Senate Committees on Health and Human Services

Department of Health Responses to Written Questions Posed during Mental Health Informational Briefing held March 2, 2009

1. **What is the process and criteria for requesting additional hours for more Case Management? Can there be a process to establish more hours for clients that need higher levels of care, rather than requesting more each month?** As AMHD first informed purchase of service providers (POS providers) in November 2008, they may request exceptions to the case management limit of 14 units per consumer per month (14 unit cap).

   Process and Criteria in Crisis Situations: A crisis is an emergent situation in which the consumer risks imminent harm to self or others. POS providers may, on a case-by-case basis request an exception to the 14 unit cap in crisis situations by faxing to AMHD utilization management staff their written request for exemption on the form provided by AMHD. POS providers must also provide to UM clinical documentation describing in sufficient detail the crisis situation, the case manager's response to it and the number of additional units needed. In case the request is rejected, POS providers are entitled to request reconsideration in writing which offers another opportunity to give AMHD the clinical documentation it needs to analyze the request. POS providers are encouraged to enlist the services of AMHD's ACCESS Line to request crisis services including response by Crisis Mobile Outreach, as appropriate.

   Process and Criteria in Non-Crisis Situations: On January 13, 2009, the acting chief of AMHD wrote to all POS providers of community based case management (CBCM) to explain how they could request additional case management units for clients who were not in crisis, but whose needs warranted such assistance. The January 13th memo clearly described

the process and criteria for non-crisis exceptions to the 14 unit cap, and stated that additional case management units could be requested in **three month increments**, thereby avoiding the need for monthly requests and allowing CBCM teams to plan ahead. AMHD both identified clients who might need extra case management units, and asked CBCM providers to identify additional consumers (up to 1% of each CBCM provider's cases) for whom the provider expected to need extra case management units. The January 13th memo was sent to all CBCM Executive Directors. In addition, the memo was re-distributed and discussed at the Oahu CBCM providers meeting on January 15th, reviewed at the Maui CBCM provider meeting on February 4th, discussed in another Oahu provider meeting on February 19th, and explained in numerous telephone conferences and face-to-face meetings with individual CBCM providers. For all consumers identified, AMHD requested that the CBCM providers fill out a written request for additional case management units supported with copies of key documents from each consumer's chart. Here is the complete list of the documentation needed for AMHD's decision about additional case management units in each case:

1. Completed Consumer Information Update/Request for Additional Units/Service Date Corrections form
2. Most recent evaluation or assessment (within 1 year)
3. Most recent risk assessment (HCR-20) (if applicable and available)
4. Current recovery plan (within 6 months of request) which includes:
    a. Consumer's current goals
    b. Expected measurable outcomes

    c. Specific rehabilitative and/or restorative interventions specifying the name of the expected provider and the duration and frequency of the proposed intervention(s)

5. Current crisis plan which includes:
    a. Triggers and warning signs precipitating a crisis
    b. Specific crisis prevention strategies to be performed by the consumer, CBCM team, and other supports
    c. Specific potential crises for which the consumer is at risk (if known)
    d. Specific interventions to be performed by CBCM team, consumer and other supports during a crisis
6. One month CBCM progress notes (including psychiatrist's notes)
7. Medication record
8. Number of additional CBCM units per month requested
9. Specific interventions that will utilize any approved additional units
10. Narrative description of the need for additional CBCM units including, at minimum:
    a. Negative outcomes the recovery team is most concerned about without additional CBCM support and any historical evidence supporting these concerns
    b. Current housing placement (care home, group home, homeless, shelter, etc) and living arrangements
    c. Current forensic status (voluntary, probation, conditional release)
    d. Unit titration plan including:
        i. The total number of additional units required per month

ii. A scheduled titration of these units over a projected period of time

iii. Specific, measurable objectives identified for each phase of the titration

iv. The specific rehabilitative and/or restorative interventions that will be provided by the CBCM team which will reflect how the additional units will be utilized. The interventions should also identify the proposed CBCM team member who will be providing the intervention and the frequency and duration of these interventions

v. The frequency and method by which the CBCM team will monitor progress towards meeting the titration plan goals.

AMHD's utilization management specialists are available to meet with CBCM providers either on the phone or in person for clinical consultation concerning applications for additional case management units. AMHD reviews and processes complete applications in less than one week.

2. **What is the current delay/waiting time for access to services from the community Mental Health Centers?** AMHD offers ongoing services at 9 Community Mental Health Centers (CMHC). There are two points at which an applicant may expect to wait when accessing mental health services from one of the CMHCs for the first time in a non-emergency situation. The first period begins when the applicant asks for a screening or assessment to determine eligibility for AMHD services, and ends when the eligibility decision is final (eligibility decisions may be appealed). The second period begins when the eligibility decision is final, and ends when an AMHD utilization management specialist

refers the eligible applicant to an AMHD provider for the ongoing service(s) he or she needs. UM makes the referrals within two business days of receipt of the eligibility determination. However, there may be a brief lag before ongoing services are initiated if no AMHD provider in the consumer's geographic area has sufficient staff to accept new referrals at that time due to open staff positions or other operational issues.

Eligibility Assessment for Ongoing Services at a CMHC: For purposes of this response, let's assume that no appeal of the eligibility determination is involved. AMHD's guidelines for eligibility determinations provide that the screening or assessment (the terms are interchangeable) will be conducted within 7 calendar days of the applicant's request. At this time there are 11 clinic sites within the CMHCs that provide eligibility determinations. Nine of those clinics complete eligibility screening within the 7 day guideline. Among those 9 clinics, the current waiting time varies as follows:

- Seven clinics have a 1 – 2 day wait time;
- In Kau, on the Island of Hawaii the wait time is 14 days due to temporary staffing shortage and absence. Normally, this clinic completes eligibility screening within a period of 1 - 4 days.
- The CMHC on Maui has the longest wait time of 15 days. The Maui CMHC is significantly short-staffed at this time. Among the vacant positions are one for a physician and one for a Licensed Clinical Social Worker. As vacant positions are filled, AMHD expects that the wait time will not exceed 7 calendar days. In the meantime, the CMHC System Administration has assigned and Advance Practice Nurse with prescriptive authority to conduct eligibility assessments by video teleconference.

Referral into Ongoing Services at a CMHC: Again, for purposes of this response, let's assume that no appeal of the eligibility determination is involved. When a clinic completes the eligibility determination, it sends the results to AMHD's utilization management service which is responsible for assigning a CMHC or purchase of service (POS) provider for the eligible applicant. A case manager must be assigned for each AMHD consumer who will receive ongoing services from a CMHC or POS provider. The waiting time for acceptance into services is therefore affected by the case management staff to consumer ratio (currently 1:30). At this time, most of the CMHC case management caseloads are full so eligible applicants would be assigned to another provider with open case management capacity. At this time, the island of Maui and West Hawaii are the only two geographic locations in which there are no immediate openings within AMHD case management providers. That will be remedied as early as next week as commercially insured consumers are transitioned to their health plans for continuing services.

3. **What is the current policy regarding access to Hawaii State Hospital (HSH)? Is admission currently limited to only forensic admissions? Is the HSH facing budget cutbacks that will further change the policy?** AMHD anticipates maintaining the same admissions process to HSH as it has for the present; 99 % of admissions are commitments through criminal courts (forensic commitments). All HSH admissions are screened first by AMHD utilization management and the AMHD Medical Director, to ensure that the individual requires inpatient level clinical supports, is appropriately committed (if a forensic commitment) and that there are no other appropriate, less restrictive options for the care and treatment of the individual. Though a challenge, HSH is addressing budget restrictions and

increased expenses (e.g., utilities and food) with no corresponding increase in appropriations, and does not anticipate that these budget challenges will lead to changes in admissions policies.

4. **The process of change for many of the clients of the Adult Mental Health Division, is a challenge and creates high levels of anxiety. Communication has been limited, and many times announcements are made of changes with little time to transition.**

   How is the transition to private insurance being managed? AMHD reviews an insurer eligibility database to verify whether current AMHD consumers have commercial insurance. When the AMHD consumer has commercial insurance, AMHD determines which services the consumer now receives from AMHD. A letter is sent to the consumer's current AMHD providers giving advance notice that the consumer will transition to the consumer's commercial health plan, the final date for which AMHD services will be authorized, the contact information for the commercial plan's customer service to obtain a list of covered benefits and participating providers, and a request that the AMHD provider help the consumer with the transition. The provider letter is sent 3 days prior to a similar letter addressed to the consumer. This gives the provider advance notice to prepare the consumer to receive his or her own letter in the mail and to start the transition planning. If the list of services the consumer receives from AMHD includes housing or representative payee, which are not available through most commercial plans, AMHD gives the consumer three month's notice of the discontinuation of AMHD services. The consumers who receive case management only or medication management only, receive 30 days notice of the transition.

What happens if current service providers are not participating providers with the private insurer? That depends on the health plan and the consumer. The consumer may have to pay a higher portion of the cost or all of the cost to continue services with a non-participating provider (if the non-participating provider wants to keep serving them). Or the consumer may opt to switch to a participating provider.

Will clients with private insurance be allowed to continue to utilize services that are not provided by private insurance (i.e. clubhouse access, housing, and case management services)? At this time AMHD does not plan to continue AMHD services for consumers who transition to their commercial health plans. For Clubhouse services, however, AMHD is reconsidering this plan. No decision has been made yet concerning continued access to Clubhouse services.

Why are consumers being told that they will lose their housing? AMHD housing providers contract with AMHD to serve only AMHD consumers in the housing providers' facilities. Consumers who transition to their commercial health plans will no longer be eligible for AMHD services, including subsidized housing. Thus, the longer transition period for these consumers.

Is there a plan for how each client will be transitioned to private insurance? The information provided in response to the four questions above describes the transition process for each consumer with commercial insurance.

What discussions are taking place between DOH and various private insurance companies to help make the transition smooth and minimize the impact to the clients? For several months, AMHD has been in contact with all commercial health plans to advise the administrators of the plans of the transition, request customer service contact information,

request the plans' participating provider lists, and request that each plan prepare their customer service and care coordination staff members for the transition.. Additionally, as described above, AMHD has identified for each health plan the consumers who will transition from AMHD services to the health plans' services, and requested that each plan assist their subscribers with the transition.

5. In light of the budget reductions, has the department of health developed a new vision of the system of care that works for their clients?

The overarching theme for AMHD's services has been, and remains the principle that everyone is entitled to an active, full life in our community. To the degree AMHD can provide services to help consumers, this vision is adapted consistent with the resources available at this time. AMHD's focus is on persons in need of mental health services who have no other access to those services. Screening, assessment, and referral will continue to be available for many, AMHD will continue to provide crisis services, although ongoing services will be reserved for consumers for whom there are no other resources. AMHD will encourage, empower and support consumers to become more autonomous and less dependent on state services.

6. What is the extent of the budget cuts and what is the impact on AMHD clients?

To be clear, for the new biennium budget, neither the Department of Health nor the Administration has proposed cuts to item HTH 420 from which AMHD pays POS providers. In FY09 AMHD had a Legislative Discretionary Reduction and an Executive Restriction totaling $2,099,733. The needed reduction in AMHD spending announced in November

2008 is due to an anticipated FY09 shortfall of over $25 million. As explained in response to question number 7 below, AMHD reviews the impact of these reductions on AMHD clients on an ongoing basis.

What other services are being targeted? In addition to capping case management units and transitioning consumers back to their health plans, AMHD has responded to the severe decrease in state revenue by eliminated or decreasing funding for its warm line program, transportation, respite services, and hospital and housing contracts. AMHD has also discontinued use of general funds for homeless outreach services. Federal block grant funds will be used for a limited amount of homeless outreach. AMHD has also changed its supported housing program by discontinuing 36 unused state-funded supported housing rental subsidies and 2 vacant supported housing specialist position. AMHD has notified Kahi Mohala that it will reduce the number of contracted inpatient beds in a phased transition that will reduce the current 32 beds to 16 beds by June 30, 2009. AMHD will not renew contracts in FY10 for transportation services on the island of Hawaii. AMHD continues to evaluate all services to determine whether reductions are indicated.

What cuts have been made in administrative costs/overhead that does not directly impact service to clients? $1,620,567 of the $2,099,733 in legislative and executive restrictions represents non-client service cuts. Additionally, travel has been restricted to court related business and monitoring visits. Delays in filing positions and equipment purchases as well as elimination of most training expenses have also been implemented.

7. What criteria and process will AMHD be using to determine the impact of cuts in

services (i.e. rate of hospitalization, incarceration, significant deterioration, increased medical costs, etc.)

Among the many data points AMHD regularly monitors, information gathered on sentinel events, patient satisfaction scores, grievances, and appeals are used, and will continue to be used by AMHD leadership and performance improvement staff to inform decisions about the type and variety of services available to AMHD consumers. AMHD has data on hospitalizations for those committed to the custody of the director of health. At this time, AMHD does not collect data on hospitalization at institutions other than Hawaii State Hospital, incarceration, or increased medical costs. The AMHD administers the Quality of Life Inventory (QOLI) to consumers at intake and at six month intervals thereafter. The QOLI asks consumers questions about the status of their own outcomes, including housing/homelessness, incarceration, hospitalization, employment, education, social relationships, physical health, and mental health. The QOLI scores can be compared before and after implementation of cost saving measures. In addition, AMHD tracks incoming calls to the Access Line to monitor increases in crisis calls.

Is AMHD measuring the effects of the reduction in services on other service providers/churches? At this time, AMHD does not regularly measure the effects of its services on other service providers outside the AMHD system of care or churches.

8. **What are the evidence-based best practices that impact the changes being made?**

The entire array of AMHD services is built on the recovery philosophy that supports the inherent capacity of consumers to recover and move toward greater independence and self-sufficiency. Therefore, every AMHD staff member is tasked with providing services in a

manner that will maximize each AMHD consumer's hope, plans and skills to achieve greater independence and success. To further enhance the delivery of such supports to AMHD consumers, a specialized array of employment, advocacy and psychosocial skills building (e.g, problem solving, medication management, symptom management, social skills/intimacy, anger/stress management, recreation and vocational skills/interests) services has been developed and substantially expanded by AMHD since the year 2000. These services include Peer Mentors, Peer Coaches, Peer Specialists, an evidence-based practice Supported Employment Service, several new Clubhouses, and the infusion of SAMHSA's evidence-based practice (EBP) illness management and self-directed recovery (IMSR) into existing psychosocial rehabilitation (PSR) programming, both in the state-operated CMHCs and in the purchase of service provider's PSR programs statewide. In the past four years AMHD has also launched two specialized forensic programs for consumers involved in the criminal justice system. Both of these forensic programs have been receiving national attention. Prior to the development of these community-based programs, most of those program participants would have been confined in hospital facilities. These programs are based on evidence based practices such as contingency management and cognitive behavioral therapy. These treatments assist consumers in building skills in problem solving, communication and impulse control. Additionally, consumers receive instruction on independent living skills. AMHD has developed a housing tenancy manual to teach consumers basic skills of independent living and tenancy skills in all PSR and residential programs statewide. This manual is also utilized for consumer training purposes at all AMHD funded group homes statewide and is available on the AMHD website at:

http://amhd.org/About/ClinicalOperations/Housing/Making%20it%20Home%20-%20Participant.pdf.

Overall, the Hawaii currently has a very high penetration rate of PSR services for adults with severe and persistent mental illness, with 15% of AMHD consumers currently receiving some form of specialized PSR supports to assist them to learn information and skills for better managing their medications, symptoms, wellness, and social and vocational adjustment. Furthermore, all of AMHD's purchase of service PSR providers are required to offer the illness management and self-directed recovery EBP and are provided ongoing training and technical assistance to assure the quality and effectiveness of this service. In addition, several state-operated agencies have piloted the provision of illness management self-directed recovery services over the past several years and the lessons learned from this SAMHSA-funded EBP pilot project will guide future development of this service and will be documented in an upcoming report to be published by AMHD.

Medication management, an Evidence Based Practice, is offered at every Community Mental Health Center through psychiatrists employed by AMHD, and on each POS provider case management team by psychiatrists under AMHD's case management contract.

Services Using EBP or Best Practices to Promote Consumer Self-Sufficiency

Oahu

CARE Hawaii EBP IMR PSR Program

The Queen's Medical Center EBP IMR PSR Program

CREST Forensic PSR Program

E-ARCH Housing Program

AMHD funded Housing/Residential programs offering Tenancy Training

Honolulu Clubhouse PSR Program

Diamond Head Clubhouse PSR Program.

Kaneohe Clubhouse PSR Program

Waipahu Clubhouse PSR Program

Makaha Clubhouse PSR Program

Kalihi-Palama CMHC EBP IMR PSR Pilot Program

Waianae CMHC EBP IMR PSR Pilot Program (with Cultural Adaptations)

Steadfast EBP Supported Employment Program.

Island of Hawaii

CARE Hawaii EBP IMR PSR Program

East Hawaii CMHC IMR PSR Pilot Program

CREST Forensic PSR Program

E-ARCH Housing Program

AMHD funded Housing/Residential programs offering Tenancy Training

Kona Clubhouse PSR Program

Hilo Clubhouse PSR Program

Steadfast EBP Supported Employment Program.

Maui

Mental Health Kokua EBP IMR PSR Program

CREST Forensic PSR Program

E-ARCH Housing Program

AMHD funded Housing/Residential programs offering Tenancy Training

Maui Clubhouse PSR Program

Steadfast EBP Supported Employment Program.

Kauai

CARE Hawaii EBP IMR PSR Program

CREST Forensic PSR Program

E-ARCH Housing Program

AMHD funded Housing/Residential programs offering Tenancy Training

Kauai Clubhouse PSR Program.

Molokai

Molokai Clubhouse PSR Program

CREST Forensic PSR Program

E-ARCH Housing Program

AMHD funded Housing/Residential programs offering Tenancy Training.

9. Does DOH recognize that the level of mental health consumers assigned to providers is often greater than those who are regularly serviced by the community mental health centers of the state? AMHD knows the reported level of acuity of its clients and assigns case management agencies based on available capacity.

10. It was stated that 1% of community based case management consumers are eligible for ACT? How did you come to this figure, is this really accurate? AMHD has not made this statement in reference to Assertive Community Treatment (ACT). ACT services ended on August 31, 2008. The reference to 1% of consumers who receive community based case management may, instead, be a reference to the limit of CBCM clients for which each

provider of CBCM services may request exceptions from the 14 unit cap on case management services in non-crisis situations. These are the exceptions that may be applied for in 3 month intervals, as explained in response to question no. 1.

11. **Are you looking at co-occurring disorders model that Alan Johnson from Hina Mauka described which incorporates integrated treatment, recovery oriented strengths based treatment, support services after treatment, and case management?** For many years, AMHD promulgated the model of service provision for individuals with co-occurring mental illness and substance abuse disorders which incorporates integrated treatment, recovery orientation, support services after treatment, and case management. AMHD received a federal COSIG grant for this purpose which supported training of AMHD contracted dual diagnosis providers, including Sand Island Treatment Center, Hina Mauka, Aloha House (Maui), and Po'ailani.

12. **Is DOH looking at implementing consumer-directed recovery services?** Consumer input has been a feature of AMHD recovery services for years. AMHD has no plans to discontinue its engagement of consumers in recovery services.

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