



Provider Bulletin

for the Adult Mental Health Division

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If you have any questions about information in this Provider Bulletin, please contact AMHD Provider Relations at (808) 586-4689.

Aloha!

The purpose of this communication tool is to provide Purchase of Service (POS) providers with up-to-date new or revised information, and to assist us when implementing new Adult Mental Health Division (AMHD) business activities and initiatives. We welcome your ongoing feedback and suggestions for improvement as we work to develop this valuable communication tool. Please contact us if there are any topics you would like to see in the Provider Bulletin.

Using AMHD Monitoring Results to Improve Program Operations

An AMHD POS provider recently shared an excellent idea which we wanted to share with other POS providers. In follow-up to an AMHD program monitoring visit, the provider utilized the comments, feedback and suggestions from the AMHD monitoring team to retroactively review their clinical charts for the same monitoring time period. Upon review, the POS provider determined that there were a number of services which should not have been billed to AMHD because they did not meet Medicaid Rehab Option (MRO) standards. Thus, the POS provider submitted to AMHD a list of the pertinent details along with money due back to AMHD. This is a great example of a provider using AMHD monitoring results to improve their program operations and reduce their own and AMHD's fiscal risk in future federal audits.

AMHD Acting Chief Corner (Dr. William Sheehan)

Effective November 23, 2009, AMHD instituted a new Community Based Case Management (CBCM) service authorization limit for hospital discharges only. For consumers discharged from the Hawaii State Hospital (HSH) or Kahi Mohala HSH replacement beds, who are being discharged without a forensic encumbrance, a limit of 34 units of CBCM services will be in place for the first month following discharge before reverting to the present 14 unit limit per month thereafter.

The purpose of this change is to facilitate targeted community reintegration services necessary to assure discharged AMHD consumers have the best possible chance of stabilizing back in their community. A broad range of services at such a critical time is essential, yet this situation does not constitute a crisis for which there is an existing CBCM unit limit exception process.

Please note that this is a very narrow, targeted exception - no other changes are made to the current CBCM service authorization limit:

- The new exception applies only to HSH and Kahi Mohala HSH replacement bed discharges, which tend to be non-acute, longer-term admissions that require more services to reestablish community tenure;
- Services provided can only be those already billable under the CBCM contract scopes of service; and
- Services must be clinically appropriate and clearly necessary in the specific case and tied directly to elements in the individual consumer's Recovery Plan.

At this time of critical shortages, assuring success for consumers following a longer hospitalization is particularly important if we want to avoid a revolving door. AMHD recognizes that this requires extra time and effort so that the consumer is linked to essential services and that services are coordinated and transition difficulties are addressed.

The process for this exception is simple: no specific action on the part of the Case Manager is required as long as the consumer has a current CBCM authorization in effect. Prior to the consumer's discharge, HSH and Kahi Mohala staff will communicate the discharge information to their assigned AMHD Utilization Management (UM) liaisons, who will then issue a revised authorization for 34 units to the CBCM agency that takes effect on the date of discharge and is valid for 30 days.

For consumers new to CBCM or who do not have a current authorization already in effect at hospital discharge, the assigned CBCM agency only has to submit the usual CBCM service authorization request. Upon receipt, AMHD's UM liaison will automatically authorize the additional post-discharge 34 units for the first month after hospital discharge and 14 units for each month thereafter.

This new exception has already been communicated at the AMHD Provider Meetings, and formal notification has been sent to our Purchase of Service Case Management Agencies. For additional information, please contact Ms. Karen Krahn, AMHD Chief of Clinical Operations, at (808) 453-6922.

Suicide Risk Assessment - Part 1 (Dr. Rupert Goetz)

In this time of shrinking resources, our public mental health "safety net" function takes on ever more importance. Being part of a safety net means always being on the lookout for emergencies, and the emergency we most readily think of in mental health is suicide. Therefore, in another two-part series, I would like to review suicide assessment in this newsletter.

Compared with other states, Hawaii ranked 41st in suicide deaths in 2006 (120 deaths). In the same year, suicide was the 11th leading cause of death in the Country, the *second* leading cause of death for the age group between 25 and 34! The Adult Mental Health Division (AMHD) has been tracking attempted and completed suicides through its sentinel event process. Reviewing the reported events between October 2006 and this December, no clear trends emerge.

But numbers don't tell the story. With each case we see at AMHD, we have the opportunity to review records, and when there has been a completed suicide, we meet with provider teams on joint plans of improvement. The personal heartache we see feels much closer to the truth, namely that even one completed suicide is too much. Families have been shattered; dedicated professionals have chosen to move to other occupations.

Mike (not his real name - story significantly simplified) had lost his marriage to his inflexibility and then lost his small business shortly after the divorce. He struggled to deal with depression that had waxed and waned since his teens, and at times self-medicated with alcohol. Now in his 60's, his retirement plan of working in his wood shop on family property seemed to be slipping away, as sale of the land loomed. Unusually, he missed his mental health appointment and attempts to locate him failed. A week later, Mike was found dead by the police in the small shop.

Since the 1999 Surgeon General's Call to Action to Prevent Suicide, numerous models have emerged, many of which show evidence of effectiveness. Without reviewing them in this limited space, allow me to select two. One model (ASIST) distinguishes the individual's role: (1) *member of the public* (awareness making it more possible to discuss suicide); (2) *everyday person* (basic skills training making it more possible to observe someone at risk and point them to helpers); (3) *helpers* (who connect that individual with professionals); and (4) *professionals* (who more formally assess and intervene). This same model then distinguishes tasks: (1) *connecting* (establishing a safe relationship in which one can talk about suicide); (2) *understanding* (getting the at-risk person's point of view); and (3) *assisting* (by either connecting with helpers or helping directly when trained).

We may be in any of these roles when we are called on to step up. Could members of the community have seen that Mike was in a particularly bad spot?

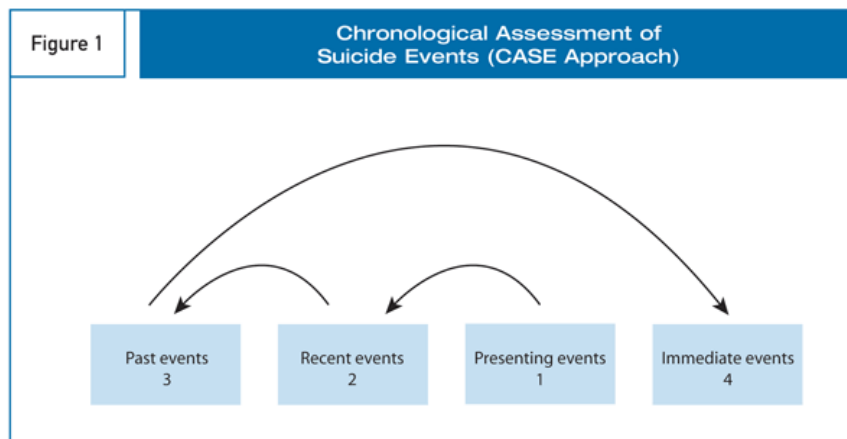
Could members of the case management team have done something different? These are questions for which we will never have an answer. However, we all want to be sure we have done what we can.

Suicide Assessment (Part 1):

One of the things preventing us from asking enough about suicide is the split-second decision to avoid opening “a can of worms.” We “know” our client, time is short and excuses abound. To avoid pre-empting what ASIST can teach, I will draw from an excellent article by Dr. Shea available in the Psychiatric Times. (The full article can be found at: <http://www.psychiatrytimes.com/display/article/10168/1491291>).

Much has been written about the *content to be gathered* in a suicide assessment (the specifics of the suicidal thinking, and the risk and protective factors), as well as the *formulation* that should weigh these factors. Yet it is *how we elicit that information* that makes “uncovering the suicidal intent - a sophisticated art” (as the article puts it). One easy-to-remember method is the CASE Approach (Figure 1), in which the clinician sequentially explores the following 4 chronological regions in this order:

1. Presenting (suicide) events (past 48 hours)
2. Recent (suicide) events (over the preceding 2 months)
3. Past (suicide) events (from 2 months ago back in time)
4. Immediate suicide events (suicidal feelings, ideation, and intent that arise during the interview itself)



The flexibility of this approach is that it can be done quickly, transitioning from one chronology to another as the conversation allows, or in-depth, over a number of sessions. Along the way, a number of techniques can enhance the interview’s validity, opening the door to using the word “suicide”. *Normalization* is one (e.g.: “When I’ve seen people in as much pain as you, I’ve also seen them think about ending it all through suicide.”), *shame attenuation* another (e.g.: “Have you ever felt so bad that suicide started to make sense?”).

Returning to the case of Mike: Would the outcome have been any different if the last visit had included such an approach to go beyond the presenting events (which were related to benefits)? A brief, but systematic CASE scan back may have presented a different picture to the clinician (who had asked about suicidal thoughts). Here is one possible application:

Presenting Events, transition to Recent Events: *“You know, this benefits thing is complicated and will take a bit. In the mean time, I’d like to know more about how things have been going recently. What have you been doing that has been fun and what has been hard?”*

Recent Events, transition to Past Events: *“When you mentioned working in your shop recently, I recall sometime ago you told me that was going to be your retirement plan.”*

Past Events, transition to Immediate Events: “You said you recently heard about the land under your shop possibly getting sold. That means your retirement options may have just changed majorly. How does that affect you now?”

We cannot know if any different outcome would have been achieved. However, if there was even the remotest reluctance to dig deeper, maybe this approach could have made it easier to begin, glean important information or just helping Mike put things in a perspective he could return to at a later session.

Remember that the CASE approach is not a complete suicide assessment! It merely facilitates the other parts: (1) gathering information related to the risk and protective factors and the warning signs for suicide; (2) gathering information related to the patient’s suicidal ideation, planning, behaviors, desire, and intent; and (3) the clinical decision making that is subsequently applied to these 2 databases to create a formulation of risk. Dr. Shea notes in his article: “...errors in suicide assessment often did not stem from poor clinical decision making. More frequently, they seemed to result from a good clinical decision being made from a bad database.”

Summary:

I still recall with a shudder one patient from early in my career as a Family Physician. She had chronic pain and just wasn’t getting better. We were both so frustrated that I was one day almost relieved when she spontaneously disclosed suicidal ideations, resulting in a trip to the hospital and ultimately the mental health treatment she hadn’t been getting from me. What makes me shudder today is that my psychiatric training only later helped me understand how complicit I had been in ignoring her emotional distress. I just didn’t know what to do with this “help-rejecting-complainer”. If you remember my “boiled frog” metaphor a few months ago, you will have seen that I tolerated ever more distress and avoided action, until luckily my patient found a way to communicate its depth.

“Just ask” is too simple a way to summarize the first rule of suicide assessment I am suggesting here; you also have to make it easy to reply fully and openly. That, in my view, is the beauty of the model cited at the top of this article. ASIST training has become internationally recognized for preparing the trainee to *connect with* and *understand* the person they are trying to help before jumping into the task of *assisting*. This connection and understanding makes us more confident in the information we get and makes it easier for the assistance to be accepted. In short, it helps make it easy to do the right thing when a suicide emergency arises, no matter what role we are in.

Remember, as a member of the public or as a basic helper, assistance for any person in severe distress is only a phone call away: 24-hour Access line at 832-3100 on Oahu or toll free at 1-(800)-753-6879.

Help for the provider seeking more knowledge and skills is only slightly more difficult:

- Speak with your supervisor, particularly if you’re facing a situation that worries you!
- For additional reading, try: M. David Rudd’s book: “The Assessment and Management of Suicidality: A Pocket Guide for Practitioners” (See: <http://amhd.org/Provider/Resources/AssessManagement.pdf>)
- For additional training: ASIST Training is being made available through the Department of Health’s Injury Prevention Branch (for registration see: <http://spreadsheets.google.com/viewform?formkey=dDZ0RnRkSmRfOEN6NnBiek5BbWJLbIE6MA..>)

In this first of two articles, I wanted to concentrate on the most difficult part, the opening of a conversation about suicide. In the next part, I will review some of the knowledge and skills involved in suicide assessment, including documentation.

AMHD RFI’s & RFP’s

The AMHD released Request for Proposals (RFP) for the following services:

- HTH 420-5-10, Specialized Residential Services Program, Statewide
- HTH 420-6-10, Crisis Services, Statewide

Current and future procurement notices are posted on the State Procurement Office's Procurement Notice website, which may be accessed from: <http://www4.hawaii.gov/bidapps/>. If you have any questions on current or future RFI's and RFP's, please contact the AMHD Contracts Unit at (808) 586-8287.

Discontinuance of Faxing Advance Procurement Notices & Schedule Delays

Effective immediately, the AMHD Contracts Unit will no longer fax advance procurement notices to current AMHD POS Providers. Due to the increased workload and staff shortage, the AMHD Contracts Unit is not able to continue to provide this courtesy notification.

Section 3-141-407(c), Hawaii Administrative Rules requires that all Request for Proposals (RFP) and Requests for Information (RFI) be posted on the internet, and the State Procurement Office has designated this location to be the State's Procurement Notice website at <http://www4.hawaii.gov/bidapps/>. Each AMHD POS Provider will be responsible to check this website for newly released RFI's and RFP's.

Please note that the Procurement Timetable, which is usually cited on page 1-1 of an RFP, represents the AMHD's best estimated schedule and is **subject to change**. Courtesy addendums **will no longer be issued** if there is a delay in the scheduled date for the release of the Statement of Findings and Decision.

AMHD E-ARCH Program

The Oahu Service Area Administration office, along with many other state offices, is officially closed on days that have been designated as a furlough day. The community mental health centers (CMHC) are also closed on designated furlough days. To assist our providers and increase community awareness of our furlough days, we have e-mailed calendars that clearly identify the furlough days for various state offices. Note: Not all state offices or CMHCs are closed on the same furlough day.

Please review the calendars and let us know if you have questions. We acknowledge that adjusting schedules because of the furlough days can be a disruption for both you and your residents. We appreciate your flexibility and understanding. If you have any positive or not-so-positive experiences regarding the furlough days, please share them us!

Reminders:

- 5th Annual AMHD E-ARCH 3-Day Training for PCGs and Private Pay RN CMs:
Save the dates!! April 28, 29, and 30, 2010. We are currently accepting pre-registration for the next 3-day training. If you have not attended the training in the last two years, we recommend you/your staff consider attending. Please continue to refer your E-ARCH colleagues, especially those who would like to be an AMHD E-ARCH provider. Please call (808) 453-6397 to pre-register.
- Vacation Notification Submitted to AMHD:
Please do not forget to send a copy of your official leave/vacation notice to the OSAA office. At minimum, the notice should include your name/E-ARCH address, leave start and end dates, and names/contact numbers for your substitute staff. We ask that you send your notice to us at least two weeks prior to the start of your leave/vacation so that we may coordinate with your substitute and the AMHD E-ARCH consumer's team prior to your departure.
- Psych Care Plan on File in Care Home:
If your AMHD E-ARCH resident does not have a current psych care plan on file in their care home chart, please request it from the consumer and/or their psych case manager. Care home staff need to be aware of the contents of the psych care plan including, but not limited to, the consumer's crisis plan, needs, and goals. We will be asking PCGs to confirm they have a current psych care plan on file.

Please continue to contact the Oahu Service Area Administration (OSAA) Team anytime you need assistance (808) 453-6397 office; (808) 453-6399 fax.

Learning Opportunities & Opportunities for Growth

SAVE THE DATE! 5th Annual Mental Health Mahalo Awards Luncheon

May 4, 2010, Ala Moana Hotel, 410 Atkinson Dr., Honolulu, 11:30am to 1:30 pm.

The event will celebrate our community leaders and agencies that have dedicated themselves to enhancing the care and treatment of people with mental health problems through positive and innovative programs and leadership, and have reduced the stigma of mental illness. It is important to recognize the long years of commitment so many have given to improving the mental health of our entire community. Please send in your nomination today for the person or organization that has significantly contributed to improving mental health in Hawai'i. Awards that will be made in the following categories:

* Outstanding Community Mental Health Leader: For any individual OR community organization that has strengthened services to the mental health community.

Criteria include providing services for a significant length of time, demonstrating cultural competence, initiating groundbreaking new programs, advocating for mental health in the larger community, promoting the leadership of others, reducing stigma, and demonstrating heartfelt passion.

* Outstanding Government Mental Health Leader: For any government individual OR governmental agency that has developed and implemented groundbreaking programs or services that fulfill an unmet community mental health need with quality, effectiveness, efficiency, and cultural competence, and/or spearheaded changes in public policy that have had a positive impact on those in Hawai'i suffering from mental illnesses.

*Outstanding Business: For a company that provides innovative workplace programs, benefits, and services designed to prevent mental illness and support mental wellness of employees and their families; AND/OR that shows support for persons with mental illnesses.