under this section. Documentation shall be maintained at the provider site.

4. The provider's senior administrator shall seal and sequester the clinical record immediately, prohibiting additional entries or modifications to the clinical record. The clinical record shall be made available to designed staff only for the purpose of sentinel event analysis. Late entries shall be made in a separate file and noted as such.

5. The provider shall conduct a Sentinel Event Conference and submit the first part (numbers 1-3) of the *"Providers/Consumer Ten Day Sentinel Event Conference Report Form"* to AMHD Performance Improvement within ten (10) working days of the event.

6. A root cause analysis shall be completed within thirty (30) calendar days of the event. Leadership of the organization, individuals most closely involved in the processes and systems under review and line staff that provided direct service to the consumer shall participate in the Sentinel Event Conference.

   a) The provider shall notify AMHD of the date and time of the Sentinel Event Conference, as far in advance as is possible. A representative from AMHD shall attend the provider's sentinel event conference.

   b) A Joint Plan of Improvement shall be developed by AMHD and the provider in order to ensure provider specific and systematic improvements are made to reduce the risk of other occurrences.

   c) The *"Steps for Root Cause Analysis in Response to a Sentinel Event Form"* shall be submitted to AMHD Performance Improvement within thirty (30) calendar days of the event.

7. AMHD Performance Improvement shall prepare a Summary Report, which shall be reviewed and approved by the AMHD Medical Director and the AMHD Quality Review Committee.

8. The provider and AMHD shall monitor the implementation of the Joint Plan of Improvement and make revisions as indicated.

Category B Sentinel Events

1. The provider shall fax the "*Consumer Sentinel Event Report Form*" to AMHD Performance Improvement at (808) 733-9277 within the same day of the event.

2. AMHD Performance Improvement shall send an event notification by e-mail immediately upon receipt to all AMHD Executive Team members during State working hours.

3. The case manager or ACT team will convene an interagency recovery plan meeting to review and update the recovery plan as necessary. At the same time the case manager or ACT team shall conduct a Sentinel Event Conference and submit the "*Provider/Consumer Ten Day Sentinel Event Report Form*" to AMHD Performance Improvement within ten (10) working days of the event. Line staff that provided direct service to the consumer shall participate in the Sentinel Event Conference. An interagency risk reduction plan or action plan shall be submitted by the case manager or ACT team to AMHD Performance Improvement.

4. AMHD Performance Improvement shall prepare a Summary Report if determined by the AMHD Medical Director. The AMHD Medical Director will refer appropriate cases to the AMHD Quality Review Committee.

5. The provider and AMHD shall monitor the implementation of the interagency risk reduction plan or action plan and make revisions as indicated.

Incidents:

1. The provider shall conduct an investigation through their quality improvement process.

2. The investigation shall, at a minimum, review the appropriateness of services provided, availability and access to services, and community provider involvement. The involvement of community providers in the investigation is encouraged.

3. The provider shall track and trend the information. If there are three (3) or more similar sentinel events in a quarter, the provider shall notify AMHD Performance Improvement.

4. A report of this investigation shall be included in the Provider Quarterly and Annual Reports, which are submitted to AMHD Performance Improvement.

5. AMHD Performance Improvement may request specific information on incidents if trends or individual concerns are identified.

ATTACHMENTS

A: Consumer Sentinel Event Report Form
B: Sentinel Event Conference Form
C: Steps for Root Cause Analysis in Response to Sentinel Form
D: Sentinel Event Activities Grid

Date of Review: __/__/__ ; __/__/__ ; __/__/__ ; __/__/__

Initials: [_____] [_____] [_____] [_____]

ADULT MENTAL HEALTH DIVISION
Consumer Sentinel Event Report
Immediate Notification

PURPOSE:

To promote the safety of Adult Mental Health Division (AMHD) registered consumers and improve the system of care and treatment, uniform processes shall be established and implemented to identify, report, analyze and investigate consumer sentinel events.

Complete the blanks as thoroughly as possible. Use an X mark in the boxes ☒ as appropriate.

1. Consumer's Name: (Last)_____ (First)_____

2. Sex: Male ☐ Female ☐ 3. Date of Birth: ____/____/____ (mm dd yyyy)

4. AMHD Reference Number: _____

5. Date of Sentinel Event: _____/_____/_____ (mm dd yyyy)

6. Sentinel Event Brief Description_____
_____
_____
_____

Event Codes: *Choose only one event code. If more than one code applies contact Performance Improvement at 808.733.4489*

Category A

a. ☐ Suicide of a consumer.

b. ☐ Homicide of a consumer.

c. ☐ Homicide by a consumer.

d. ☐ Medication Error – any consumer death, paralysis, coma, or a permanent loss of function associated with a provider medication error.

e. ☐ Serious consumer injury resulting in permanent loss of limb or function or risk thereof.

f. ☐ Suspected abuse/sexual/neglect of a consumer.

Category B

g. ☐ Attempted suicide of a consumer.

h. ☐ Attempted homicide of or by a consumer.

i. ☐ Elopement from a crisis shelter, residential treatment facility or group home and that poses significant personal/public safety risk.

j. ☐ Physical Assault of Staff/Citizen by a consumer resulting in permanent loss of limb or function or risk thereof.

k. ☐ Unknown Death of a consumer.

l. ☐ Accidental Death of a consumer.

m. ☐ Medical Death of a consumer, unanticipated, may have resulted from lack of treatment or otherwise not clearly and primarily related to the natural course of the consumer's medical illness.

n. ☐ Elopement from a HSH/AMHD contracted inpatient bed.

o. ☐ Non-adherence to HSH discharge plan, whereabouts unknown within 30 days of discharge from aHSH/AMHD contracted inpatient bed.

p. ☐ Revocation of Conditional Release within 30 days of discharge from a HSH/AMHD contracted inpatient bed.

q. ☐ Homelessness of a consumer, i.e. living in a temporary shelter; living on streets/beach within 30 days of discharge from a HSH/AMHD contracted inpatient bed.

r. ☐ Readmission to HSH/AMHD contracted inpatient facility within 30 days of discharge from a HSH/AMHD contracted inpatient bed.

7. Place of Sentinel Event: a. ☐ Hospital c. ☐ Consumer's residence
b. ☐ Treatment Program d. ☐ Other_____

8. Legal Status:

a. ☐ 704 - 404	d. ☐ 704 - 411(1) (b)	i. ☐ Probation
b. ☐ 704 - 405	e. ☐ 704 - 413	j. ☐ Voluntary
c. ☐ 704 – 406	f. ☐ 704 - 415	m. ☐ MH4-MH6-MH9
d. ☐ 704 – 406 (1) (a)	g. ☐ 706-607	n. ☐ Other (specify)
e. ☐ 704 – 411 (1) (a)	h. ☐ Parole	_____

9. Date of discharge from HSH or AMHD contracted inpatient bed (if within 30 days of discharge) mm/dd/yyyy _____/_____/_____

10. Axis I Primary psychiatric diagnosis (use DSM IV codes) _____

_____

11. Co-occurring disorder: a. ☐ ETOH
b. ☐ drugs
c. ☐ ETOH and drugs
d. ☐ none
e. ☐ unknown

12. Axis II (Use DSM IV codes) _____

_____

13. Mental Retardation: a. ☐ mild (including borderline intellectual functioning)
b. ☐ mild to moderate
c. ☐ moderate
d. ☐ not applicable

14. Number of medications taken daily (Add total psychiatric and non-psychiatric including over-the counter and herbal/vitamins):
a. ☐ 0
b. ☐ 1 - 2
c. ☐ 3 – 5
d. ☐ 6 - 8
e. ☐ 8 or more
f. ☐ unknown

15. Current Medications (List names and doses)_____

_____

_____

16. Level of Case Management:

a. ☐ Care Coordination
b. ☐ Crisis Support Management
c. ☐ Crisis Mobile Outreach
d. ☐ Targeted Case Management
e. ☐ Intensive Case Management
f. ☐ Assertive Community Treatment
g. ☐ Community Care Services (CCS)
h. ☐ Developmental Disabled Branch
i. ☐ Inpatient Hospital Services
j. ☐ Homeless Outreach
k. ☐ None

17. Case management agency _____

18. Case management ratio (# of consumers per this consumer's case manager) _____

19. Date of last face-to-face contact prior to event: _____/_____/_____
mm dd yyyy

20. Psychiatrist:
a. ☐ POS
b. ☐ CMHC
c. ☐ HSH
d. ☐ Private psychiatrist
e. ☐ VAMHC

21. Area Services Received:

a. ☐ Oahu
b. ☐ Maui
c. ☐ East Hawaii
d. ☐ West Hawaii
e. ☐ Kauai
f. ☐ Molokai
g. ☐ Lanai

22. Housing:

a. ☐ Independent (living on their own of with family/boarding home/others
b. ☐ 8-16 hour group home
c. ☐ 24 hour group home
d. ☐ Supported Housing/Bridge Subsidy
e. ☐ Interim Housing
f. ☐ Licensed Specialized Residential
g. ☐ Licensed Crisis Residential Services
h. ☐ Homeless
i. ☐ Homeless shelter
j. ☐ Care home
k. ☐ Nursing home
l. ☐ Hospital
m. ☐ Hospice
n. ☐ HUD rental subsidy (Section 8, Shelter Plus Care)

23. Name of Housing Provider if applicable:_____

24. Date of last discharge following hospitalization for psychiatric services: prior to event: ____/____/____
mm dd yyyy

25 Name of facility of last psychiatric hospitalization prior to event _____

Skip to # 31 if not Medical/Unknown Death - *Complete # 26 thru 30 only for Medical Deaths and Unknown Deaths*

26. Axis III:

a. ☐ cancer
b. ☐ diabetes
c. ☐ respiratory
d. ☐ cardiac
e. ☐ obesity
f. ☐ stroke
g. ☐ malnutrition
h. ☐ brain injury
i. ☐ other (specify)_____

27. Date of last non-psychiatric hospitalization prior to event: ____/____/____
mm dd yyyy

28. Facility Name of last non-psychiatric hospitalization: _____

29. Primary Care Physician (Last Name, First Name): _____

30. Date last seen by treating medical physician: ____/____/____
mm dd yyyy

* * * * * * * * * * * * * * * *

Please complete the following information about your agency:

31. Agency completing the form: _____

32. Program name: _____

33. Reported by (Name, Title): _____

34. Phone number: _____

35. Date form completed: _____/_____/_____
mm dd yyyy

	Signature	Date
Reported by	_____	___/___/___
AMHD Quality Improvement Administrator	_____	___/___/___
AMHD Performance Improvement Coordinator	_____	___/___/___
AMHD Medical Director	_____	___/___/___

ADULT MENTAL HEALTH DIVISION
Provider/Consumer Ten Day Sentinel Event Conference Report
(Required for all Sentinel Events)

Consumer's Name: (Last)_____ (First)_____

Sentinel Event Date: _____ / _____ / _____
mm dd yyyy

Section I

In accordance with the AMHD Sentinel Event policy, the Sentinel Event Conference and Sentinel Event Conference Report are required from you within ten (10) working days of the event. Please briefly describe the event, the date of the conference, and the future plans. (If the Sentinel Event is a Category A, a Root Cause Analysis and a Joint Plan of Improvement Conference should also be completed within 30 days.)

_____

_____

_____

_____

_____

Remembering an important goal of sentinel event reporting and analysis is system improvement, please complete this form. Keep in mind any gaps that might have contributed to the event within 1) your provider system, 2) other provider systems that served the consumer, 3) the Legal system, and/or the greater AMHD system.

Address the following questions for the ten day report.

Items may have more than one response from the lists provided. Mark an X in the boxes ☒ *that apply.*

1. What is the consumer's outcome?

   a. ☐ voluntarily returned from elopement
   b. ☐ involuntarily returned from elopement
   c. ☐ whereabouts unknown
   d. ☐ maintained tenure in program
   e. ☐ encounter with law enforcement (not incarcerated)
   f. ☐ discharged from program
   g. ☐ admitted to HSH/AMHD contracted inpatient facility

h. ☐ admitted to community psychiatric inpatient facility
i. ☐ admitted to medical inpatient facility
j. ☐ moved to new community placement
k. ☐ homeless
l. ☐ incarcerated
m. ☐ expired

2. What may have contributed to the sentinel event?

a. ☐ inadequacy of consumer assessment
b. ☐ inadequacy of care planning
c. ☐ lack of communication among staff
d. ☐ lack of communication between providers
e. ☐ lack of communication between staff and AMHD
f. ☐ lack of supervision of staff
g. ☐ inadequacy of staffing
h. ☐ lack of staff competencies
i. ☐ lack of availability of service
j. ☐ lack of accessibility of services
k. ☐ lack of continuity of care
l. ☐ lack of crisis planning,
m. ☐ lack of coordination of care,
n. ☐ inadequate discharge planning
o. ☐ lack of coordination between behavioral health and medical care
p. ☐ lack of family or significant other support
q. ☐ inadequacy of CM contact
r. ☐ inadequacy of police response
s. ☐ lack of appropriateness of discharge from ER/hospital
t. ☐ inadequacy of Probation/Parole Officer contact
u. ☐ lack of appropriateness of placement
v. ☐ inadequacy of ACCESS
w. ☐ lack of collaboration with court
x. ☐ inadequacy of transition
y. ☐ inappropriateness of level of care
z. ☐ lack of quality of services
aa. ☐ undetected worsening condition
bb. ☐ other (specify)

3. What actions were taken in response to the sentinel event?

a. ☐ consulted program manager
b. ☐ consulted psychiatrist
c. ☐ consulted RN
d. ☐ consulted CM
e. ☐ consulted UM
f. ☐ consulted AMHD Medical Director
g. ☐ consulted Medical Director of program
h. ☐ consulted Probation/Parole Officer
i. ☐ consulted Forensic Coordinator
j. ☐ consulted MISA Coordinator
k. ☐ notified APS
l. ☐ contacted legal guardian
m. ☐ arranged peer support
n. ☐ police called
o. ☐ MH1 police transport to ER
p. ☐ ambulance called
q. ☐ staff transported to ER
r. ☐ alternate housing provided
s. ☐ called ACCESS
t. ☐ used crisis services
u. ☐ notified OHCA
v. ☐ increased level of care
u. ☐ other (specify)

Section II – Category B Only

If category A, omit the table and skip to Section III page 5.

For Sentinel Events in Category B, use the table below to answer question 4 and 5. If an action does not apply, leave it blank.

From your causal analysis and risk reduction plan, which organization may have responsibility for each risk reduction action you identified? Check the boxes that apply for organization listed in A-C below.

From your causal analysis where the risk reduction plan is targeted for your organization, enter the target dates (D), persons responsible (E) and position of responsible person (F).

Table: Causal analysis/Risk reduction plan

Action	A. AMHD System	B. Legal System	C. Provider Services	D. Target Date	E. Person responsible	F. Title of responsible person
a. establish staff competency standards						
b. implement evidence-based best practices						
c. train staff						
d. educate family						
e. increase frequency of CM						
f. increase medication monitoring						
g. facilitate access to psychiatrist						
h. use one-to-one services						
i. increase level of care						
j. access CBI funds						
k. collaborate with MISA Coordinator						
l. collaborate with Forensic Coordinator						
m. collaborate with Probation/ Parole Officer						
n. collaborate with other agencies						

Action	A. AMHD System	B. Legal System	C. Provider Services	D. Target Date	E. Person responsible	F. Title of responsible person
o. communicate with court system						
p. revise ISP						
q. increase participation in treatment team						
r. increase clinical staff supervision						
s. change agency policy and procedures						
t. request AMHD technical assistance						
u. other (specify)						

Section III
(Complete for Category A and B sentinel events)

If you have additional comments regarding this sentinel event, please add them:

_____

_____

_____

_____

_____

Who completed this form: _____

Who attended the conference: (include title): _____

_____

_____

Program name: _____

Reported by (Name, Title): _____

Phone number: _____

Date form completed: (mm/dd/yyyy) _____

	Signature	Date
Program Manager	_____	___/___/___
Provider Medical Director	_____	___/___/___
Provider Quality Management Coordinator	_____	___/___/___
AMHD Quality Improvement Administrator	_____	___/___/___
AMHD Performance Improvement Coordinator	_____	___/___/___
AMHD Medical Director	_____	___/___/___

Steps for Root Cause Analysis
In Response to a Sentinel Event

Describe your root cause analysis for all Category A Consumer Sentinel Events. Fill in the blanks for the questions asked using the form below.

The three columns on the right are provided to be checked:

- "Root cause?" should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system. Be sure that it is addressed in the analysis with a "Why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- "Ask 'Why?" should be checked off whenever it is reasonable to ask why the particular finding occurred. Each item checked in this column should be addressed in the analysis with five "Why?" questions. It is expected that any significant findings that are not identified as root causes have "roots".
- "Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed in the action plan. It will be helpful to write the number of the associated Action Item on page 5 in the "Take Action?" column for each of the findings that requires an action.

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
What happened?	Sentinel Event	What are the details of the event? (Brief description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				

Steps for Root Cause Analysis
In Response to a Sentinel Event

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
		When did you learn of the event?				
Why did it happen?	The process or activity in which the event occurred.	What are the steps in the process, as designed? (A flow diagram may be helpful here)				
What were the most proximate factors?		What steps were involved in (contributed to) the event?				
(Typically "special cause" variation) Systems of human factors. Such as inadequate staffing, lack of training or communication breakdown.	Human factors	What human factors were relevant to the outcome?				
Family, housing, work	Social factors	How did the consumer's social situation affect the outcome?				
Coordination of services, level of care, or ISP	Controllable Treatment factors	What factors directly affected the outcome?				

Steps for Root Cause Analysis
In Response to a Sentinel Event

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
Legal , courts, police	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influenced this outcome?				
		What other areas or services are impacted				
Why did that happen? What systems and processes underlie those proximate factors?	Human Resources issues	To what degree is staff properly qualified and currently competent for their responsibilities?				
(Common cause variation here may lead to special cause variation in dependent processes) May want to stratify processes.		How did actual staffing compare with ideal levels?				
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				

Steps for Root Cause Analysis
In Response to a Sentinel Event

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
		To what degree is staff performance in the process(es) addressed?				
		How can orientation and in-service training be improved?				
	Communication and Information management issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				

Steps for Root Cause Analysis
In Response to a Sentinel Event

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
		What emergency and failure-mode responses have been planned and tested?				
	- Encouragement of communication	What are the barriers to communication of potential risk factors?				
	- Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?				
	Uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

Root Cause	Risk Reduction Actions: include process steps and the responsible person by title only	Target date
If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.	**Action Item #1:**	
Consider whether pilot testing of a planned improvement should be conducted.	**Action Item #2:**	
Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	**Action Item #3:**	
Cite any books or journal articles that were considered in developing this analysis and action plan.	**Action Item #4:**	

Steps for Root Cause Analysis
In Response to a Sentinel Event

Level of Analysis	Questions	Findings	Root Cause?	Ask "Why?"	Take Action
	Action Item #5:				

Table: Causal analysis/Risk reduction plan

Complete this form with your Root Cause Analysis

From your root cause analysis and risk reduction plan, what organization may have responsibility for a risk reduction action identified in the table below? Check the boxes that apply for organizations listed in A-C below.

From your causal analysis where the risk reduction plan is targeted for your organization and is not detailed in your risk reduction plan, enter the target dates (D), persons responsible (E) and position of responsible person (F).

If an item does not apply, leave it blank. Send this form to AMHD with the root cause analysis.

Risk Reduction Action	A. AMHD System	B. Legal System	C. Provider Services	D. Target Date	E. Person responsible	F. Title of responsible person
a. establish staff competency standards						
b. implement evidence-based best practices						
c. train staff						
d. educate family						
e. increase frequency of CM						

Steps for Root Cause Analysis
In Response to a Sentinel Event

Risk Reduction Action	A. AMHD System	B. Legal System	C. Provider Services	D. Target Date	E. Person responsible	F. Title of responsible person
f. increase medication monitoring						
g. facilitate access to psychiatrist						
h. use one-to-one services						
i. increase level of care						
j. access CBI funds						
k. collaborate with MISA Coordinator						
l. collaborate with Forensic Coordinator						
m. collaborate with Probation/Parole Officer						
n. collaborate with other agencies						
o. communicate with court system						
p. revise ISP						
q. increase participation in treatment team						

Steps for Root Cause Analysis
In Response to a Sentinel Event

Risk Reduction Action	A. AMHD System	B. Legal System	C. Provider Services	D. Target Date	E. Person responsible	F. Title of responsible person
r. increase clinical staff supervision						
s. change agency policy and procedures						
t. request AMHD technical assistance						
a. other (specify)						

Include any additional information here._____

Steps for Root Cause Analysis
In Response to a Sentinel Event

	Signature	Date
Program Manager	_____	___/___/___
Senior Program Administrator	_____	___/___/___
Provider Quality Management Coordinator	_____	___/___/___
AMHD Quality Management Coordinator	_____	___/___/___
AMDH Clinical Medical Director	_____	___/___/___

From: Marya Grambs [Marya@mentalhealth-hi.org]
Sent: Sunday, March 01, 2009 2:05 PM
To: HTHTestimony
Subject: Testimony for Sen. Health and Human Services Info Briefing 3/2 at 2:45

Categories: Green Category, Blue Category

To: Senator David Y. Ige, Chair, Committee on Health
Senator Josh Green, M.D., Vice Chair, Committee on Health
Senator Suzanne Chun Oakland, Chair, Committee on Human Services
Senator Les Ihara, Jr., Vice Chair, Committee on Human Services
Committee Members
From: Marya Grambs, Executive Director, Mental Health America of Hawaii
Date: March 1, 2009
Subject: Informational briefing on the reduction in services to people with serious and persistent mental illness by the Department of Health
Date/time: 2:45, Monday March 2, room 16

As we all know, the State is suffering from a severe economic crisis that has necessitated harsh cutbacks in all departments. This briefing focuses on the Department of Health cuts to services to people with serious and persistent mental illness. We know the Department of Health is faced with making decisions that no one, including them, like, and that there are few good options available. But we also think that it is important for legislators to know, as much as possible, the human costs to the cuts, in case funding from other sources can be found to mitigate some of the most egregious and possibly tragic consequences of these actions.

The people who are most affected by the cuts are often not in a position to speak for themselves, nor are their providers, who are funded by the Department of Health and generally refuse to speak out or testify because they don't want to anger (and potentially suffer additional cuts in retribution from) the department that funds them. That is very unfortunate, because it means that you, the legislature, are less likely to hear from those most intimately involved in serving these clients under the new circumstances.

MHA is not a direct provider of services, but rather a statewide organization that advocates for the safety, care and treatment of each and every person with serious mental illness who needs the services that have been specified as the responsibility of the DOH under past Justice Department oversight.

Following are some of our concerns, which we have heard from people in the community, including clients and providers:

1. DOH has announced **reduced case management hours from 3 hours per day to no more than 3.5 hours per month**, and agencies have laid off more than half their staff, with resulting case loads growing exponentially, at the very least **doubling**. It is doubtful that case managers can adequately respond to clients in crisis when they have such high caseloads and vastly reduced units of service.
2. This is of special concern given that ACT – which provided 24-hour wrap around services for the most acutely ill patients and was designed to keep them out of the hospital – was terminated last fall. **How can these more acute patients possibly be well taken care of in 3.5 hours a month?**

3. To summarize, **our greatest concern is with those clients who are the most seriously ill and need the greatest amount of support to remain safe, to themselves and others,** in the community.
4. DOH has said that if case managers need extra hours for a client they can request an extension. But we are told that **there is a great deal of confusion among providers about the circumstances under which this extension can be requested;** some providers understand that an extension can only be requested if the client is of danger to self or others. Additionally, timeliness of the response to the request appears to be a factor, as sometimes the extra time needs to be utilized immediately or it won't be useful. Providers, we are told, have had many experiences in the past with the Department of Health in which requests like these are not responded to in a timely manner, and/or are denied.
5. Apparently, a **change in the number of "sentinel events" – homicide or serious injury by or upon client, or suicide – is the Department's major current measure of the impact of these cuts.** But we don't know how anyone besides DOH management learns about sentinel events. This doesn't appear to be public information; in fact, we have been told that providers are not even informed about sentinel events that occur among the general client population. **Can the legislature at least be regularly informed about these events?** We also hope that other indicators would be tracked, and that this information would be made public as well, such as number or rate of client hospitalizations, E.R. visits, homelessness, incarceration, or significant deterioration of mental health conditions.
6. As so many case managers have been laid off at so many agencies, we are concerned that this may have resulted in problems with **access to rep payees.** These are persons who handle clients' money, and if clients can't get to their rep payee, they are not able to get their own money to pay for necessities.
7. With regard to **clients in the state mental health system who have private insurance:**

    a. Clients with private insurance have already been told they **can no longer reside in State subsidized group housing,** and are being given 90 days to find a new residence. Private insurance companies apparently have few if any arrangements for subsidizing housing for those in need because of their psychiatric disability. With the housing market as it is, this appears to be a recipe for homelessness.
    b. Clients with private insurance have been informed that they will **no longer be served by state funded case managers;** again, private insurers offer very little in the form of case management.
    c. It has been announced that DOH is **considering dropping consumers with private insurance from participation in Clubhouse**, which is a daily, all day every week day, program for those with serious and persistent mental illness, offering paid employment, training, socialization, and support. This may not affect many individuals, but for those it does affect, this is terribly traumatic, because Clubhouse is a daily lifeline for many, and is the only thing keeping many out of the hospital, or enabling them to not be totally housebound or roaming the streets.
    d. We would suggest that someone **work with the private insurance companies to negotiate increased case management services, subsidization for Clubhouse participation, and subsidized housing**, as this should be determined to be included in their responsibility to care for those with serious and persistent mental illness; or else they should pay the state to continue their care. After all, we do have parity for mental illness in this state. Is this something the legislature could direct?
    e. It is also odd that for all these years, in which the Department had to request $10M in emergency funds each year, they were serving these clients with private insurance, and no one ever thought (or figured out a way) to bill the private insurance companies.
8. We understand that in some areas there is a considerable wait time to be seen at a Community Mental Health Center, as long as 8 weeks in one case. **That is a dangerous situation for someone who**

is psychotic, which almost all clients who are eligible for service by the state mental health system, are. How is this being addressed?

9. It would seem inevitable that at least one outcome of these reduced services will be an increase in clients who need to be hospitalized at Hawaii State Hospital. We know that the Hospital has been greatly overcrowded for many years. We are told that **currently the Hospital only admits forensic patients** -- those who have been arrested and are referred from the criminal justice system. With this policy in place, how is the Hospital going to accommodate an influx of new patients? **Will the only way someone can be hospitalized continue to be by being arrested?** And I wonder if the Hospital is facing cutbacks as well?

Testimony to the Hawaii State Senate Committee on Health – Informational Briefing

Chuck Freedman, Board Member Mental Health America of Hawaii

March 2, 2009-Hawaii State Capitol Room 016

Senate Health Committee Chair Ige and Committee Members;

Thank you for this opportunity to testify regarding mental health budget cuts. I have a central issue of focus and am speaking as a Board Member of Mental Health America of Hawaii and a person whose family has a member who is a client of mental health services as provided through a state-funded private provider.

My observations have to do with a point made public by the Department of Health at the time budget cuts to mental health providers were instituted several months ago. At the time the cuts were announced, the state administration explained that it was reducing what I will call "billable" clients hours for service providers to no more than 3.5 hours per month per client. The state justified this reduction, as I understand statements reported in the newspaper, because the state had evaluated service given to mental health clients and could find no improved outcomes in those clients served more frequently than 3.5 hours per month with those served that amount of time per month or less.

Rather than directly challenge the data, I will speak from experience in suggesting that this rationale is weak and could have serious, negative impacts on those striving for mental wellness. Simply put, for those clients with highly serious challenges like bipolarism or schizoaffective disorders, the premise that an improved outcome is the only positive measure is incorrect. Although improvement is possible and certainly desirable, there are points in time when people suffering from these illnesses and their support groups are striving to stabilize the condition. Non-degradation --- ensuring the condition does not worsen or that another episode does not occur --- is a path to progress. Professionals agree that every episode increases the likelihood that there will be another episode. It is a vortex, and frequently requires the right mix of love, professionalism and timeliness to modulate and manage.

I respect the job the state has in front of it to control spending. But creating a specious premise that conveniently allows for new formulas for mental health services, the result of which will be real harm to people struggling to stabilize their mental health and create a management plan to mental wellness is the wrong way to rationalize budget cuts.

It may well be that for a number of clients suffering from more manageable forms of depression, who may also be served by a range of community-based programs, may need 3.5 case management hours per month and show improved outcomes. But there needs to be a flexible case management mechanism for people with more severe disorders who at given points in time need increased attention by professionals.

In the interest of brevity, I will end here. I recognize there are many interests to balance. Indeed if the state does not have the case management resources to adequately help people with more severe mental disorders, it might be better to openly declare the shortcoming, so our society is aware of it and perhaps can mobilize in other ways, rather than to camouflage the problem, as appears to have been the state's first policy choice. The preferred policy challenge, I believe, would be for the state to declare what financial resources it has and ask for an expedited yet comprehensive proposal from the mental health community. I believe this Committee is trying to do just that and I am grateful for the opportunity to testify.

Chuck Freedman (388-1927)

To: Senator David Y. Ige, Chair, Committee on Health
Senator Josh Green, M.D., Vice Chair, Committee on Health
Senator Suzanne Chun Oakland, Chair, Committee on Human Services
Senator Les Ihara, Jr., Vice Chair, Committee on Human Services
Committee Members

From: Joanne Lundstrom, ACSW, MPH Phone Contact 734-0660
Date: March 2, 2009 email: yojo@hawaii.rr.com

Subject: Informational briefing on the reduction in services to people with serious and persistent mental illness by the Department of Health

Why is the world would the Department of Health be punishing the victims—i.e. people with serious mental illness who can get better with community recovery services—in their quest to make their budget balance? How shortsighted an approach—much like throwing out the baby with the bathwater.

I have been a part of the mental health system of services since 1962—working at Hawaii State Hospital during the era of deinstitutionalization, moving on to the state community mental health centers, and stepping into the non-profit mental health sector 30 years ago to offer community based recovery services to people with mental illness. What I know from working with people with mental illness is that the most critical piece in the recovery process is the person-to-person piece—having someone who is there for you, who can reach out when you are slipping back, who can make those connections to normal living when you are too frightened or overwhelmed to go it alone, who can be the bridge to your doctor and family, and who can most importantly be your touchstone to a sustained recovery. That's what the best of case managers do. And if they aren't doing it—you get rid of the case manager—you do not dismantle the whole system.

Hawaii was finally getting it right after years of shameful inattention to people with mental illness—remember being ranked 50th in the nation for several years running, and remember having the Federal injunction hanging over the head of the Mental Health Division for more then 10 years? Millions of dollars were spent in quest of compliance, accreditation standards were being required of public and private providers of services, billing systems were set up to bring in Federal reimbursements for services, and people with mental illness were recovering.

Now, with a click of the heels, the system is being dismantled. Yes, there has likely been waste--yes, there have likely been wastrels among the overseers and providers of services--yes, we are in the midst of an economic crisis—and no, pulling the supports out from under the people receiving them is not right. There are alternative case management systems that work, there are knowledgeable people who can design and implement more consumer friendly, cost effective systems, and there is the will, I hope, on the part of the mental health community, the Legislative body and the Executive Branch to do what is pono for people with mental illness.

Mahalo for asking for input from the community of caring people. *Joanne Lundstrom*

February 27, 2008

Dear Senator Ige and Senate Health Committee members:

Thank you for your interest in the state of mental health in Maui County. Mental health services in Maui are currently in a crisis. More than fifty mental health workers have lost their jobs since last summer. As a result, the mental health of their seriously and persistently mentally ill clients is at risk because people who were stabilized now have to find or transfer to new mental health workers.

In addition, many in the aged, blind, and disabled population under Medicaid, are in the process of finding new providers.

Nevertheless, Maui's dedicated mental health workers continue to work closely together doing their best to help our County's mentally ill.

We ask that you find a way to discontinue the budget cuts affecting mental health services and to please find creative new ways to fund mental health so that this population may remain as stable as possible.

1. Our Community Mental Health Center workers are working hard and doing a good job of taking care of their clients. Appointments for initial mental health evaluations to determine eligibility, however, are still taking 4-6 weeks. Please help to find a way around a State hiring freeze for mental health workers!
2. Community case management services were shown by the National Mental Health Association for many years to be the most effective way to maintain independent living for people with serious mental illnesses. They are also a deterrent to hospitalization (homelessness, jail, etc.). The move away from community based case management will cost our State an enormous amount of money in the long term for HHSC and the Hawaii State Hospital, police, Courts, jails, prisons, Department of Human Services (protective services and especially QUEST/Medicaid, which pays hospital costs for the indigent).
3. There is a Federal match for state Medicaid waiver services. By cutting these services, we are losing more than one Federal for each State dollar for each of these services. Finding a way to reinstate these services, will help to stimulate our State economy. Please look carefully at the new economic stimulus package to see how Hawaii citizens and our state economy can benefit from Federal dollars that can be used by the Department of Health and Department of Human Services.

While our current Maui County mental health workers will do all that they can to provide quality care, please do not move to erode current services further. And please do everything that you can to reinstate a quality system of basic mental health care.
Mahalo,

Colleen O'Shea Wallace, MPH, Maui Branch Director
Mental Health America in Maui County

SENATE INFORMATIONAL BRIEFING TESTIMONY of Sarah M. Eum, HCPS

Impact of Budget Cuts on Mental Health Consumers

DATE: Monday March 2, 2009 TIME: 2:45 PM PLACE: Conference Room 16

COMMITTEE ON HEALTH
Senator David Y. Ige, CHAIR
Senator Josh Green, M.D., VICE CHAIR

COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, CHAIR
Senator Les Ihara, Jr., VICE CHAIR

TESTIMONY FROM: Sarah M. Eum, HCPS
Hawaii Certified Peer Specialist
Mental Health Consumer & Advocate
Veteran, U.S. Army
808-220-5996

I would like to inform you of the impact recent cuts in mental health services are having on consumers and on their continuity of care and well-being. In addition to this, I would like to report my observations on how these cuts in service are being implemented with regard to the particular population that's being directly affected – those of us suffering from serious mental health issues.

In the past 6 months major changes in service have occurred:

a. Discontinuation of major POS (Provider of Service) in Waianai.
b. Elimination of ACT Teams (Assertive Community Treatment)
c. QExA Transition (Quest Expanded Access) for Medicaid Managed Care
d. Case Management maximum hours capped at 14 units (3 ½ hrs) per month per consumer.
e. Consumers with private insurance (i.e. HMSA) being transitioned out of AMHD's services.
f. Dismissal of key consumer advocate within the Office of Consumer Affairs.

These are only the actions that I can best remember. To summarize the impact of these actions:

a. The suddenness of announcements of these major changes in service, coupled with the very short transition time given to consumers and providers (in some cases only 30 days) created excessive distress, confusion, and frustration to consumers.
b. The turmoil created by all the reduction in services and lack of information for both consumers and providers for carrying out the department's decisions is exacerbated when consumers have no one to turn to for help or assurance, because no one really knows how or what they should do or expect.
c. The secondary ramifications of these cuts were not considered thoroughly before their implementation. For example, the transitioning of HMSA clients out of the system also causes these clients to lose their housing, creating a situation of imminent homelessness for these consumers.
d. The severe reduction in case management hours has caused many providers of service to dismiss a greater number of their case managers, thereby causing higher case loads to the remaining case managers on staff. The dropping off of consumers at ER departments is often coupled with a case manager stating that he's capped out his units.

e. Many consumers are experiencing difficulty getting in touch with their case managers, and having phone calls responded to. They are feeling left out in the cold.

We understand that the budgetary situation is critical. We are willing to make some sacrifices and adjustments in our delivery of care. However, it seems that we are not being included in any of the planning processes, decision making, or in receiving adequate information to prepare ourselves and each other for these changes. It seems that the department is not interested in dealing with the impact their decisions are having on their consumers, or doing much to help with our transitioning. We are reduced to receiving notice from a letter in the mail without any forewarning or preparation or adequate resource to turn to. We are told to call the Office of Consumer Affairs if we have any questions, but this is little help.

Following the surprise announcement back in June 2008 of the Waianai coast affair, we implored AMHD to involve us and to adequately allow for adjusting to the news of any impending disruption in our usual routine of care. We expressed the deleterious effect such abrupt changes had on us and our fellow consumers. Routine is vital to most of us for keeping our wellness. Yet the following November 2008, on Thanksgiving Day, the announcement that the case management hours were to be capped was dropped in our laps. Most stakeholders found out this news through the newspaper headlines.

While there is much discussion on what services AMHD is cutting and what effects they may have on outcomes in the future, I am most concerned with how AMHD is making these cuts. One of AMHD's core values is that of collaboration. It states: "We value teamwork and endeavor to build partnerships, consumer and community participation to attain our goals." And two of their guiding principles are: a) "Empathic and hope instilling relationships are an essential component of all services" and b) "Consumers are an integral component of the service systems design throughout AMHD".

I would like to feel that consumers have an authentic two-way communication process within AMHD, and are not unrepresented to go unheard and dismissed. Please let us all try to have more openness, and work together to ease and lessen the changes and adjustments that we all must endure during these budgetary slashes. Consumers can help AMHD help consumers through these distressful times if only we are kept informed and abreast of possible upcoming plans that may be implemented. Then we can prepare correct information and procedures to pass on to our peers to assist them through whatever changes need be made.

We consumers, Hawaii Certified Peer Specialists, Peer Mentors, Peer Coaches and all the rest of consumer advocates can be a true "Coconut Wireless" for helping disseminate the correct information to all, and to help quell the anxiety of uncertainty. I am simply asking to be kept informed in a timely manner so that we can help everyone through this.

Sincerely,

Sarah M. Eum, HCPS
808-220-5996

From: Peter Gonzalez [petergonzalez1956@yahoo.com]
Sent: Monday, March 02, 2009 8:16 AM
To: HTHTestimony
Subject: Fw: Written Testimony on Health and Human Services regarding consumers cut backs:

Categories: Green Category, Blue Category

--- On **Sun, 3/1/09, Peter Gonzalez** <*petergonzalez1956@yahoo.com*> wrote:
From: Peter Gonzalez <petergonzalez1956@yahoo.com>
Subject: Written Testimony on Health and Human Services regarding consumers cut backs:
To: "David Ige" <sendige@capitol.hawaii.gov>
Date: Sunday, March 1, 2009, 12:15 AM

The Senate
The Twenty-Fifth Legislator
Regular Season Of 2009

COMMITTEE ON HEALTH
Senator David Y. Ige, chair
Senator Josh Green,M.D,vice chair

COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair
Senator Les O'Hara , Jr.,Vice Chair

Peter D, Gonzalez
42, Ing Place
P.O.Box 896,Kaunakakai Molokai Hawaii,96748

Aloha,Chair person Senator David Ige,Vice Chair Senator Josh Green, on the Health Committee, also my aloha to Chair person Suzanne Chun Oakland and Vice Chair Les Ihara Jr. on the Human Service Committee.

I am writing in regards to my concerns about how the budget cuts are affecting the rural Island of Molokai. Let me explain a little history about my background, so that you have an idea how I am connected with the mental health system as far as Molokai

I have experience psychological and severe episodes of bipolar which caused me to have extreme anxiety and manic behavior, since I was 16 years old while attending high school at Pearl City High. At that time in the year of 1974 through the present of 2009 I have experienced the mental health system first hand. You could say I learned to be where I'm at today by hands on experience, and not from going to school and getting a bachelors degree, neither a Masters or even a P.H.D. in health, or human services.

What I'm trying to get at is that I got married to a Molokai girl that I met in Honolulu at the age of 20 she was a special young lady, because although she knew of my mental illness she agreed to be my wife

regardless of my illness, and I have been married to her ever since for 30 years now. I have 4 children from her, 2 boys and, 2 girls all grown now, and I also have the 2 most precious granddaughters which makes me want to preserve my life for them, and continue to help my fellow consumers "Live Recovery" like the vision Dr. Hester the former Chief of the (AMHD) left us with to endure and to restore.

When I first was confirmed to the State Council on Mental Health in 07,by Governor Linda Lingle and, probably by you Senator David Y. Ige. I asked Dr Hester at one of my first board meetings as a council member, if he would be interested in coming to Molokai for the first Chief Round Table Meeting, which he graciously attended,and ever since he came to Molokai I was able to accomplish a variety of projects. I was able to organize a collaboration of administrators, people in the government and also local citizens in the community to establish a new renovated Club house.

When I was going through my training to be a certified peer specialist , I found out about the Uluakupu grant who subsides and allocated a grant called the Uluakupu grant through the Transformation grant team who manages and distribute the monies, that was awarded approximately $11,000,000,000 when everything was finally adjusted through the office of Governor Linda Lingle in 07 from the organization known as (SAMSHA) the substance abuse and mental health services.

Anyway after the two weeks of the peer specialist training I later found out that I passed the exam and was certified as an Hawaii Certified Peer Specialist, and because of that accomplishment, and after 2 hard excruciating trials to pass the examination, the first one on the big Isle and the second one which I succeeded in passing the written and oral exam in Honolulu. Well after passing the exams I was determined to write a grant for the infrastructure for the clubhouse, because of the lack of funds, being that we spent all the money we had on the physical part of the project which was the clubhouse facility, We needed to find funds for the infrastructure and programs to facilitate and operate the clubhouse.

It was my first try at writing a grant. My social worker Glenn Izawa who was my social worker for over 20 years and, who recently retired this pass December, challenged me to write the grant on my own so I did, However because of Glenn's unique experience in writing grants, and since I proved to him my intuition to do it on my own.He help me out in the areas that I wasn't familiar with and he taught me how to write the grant practically by hands on experience, and we both went over it thoroughly,and finalized it to a tee. I owe a lot to my social worker Glenn Izawa he was a major element to my miraculous recovery and a major factor in helping me learn how to write this particular grant.

To make a long story short I applied for the max which was $25, 000, but I was awarded $19,000 for the infrastructure instead of the original $25,000 by the transformation team, because of the reduction in the amount that could be distributed to all who was awarded,and to me it was a blessing, because I really didn't expect to get awarded anything. For me, being it was the first try at writing a grant it was a long shot. Anyway out of 53 applicants only 17 recipients was awarded the grant and to my surprise I was 1 out of the 17. I attended the award ceremony on Jan 22 2009 at Kinau Hale Heath Center and was awarded my grant in the name of Hale Ka Lima Clubhouse, translated to the meaning of "Hands working Together".

The reason why I wrote my testimony in this fashion is because, although we have a lot of issues concerning mental health on Molokai in the most severe way, and because of our geographic location,and as you may not know,because of our rural life style that surrounds our environment and our diverse culture, and also the people of Molokai who sacrifice everyday the commodities that you people take for granted in Honolulu in your everyday life. We as survivors instead,learn to improvise to meet the needs of our community, whether it be mental health or just being able to help the guy or gal next door,and regardless of the circumstances we manage to survive. Why because, in time of need no matter who you are or what you need the "pono" between us as a community, and our personal belief of humanities, human service and also taking care of our well being and our health, we arei always taken care of , because we as the people of Molokai work and

unite together in a special and compassionate way to bond, and make sure that everyone is accounted for, simply because we care and work together to make amendments to agree to disagree in our own democratic way.

I really think that no matter what you do to try and help us, you cannot help us because of your political bureaucracy that you Senators as politicians play to ploy day by day and also, night by night. My purpose to write this to you senators who supposedly always seem to listen and have all the answers, but don't do anything, but, debate among each other for the means of your own personal gain, in my own personal opinion and, besides I'm not a politician, to me it's just local politics as usual. That leaves me to stand a loner, a consumer without any political background or fancy degree, but besides the odds was able to at least come up with a solution in a comprehensible way rather than how you people always pretend to do so.By at least sustaining the entity for my constituents or consumers as we are called, to provide them with a sense of hope so that they could have something for them that you as people in the capitol can't agree on to help not only the consumers of Molokai, but also consumers statewide. Thanks, but no thanks for your time. This testimony of mine is my own personal opinion and not of anyone else of special interest either on the State Council, Administration or in the community of Molokai. However I wish all of you a fond Aloha from all of us here on Molokai take care in the meantime and God Bless!!!

Mahalo,

Peter D, Gonzalez HCPS

From: Lawrence Scadden [lscadden@hawaii.rr.com]
Sent: Sunday, March 01, 2009 9:47 AM
To: HTHTestimony
Cc: Sen. Josh Green
Subject: Funding of mental health services

Categories: Green Category, Blue Category

Testimony for the Hawaii State Senate Committee on Health regarding
funding for mental health services

March 1, 2009

Senators:

I am writing to express concern regarding proposed reduction of funding for public mental health services. As you know, a significant proportion of the homeless population suffers from serious mental illnesses that can impede their ability to access and benefit from available community resources. Public mental health services are extremely important for these individuals and families to overcome the obstacles they face in obtaining and maintaining housing. Service providers who work with the homeless people are dependent on the availability of mental health services for their clients particularly for case management services. We on the Big Island who are deeply involved in addressing the issues that lead to chronic homelessness are concerned that reductions in mental health services will render ineffective the existing case management services that homeless people with mental illnesses need, in turn resulting in an increase in homelessness, dangerous behaviors, hospitalization, incarceration, and death.

Of particular concern is the recent decision to limit case management services to 3.5 hours per consumer per month. With the distances that case managers must travel on the Big Island, a single routine home visit for one consumer could require more time than is being allowed for a single month.

We do understand and accept that during the current fiscal climate that cuts to state services are inevitable. However, we also believe that budget cuts can be an opportunity to move a system of services toward its strategic priorities by making greater cuts to lower priority services, and, sometimes, even adding resources to higher priority services. I believe that mental health services should be a high priority to assist us address the growing homeless issue in our state and on our island. I urge you to reject serious reductions in mental health service funding.

Lawrence A. Scadden, Ph.D.
76-177 Kamehamalu Street
Kailua-Kona, HI 96740
Tel: 808.329.7133
E-mail: LScadden@hawaii.rr.com

To:	Senator David Y. Ige, Chair, Committee on Health Senator Josh Green, M.D., Vice Chair, Committee on Health Senator Suzanne Chun Oakland, Chair, Committee on Human Services Senator Les Ihara, Jr., Vice Chair, Committee on Human Services Committee Members
From:	Joyce Ingram-Chinn, Ph.D. contact: 808-551-3853
Date:	March 2, 2009
Subject:	Informational briefing on the reduction in services to people with serious and persistent mental illness by the Department of Health

Thank you for the opportunity to submit testimony regarding mental health care in the State of Hawaii. Although I am presently retired, my thirty years of work in Hawaii's alcohol, other drug, and mental health fields – as a public as well as private sector employee - has provided me with an in-depth understanding of the challenges facing the State in providing quality care to those with mental illness.

Case management is at the core of effective and efficient care for individuals with mental illness. **My recommendation to the State Legislature is that AMHD be required and expected to explore other methods of case management, including the Department of Human Services (DHS) funded Community Care Services care management system, and move to adopt a more consumer-friendly cost effective model.**

The statements made by the Adult Mental Health Division (AMHD) regarding the lack of differences in outcomes for those receiving extensive case management from those receiving limited case management is puzzling. AMHD's limiting case management hours to 3.5 hours per month per consumer seems to show a lack of knowledge of the research literature and a lack of understanding of what consitutes effective care for individuals with mental illness.

There is an extensive body of literature reporting the well researched impact case management has on the wellness of individuals suffering from mental illness. In fact, a longitudinal study conducted while I was Director of Community Care Services (CCS), the DHS funded Medicaid managed care program for QUEST adults with serious mental illness, showed that the 92 individuals in the study who received as much case management as they needed from 1995 through 2000, had a 50% decrease in hospitalizations, crisis services, and crisis response episodes. The estimated cost for mental health services for these individuals went from $355,000 in 1995 to $201,000 in 2000, a savings of 43%. What is most important, however, was that these individuals were healthier, more productive citizens as a result of the managed care they received. These individuals received as much case management as they needed, when they needed it.

There are major differences in the management of care received by CCS members from the management of care received by consumers through the AMHD. CCS has a team of professionals and paraprossionals who work with each member to determine the care and levels of care needed. Members who need and want intensive care, get it; members who need and want periodic support, get it. As I understand the AMHD method, decisions regarding the type and level of care to be received by a consumer is made by administrative, non-treatment team AMHD staff. . In addition, AMHD has now limited the amount of case management a consumer may receive to 3.5 hours per month.

Consequently, the consumer is not involved in the decisions made regarding his/her care nor is the consumer's coordinated care on the consumer's need for more or less services.

Hawaii's adults with serious mental illnesses deserve to be treated with respect and dignity. They deserve to be involved in their own treatment decisions and they deserve to have as much care coordination as they need to remain in the community. Hawaii has a nationally recognized proven model of care coordination for QUEST members with serious mental illnesses. Why shouldn't all of Hawaii's individuals who need this type of care be receiving it?

Thank you for this opportunity to suggest an alternative to the way in which AMHD provides case management to adults with serious mental illnesses.

To: Senator David Y. Ige Chair
Senator Josh Green Vice Chair
And Members of the Senate Committee on Health

From: Darrin Sato
Chief Operations Officer
Kalihi-Palama Health Center

Information Briefing: HTH-HMS 03-02-09 at 2:45 p.m.

Thank you, Chair Ige and Vice Chair Green and Members of Senate Committee on Health, my name is Darrin Sato Chief Operations Officer at Kalihi-Palama Health Center. (KPHC) Kalihi-Palama Health Center has a homeless outreach and case management program funded through AMHD. We have a good collaborative working relationship with Department of Health and AMHD. We understand the difficult decisions needed to be made with the budget deficit. The impacts to the cuts which KPHC has experienced is in the engagement process of the homeless clients.

- It takes much time and effort to build the required trust and rapport in order to provide treatment, housing and other basic needs for this vulnerable population.
- All of the homeless outreach programs on Oahu were cut except for KPHC's. This has reduced the outreach workers to 2 who cover the entire island.
- At our primary care sites, we have experienced an increase in calls from outside referrals for behavioral health services from persons in need of treatment, community resources and private doctor's offices. There has been an increase in walk-ins of persons seeking treatment.
- We have experienced calls from patients who are frustrated and wanting to change their case manager and psychiatrist due to the difficulties they are experiencing in contacting their case manager and or psychiatrist who will not see them without their case manager.
- Our staff have tried calling other agencies however, have had difficulty in contacting the case manager or the case manager no longer is employed.

As a primary care facility, KPHC is not equipped to deal with the ongoing needs of those with Severe and Persistent Mental Illness. Our homeless programs can provide services for that particular population. However, our primary care facility at 915 has one waiting room for Pediatrics, Adults and Pregnant women. We require the patient's case manager to accompany them at their visits and we are having difficulty contacting them.

Thank you for your time in hearing my testimony.

Eh, got one house?
P.O. BOX 2819
Kailua-Kona, HI 96740

Chiyome Fukino, MD
Director of Health
State of Hawaii
1250 Punchbowl Street, 3rd Floor
Honolulu, HI 96813

January 2, 2009

Re: Big Island Mental Health Service Reductions

Aloha Dr. Fukino,

I am writing on behalf of the Big Island Community Alliance Partners (CAP) to express our concerns about the reductions in public mental health services, and to ask that you do everything possible to both ameliorate and redirect the decisions to reduce services that are currently being implemented. We have questions as to whether the degree and distribution of cuts to mental health services is necessary and fair. As important, we believe that they are being made in a manner that will cause unnecessary harm to those with the highest level of need, and, in addition, will waste the precious resources that remain.

The CAP is a broad based consortium of homeless services providers and community members that work to implement the state plan to end homeless in the County of Hawaii. This includes delivering and assuring the availability of programs that homeless individuals and families need to overcome the obstacles they face in obtaining and maintaining housing. As you know, a significant proportion of the homeless population suffers from serious mental illnesses that can impede their ability to access and utilize the community resources that are available for them. Therefore, a large number of the homeless people that CAP providers work with are dependent on mental health treatment, and particularly, case management services, in order to succeed in community settings.

We are concerned that the mental health service reductions on the Big Island will render ineffective the case management services that homeless people with mental illnesses need, and this, in turn, will result in an increase in homelessness, dangerous behaviors, hospitalization, incarceration, and death. Our members are already reporting an increase in symptoms and the crises among homeless individuals.

First of all, we would like to be assured that people with mental illnesses are being treated fairly in Hawaii. We understand that there is a budget crisis that is affecting everyone, however, we would like to know whether the Department of Health (DOH) is being cut disproportionately to other state funded services, and that within the DOH that mental health services are not being reduced to a greater degree than other health services. If the cuts to mental health services are greater than for other health services we would like to know why and what you are doing to correct this situation.

Secondly, within the DOH adult mental health system, we would like to understand why services to the most seriously mentally ill are being most severely impacted. Earlier this year DOH decided to eliminate all of the Assertive Community Treatment (ACT) teams in the state. This approach to treatment has repeatedly been demonstrated to be most effective for the highest need individuals with serious mental illnesses including those who are homeless or at-risk of homelessness. We were assured by your department that Community Based Case Management services (CBCM) would continue to be available to address these needs. Now we are learning that the CBCM services are both being dramatically reduced and those that remain will be restricted in a manner that will render them ineffective.

Of particular concern is the decision to limit case management services to 3.5 hours per consumer per month. With the distances that case managers must travel on the Big Island, a single routine home visit for one consumer could require more time than is being allowed. We would like to strongly suggest that if CBCM services must be cut, that the decisions about how the remaining services will be used, in terms of who receives priority for these services and how they are distributed within the caseload, be made locally by the providers who understand the unique situation of the Big Island. In this way we will be able to assure that the CBCM services that remain available are implemented in keeping with the intent and principles of case management programming, so as to minimize the destructiveness of these cuts.

We are also wondering why the programs offered by contract providers that serve those in greatest need are apparently being reduced to a greater degree than state operated programs that, in general, serve a broader population of people with mental illnesses.

We do understand and accept that during the current fiscal climate that cuts to state services are inevitable. However, we also believe that budget cuts can be an opportunity to move a system of services toward its strategic priorities by making greater cuts to lower priority services, and, sometimes, even adding resources to higher priority services. At the very least, the cuts should be made in a way that will maximize the effectiveness of the funds that remain. We do not see how the cuts that are now being implemented achieve either of these goals. We would expect that DOH strive to maintain the evidence based programming that has been established in recent years as a result of Federal supervision of our system of care. This system has raised Hawaii from being one of the lowest ranking mental health systems in the country to one of the best, and, we, on the Big Island, have experienced the positive results of this programming. We are concerned that this services system is being systematically dismantled as a result of the current budget crisis. In our view this will maximize the pain for highly vulnerable people, result in cost increases in other areas and waste the precious treatment resources that remain.

We would appreciate a response to the questions and concerns we are raising. We would also ask that your staff work with Big Island representatives and providers to redirect the cuts you are making to best respond to our particular needs. We thank you now for your time and consideration and await your reply.

Sincerely yours,

David Garcia
Chair, Community Action Partners

cc: State Legislators

From: Lawrence P Ritter [lritter@hawaii.edu]
Sent: Sunday, March 01, 2009 2:41 PM
To: HTHTestimony
Subject: Senate Informational Briefing Testimony on Impact of Budget Cuts to Mental Health Consumers
Attachments: AMHD Office of Consumer Affairs.doc

Categories: Blue Category

Senate Informational Briefing Testimony on the Impact of Budget Cuts on Mental Health Consumers

Date: Monday, March 2, 2009
Time: 2:45 pm
Place: Conference Room 16, Hawaii State Capitol

Committee on Health: Senator David Y. Ige, Chair
Senator Josh Green, MD, Vice Chair

Committee on Human Services: Senator Suzanne Chun-Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

Senators,

I'm submitting this testimony at the request of Sarah Eum, HCPS who had received an invitation to testify. Attached is a letter that I recently wrote to the Adult Mental Health Division, Office of Consumer Affairs with email cc to various pertinent parties. I feel the AMHD is unable or not fully thinking through actions that affect mental health consumers. Even with the exceedingly large budget cut consumers should be asked to participate and be kept informed in a timely manner. It should be noted that as an addendum to my letter that at the Chief's Round Tabe Meeting last Friday it was mentioned that a 90-day notice is given for those with AMHD contracted housing. This is still problematic for me.

Sincerely,

Lawrence P. Ritter
1210 Wilder Ave. #206
Honolulu, HI 96822
(808)-524-1689

Lawrence P. Ritter
1210 Wilder Ave. #206
Honolulu, HI 96822

Bill Lennox, Chief
Office of Consumer Affairs
State of Hawaii
Department of Health
Adult Mental Health Division
P.O. Box 3378
Honolulu, HI 96801-3378

February 26, 2009

Dear Bill,

I am one of the recipients of the letter regarding consumers of Adult Mental Health Division (AMHD) services that happen to have third party commercial insurance. According to the letter dated February 12, 2009 I will no longer be eligible for services provided by AMHD because I carry insurance on my own initiative from Hawaii Medical Service Association (HMSA). I did this when I moved to Hawaii in 1989 to ensure my well being and as a plank in a platform to move toward independence sometime in my future. I have been working hard twenty years here in Hawaii in a recovery process that would enable employment once again and to contribute to the community in a more productive way. Now I will lose my case management and peer coach services, and most importantly, my housing at a time when I am very close to accomplishing my goals.

Per the AMHD letter I am directed to refer to services from HMSA providers. After many phone calls and a visit in person with HMSA staff the information I was given is that case management and peer coach services provided by an outside agency would not be covered. In house HMSA "case management" consists only of support and referral over the phone, known as the Behavioral Care Connection. Only psychiatrists and psychologists are covered by my HMSA 65C+ behavioral health plan. Fortunately I will be able to keep my psychiatrist since she is on the HMSA provider list. Usually other supportive services are only considered for coverage when deemed a "medical necessity", something not likely to happen.

Upon further inquiry after I received the letter of discontinuation of services from AMHD agencies I found that my housing may be jeopardized. This fact was not stated in the letter. I came to my own conclusion that I might lose my housing if I no longer were getting case management services from an AMHD contracted agency. I just happen to have had the experience when searching for case management services in the Spring of 2008 that these services would have to be with an agency contracted by the AMHD since I am in a Steadfast Housing Development Corporation (SHDC) residence. So I signed up with North Shore Mental Health, an AMHD contracted provider, to satisfy SHDC and keep my housing. It should be noted that I was already planning to seek alternative housing after I finished school at the end of this summer (2009). However, I was hoping

to be in independent but supported housing with SHDC during my transition to full independent living and employment.

The AMHD providers involved were not even officially notified until after letters were mailed out to consumers with basic case management services that carried HMSA insurance. HMSA was a starting point since it is the largest commercial insurance company in Hawaii. Consumers with other commercial insurance companies are soon to follow and will probably lose their supportive services. Given less than one month's notice (by the time I received the letter) is stressful enough. This sets up a recipe for possible crises situations, especially had I been in a relapse phase of my disorder. For me stress is increasing even with the assurance of SHDC staff that landlord/tenant guidelines would be followed, for example, I would have at least 45 days notice to move. That I am assuming is from the March 12, 2009 effective date of the AMHD letter for discontinuation of AMHD provider services. I have major stressors currently in my life that include my wife's hospitalization in ICU for over a week with the likelihood of surgery after being stabilized. Even with my wife back at her home I am saddled with care giving responsibilities since my wife is bedridden. This includes financial expenses that bring my relatively good income to a level equivalent to most other mental health consumers, that is, poverty level. AMHD is making assumptions about the financial state of consumers carrying commercial insurance. I am also in the middle of my next to last semester in graduate school. A big change such as loss of housing, or even a change in housing at this point would be an extreme psychological and financial burden, even possibly being the "straw that broke the camel's back".

I have received services from AMHD for twenty years now. Since 1999 I have been in Steadfast Housing Development Corporation (SHDC) residences. For these services I am grateful. However, I am not appreciative of the manner notification of termination of services was handled. I am currently able to speak up for myself. What about mental health consumers who are not able to, or are afraid to speak up? Are they to be tossed out with the bath water? I happened to attend the AMHD Provider's Meeting on Thursday, February 19, 2009 at Helping Hands Hawaii as part of my classroom assignments. A couple of matter-of-fact comments made were, "We just thought we would try this out and see what happens." and in response to query, "Yes some people are going to lose their housing." According to the minutes from the January 15, 2009 Provider's Meeting, Department of Health (DOH) director Dr. Fukino had announced in November of 2008 that "diversion of individuals with commercial insurance" would "represent AMHD's best effort to delay any stop in payment [of funds to providers], along with "the case management 14 unit cap". It was brought to my attention today that this tactic was also reported in the Honolulu Advertiser and the Honolulu Star Bulletin in November, 2008 within the general article on AMHD budget cuts. I was also informed that the proposal was reported in the December, 2008 AMHD Newsletter. By the way, what amounts to a 75% cut in budget for the AMHD is a heavy burden to place on those who are among the most marginalized and vulnerable people in our society.

Why wait so long to officially give consumers some "heads up" and then dash off a letter with only a month's notice? I, for one, was not aware that consumers with commercial insurance plans were being targeted for release from services by AMHD contracted agencies. I realize budget cuts are affecting all government agencies but why does it seem the first place to balance the budget is on the backs of those most

vulnerable? As far as dealing with mental health consumers, is it perceived that we are so apathetic, ignorant, overmedicated, etc. that we are passive enough to be led around like sheep without any say in the matter? Participation, transparency and accountability are paramount.

From the Adult Mental Health Division website, http://amhd.org, Guiding Principle #5 is relevant to me as well as other consumers. Guiding Principle #5 states that, "The major goal of services is a safe and decent place to live, meaningful relationships and activities." Perhaps the Adult Mental Health Division Mission and Vision statements as well as the Core Values and Guiding Principles should be revisited.

Sincerely,

Lawrence P. Ritter
Mental Health Consumer

Cc: various pertinent parties