AMHD
ADULT MENTAL HEALTH DIVISION

Provider Bulletin

for the Adult Mental Health Division

March 2010

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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.

AMHD Chief Corner (Acting Chief, Dr. William Sheehan)

There are two topics for my note this month: First, the state budget situation; and second, the transition of Med-QUEST beneficiaries from AMHD to receive mental health services from their health plans.

First, the state budget. As of the time I'm writing this, on the morning of March 8, 2010, the House of Representatives of the Hawaii Legislature has proposed a budget, in HB 2200, which calls for a 20% decrease in the AMHD budget for purchase of service provider contracts. The amount is about 11 million dollars.

We have not had a chance to analyze the numbers proposed in the House budget, or the potential impact on AMHD services. And, as this is only a bill, it has not been passed, and it is expected to have a lot of review and discussion before it takes final form. So, there will be a period of uncertainty as the details get worked through the legislative system. There will be an opportunity to comment on and submit testimony on this proposal.

I do have some thoughts on what AMHD providers can do right now, regardless of how this plays out. Focus on the basics and provide high quality, cost effective services, no matter what service is provided by your agency. Conduct thorough assessments. Use the assessment to inform the process of recovery plan development. Implement recovery plan interventions. Monitor the consumer's progress. Incorporate the progress report into the recovery plan to keep it relevant and current. Repeat the cycle, from assessment through recovery plan modification. Help the consumer gain recovery and independence, as much as is appropriate. Document thoroughly. Bill the AMHD only for reimbursable covered services. Supervise your staff well. By sticking with the basics, your agency should be positioned as well as possible to withstand any legislative or budgetary challenges that will come.

Second, the transition of Med-QUEST beneficiaries. Some time ago, the Directors of Health and Human Services, and their staff, determined an integration of mental health services and medical services being provided by the same health plan was a goal. The splitting of mental health services from general medical services results in fragmentation of care, adverse health outcomes, and financial inefficiencies. A plan has been developed to bring both mental health and medical services under the auspices of single entities, the health plans, for those individuals now receiving services under the Adult Mental Health Division.

We are planning a public announcement sometime in the near future to formally talk about the implementation of this plan. For now, the Department of Health, Department of Human Services, and QUEST plans have met to discuss this transition. When the announcement is made and plans are finalized, AMHD will work with your agency and our consumers to achieve the best transition possible.

I think this is an opportunity for consumers to receive better integrated care, under their QUEST health plan. I have confidence that Kaiser, HMSA, and AlohaCare, all of which have been key providers of health services in Hawaii for many years, have the ability to accomplish this goal. There will be challenges as we implement this transition, but I know that by working together we can make it happen.

Suicide Risk Assessment, Intervention & Documentation - Part 2 (AMHD Deputy Medical Director, Dr. Rupert Goetz)

Two months ago, I began a two-part series on suicide risk assessment. In this issue, I would like to conclude the series with some further thoughts on assessment, adding some issues of intervention and documentation. Suicide is so important, so much studied, and so many articles, books and even standardized course exist, that I cannot cover it here. Rather, this article is written from the perspective of an emergency and community psychiatrist who reviews Sentinel Events reported to AMHD and who has developed some opinions. Please bear with me.

Suicide Assessment (Part 2):

The last article focused primarily on “making it easy to reply fully and openly” for our clients when suicide thoughts come into the picture; it was on the *process* of the assessment. Now, I would like to emphasize a few points about the *content* of the assessment.

The main thing is that every clinician and every organization doing suicide risk assessments should have some sort of comprehensive plan or format *before* it’s needed. All too often, when I read progress notes of clinical encounters that occurred before a sentinel event, I get the impression that the clinician was reacting in the moment, discovered suicidal ideations and failed to shift into suicide assessment gear. The progress note is too similar to earlier notes, despite the new, troubling issue. Suicidal ideation was uncovered, but the conversation centered around current situational factors, without supporting detail or placing them into an overall context.

I think of those as “Oh My Gosh” evaluations. Surprised and unsure what to do next, the clinician does what they generally do, namely stays with familiar topics and provides support.

What I am hoping first to see is a review of risk factors. There are many, so this can be overwhelming in the moment, unless preparation occurred earlier. One excellent summary can be found in a recent NASMHPD Report*. (More on documentation later.)

A second important perspective is placing risk factors found into an overall context. Three things stood out for me in my progress note reviews; *prior attempts*, *dangerousness* and *existential context*. One critical risk factor is that of *prior attempts*. It is much different to be evaluating a person with a pattern of attempts than evaluating suicidal thoughts for the first time. The fact that there is a pattern is in itself helpful - you can look for changes in the pattern. Are the attempts getting more serious, the cutting deeper, the pills ingested more? *Lethality of method* (either previously used or now contemplated) is the second thing that stood out for me. You can’t change your mind and call for help after jumping, hanging, using a gun or a car. The prevention plan you come up with would need to be different. That brings me to the third element. What does the possibility of suicide mean in the *existential context* of the person’s life? Does living make more sense than dying for your client? (You remember “Mike” from the first installment. He didn’t seem to have much left.)

While the risk factor and potential “critical areas to explore” list is long when you delve into the many recommendations in the literature, I encourage us all to be prepared beforehand.

Suicide Prevention Interventions:

After doing a comprehensive assessment, my point in this section should be clear: Do a comprehensive intervention. I tend to think in terms of emergency intervention and a bio-psycho-social plan.

With emergency intervention, I mean intervening even against a person's will - e.g.: getting them to an Emergency Room for an involuntary admission assessment. There's more than another article there, but your best friends may be the Crisis Mobile Outreach team and first responders, like police. In an emergency, you have to first act to assure safety and then repair your therapeutic relationship harm later. (For when to consider taking over, see: "Danger and Mental Status Together," in the July, 2009 Provider Newsletter.)

In my highly personal view, a comprehensive intervention includes consideration of biological, psychological and social dimensions. While you may not be a physician or prescribing nurse, it's still important to consider whether you and/or your client think medications are needed or working. One of your interventions may be an urgent (or even emergent) medication assessment. Psychologically, therapies should be considered next. Supportive counseling (the kind we see the most often) is great, but is a different kind of therapy needed to help the client shift gears? It may be hard to get, but what about Cognitive-Behavioral or Dialectic Behavioral Therapy? Again, a referral to at least explore the need and options, whether within the organization or outside, may be considered. Finally, what about the social elements, food, clothing, shelter, friends, or even work? Are there possible interventions there? What about peer support? Again, you cannot always do everything, but your must plan hold water from all three of these dimensions.

Please allow me a final "soap box:" The "No Harm Contract" (NHC) is an *assessment* tool, not an intervention! This topic has been explored a good deal: Having a signed NCH provides little to no protection either to the patient or the clinician absent a comprehensive plan. However, the process of developing one can be very instructive - doing one can easily change your plan. But, please be particularly sure that your note can't be read as "client agreed to sign NHC, therefore I assumed safe." Even if the "contract" had meaning, remember we're terribly poor at predicting an individual person's future behavior beyond just a few hours.

Documentation:

Sitting down for documentation is a wonderful opportunity to double-check what we just did. Entries after a suicide assessment (and possibly intervention) are particularly important. In this connection, let's remember some basics:

- Notes should be contemporaneous (i.e.: written as soon as possible after the visit) and should be dated, timed and signed. (Add name and degree if signature is not legible.)
- Notes should be comprehensive. (This doesn't mean long, it means that a note could stand alone still and give the reader an idea of what you observed, thought and did.)
- Notes should never be changed. (If you forgot to do something, do it and then write another note; if you forgot to write something, write an addendum as soon as possible after the original note and make clear what note the addendum pertains to.)

So now, what to write? Whether you use SOAP or DAP format, the progress note shouldn't simply be a narrative of what happened. (I've heard one facetious reviewer call that a "Dear Diary" note.) A model that one malpractice attorney successfully embedded in my mind is: "Show that you discharged your duty." So I asked: "What is my duty?" The attorney responded that it is to:

1. Discover the relevant facts;
2. Weight them; and
3. Do something reasonable about it

In the context of suicide assessment and intervention, this makes the first part of the note potentially the longest. What did you *discover*? (Whatever assessment format you used, most experts agree that obtaining sufficient detail is critical. Unfortunately, that also means you have to document it. Remember? "If it's not in the note, you didn't do it.")

From notes I sometimes see after sentinel events, I am struck by how little exploration seems to have taken place. I bet there was more, but it wasn't documented. Not that this needs to turn into a multi-page affair. But it is important to convey the completeness of the assessment. Even a note that the clinician "used suicide risk checklist to assess situation" would be a world better than silence.

The second part (*weighing* the facts - often placed in the "Assessment") is critical. This is not merely a restatement of the client's diagnosis. This is you thinking in writing about what you make of the information you just obtained. What do you think of the risk-increasing and risk-preventing elements? What is your sense of the overall (resulting) risk?

Then, how does this risk align with the interventions you are about to describe next in the "Plan" (the doing something *reasonable*)? Whether you put that reasonableness discussion in the "Assessment" or "Plan" section is less important, but be explicit. What choices do you have? They may not all be possible.

> Forgive me one pet peeve in this connection: Running out of "Units" at a time of crisis is no reason to abort further action! Crisis exceptions can and should be requested and, with the documentation discussed here, they should be easy to support. These are tight financial times, but we must remain our clients' documented advocates.

Back to the reasonableness of your plan: You might consider one intervention (e.g.: recommending hospitalization), but then decide to go with another one, because of what your clinical training and therapeutic relationship tells you is best. When you re-read your note, can the reader tell why you landed on this option? Does it seem reasonable? Here it is good to remember that you can't be sure you're going to be right in 20:20 hindsight. What you have to shoot for is making the reasonable choice at the time, given all the facts you have.

And that leads to the last part, the actual "Plan" (*the doing* something reasonable). What are you going to do about what you found? (Do later notes bear out that you did it?!) After all, we're talking about a suicide risk assessment. This is the part that most often makes me shudder when I read sentinel event-related progress notes after the fact. What I find is a practically verbatim re-statement of previous plans: "Will see again in a week" (or something like that). That may in fact be part of the plan, but then it had better be very well supported by your *discovery* (e.g.: few risk factors), your *weighing* (e.g.: risk of suicidal action seems very low) and your alternatives. More often, some additional interventions are indicated, minimally like: "Crisis plan reviewed, updated and confirmed that client is comfortable with how to activate it if things change."

Summary:

In this second of two articles, I wanted to offer some thoughts how we might learn from the tragedies we invariably face in community mental health care. This is my highly personal perspective, built primarily on what left me worried from my sentinel event reviews. As professionals in community mental health, we are the safety net. The potential for suicide tests that net. Risk assessment, prevention and intervention should be as familiar to us as a "code" is to trained EMTs. Thankfully, our clients' resilience means we are less often tested than we might expect. That means we have to work particularly hard to stay sharp for when these skills are needed!

Reference: *Litts, D. A., Radke, A. Q., Silverman, M. M. (Eds.). (2008). Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority. Washington, D.C. National Association of State Mental Health Program Directors/ Suicide Prevention Resource Center. (URL: http://www.sprc.org/library/SeriousMI.pdf)

Hawaii Quality of Life Inventory (QOLI) Surveys

AMHD has upgraded its QOLI software to version 5.1. If you are not using that version, we would like to make it available to you. The new version makes it easier to enter information accurately and upload it through SharePoint. In the meantime, you can keep entering data into your existing QOLI database. The upgrade will carry over the data from older versions into the new version.

It is essential that **all providers complete Hawaii Quality of Life Inventory (QOLI) surveys for each consumer served**. Please, ensure that every consumer who has not completed a QOLI within the last 6 months is given a QOLI and the results are uploaded this month. Failure to do so will decrease the ability of the AMHD to justify existing programs to the Hawaii Legislature, which looks at the resulting service measure outcomes for guidance.

Reminders:

- The QOLI must be completed at intake, every 6 months, and at discharge.
- The first QOLI must be completed before working on the treatment plan so that QOLI Clinical Feedback Form can be used in developing the treatment plan with the consumer.
- The data must be entered into the ACCESS database provided to you by AMHD and the data must be uploaded to your SharePoint **every month**.
- If you have any questions or need the upgraded version, please contact John Jansen at john.jansen@doh.hawaii.gov or (808) 236-8393.

As you are aware, our state's budget shortfall is causing our legislators to look hard at every dollar spent. The Department of Health and the AMHD in particular will most likely face more scrutiny over its budget in the near future. The best way to show the value of appropriations is through positive outcomes. Unfortunately, the compliance rates for the QOLI survey required for every consumer receiving case management services is at an all-time low.

We understand that many providers are short-staffed and over-worked at this time, but we urge you to plan for the future and turn in the surveys by the deadline.

Why the QOLI is critical to our system of care:

1. **Federal and State Requirements:** The QOLI data are required for a variety of reports to funding agencies including Block Grant reporting, the National Association of State Mental Health Program Directors Research Institute (NASMHPD) Report and most importantly, the Legislative Report.

2. **Program Survival:** In this time of fiscal distress, justification for how funding is being allocated is key to survival of our programs. What is not measured does not get counted.

3. **Treatment Planning:** The QOLI provides valuable clinical information and the Clinical Feedback Form was designed to help clinicians with their treatment planning regarding 7 key quality of life domains: (a) Health and Level of Functioning (b) Criminal Justice Involvement and Victimization, (c) Finances/Benefits, (d) Relationships/Resources, (e) Hospitalization/Medication, (f) Housing, and (g) Employment/School.

4. **Performance Indicators:** Administrators cannot make informed plans to improve our system of care without knowing about consumers' living situations, their employment status, how they feel about their physical and mental health, and whether or not they have appropriate social and financial support.

Mahalo for your cooperation and understanding.

AMHD Office of Consumer Affairs (OCA)

AMHD has recently compiled results of provider monitoring that were completed in calendar year 2009. The overall system has improved with regard to explaining to consumers what their rights are and the ways they can voice dissatisfaction. However, we also noted across the system that many providers were not informing consumers that they may also contact AMHD with their concerns.

The Office of Consumer Affairs (OCA) is the contact point for consumer grievances for AMHD. They can be contacted at 586-4685. The definition of a grievance is any expression of dissatisfaction with a service or housing. OCA encourages consumers to resolve grievances directly with their providers. However, consumers should be instructed on their option to file a grievance with OCA as a part of program orientation. OCA recognizes that it often takes courage to file a grievance and can assist a consumer through the process.

Providers also need to provide reassurances that there will be no retaliation for voicing dissatisfaction. The goal of the grievance process is not to punish, rather is it an opportunity for learning and improving. Within an agency, a consumer should be informed on the various options to express dissatisfaction. A variety of avenues are necessary to build a sense of safety for the consumer both in expressing their concerns or dissatisfaction and appealing decisions they do not agree with. Many grievances can be resolved with good clear communication between the provider and the consumer. It is suggested that agencies continuously review and update this information for staff.

The OCA has a process for logging, tracking and forwarding consumer concerns to the appropriate areas for follow-up. OCA is available to provide training on consumer grievances and appeals in person on Oahu, and for the Neighbor Islands, by teleconference. To arrange for training, please call the OCA at (808) 586-4688.

E-ARCH Program

We have heard from several of you about concerns regarding state funding of services and programs. While we cannot promise you with a guarantee that money will be available to pay you for your services through the end of the current fiscal year and beyond, we want you to know that we are doing our very best to monitor our fiscal and budgetary obligations. Several providers have asked for advanced notice if AMHD should run out of money or decides to delay payments to providers. We assure you that we will do whatever we can to notify you as soon as we are able to about slow downs or extended delays in payment. As in previous fiscal years, we traditionally experience a slower payment turn around the months of May through July. We understand that the majority of AMHD E-ARCH providers are sole proprietors who rely on regular monthly reimbursement from AMHD to pay for business operations like electricity, water, food, therapeutic activities, and transportation for their AMHD resident(s). If you have questions and/or concerns or are hearing statements in the community that are causing you distress, please call Linda or Stacy so that we may have an opportunity to verify the current status of your AMHD claims payment. Thank you for your patience and understanding.

Monthly Provider Meeting:

- Check your 2010 E-ARCH Provider Meeting Schedule for the new meeting days. Attendance is voluntary for most meetings. We will let you know in advance which meetings are mandatory. Thank you for adding these meeting dates to your calendar!
- Please RSVP by calling 453-6397 if you plan to attend the next AMHD E-ARCH provider meeting. This month's meeting is an educational meeting and will focus on progress notes/chart notes and supporting documentation (topic was originally scheduled for the February 2010 meeting).

  Tuesday, March 23, 2010
  9:30 a.m. – 10:30 a.m.
  870 Fourth Street, Pearl City (Linda Appel's and Stacy Haitsuka's Office)

AMHD E-ARCH Program News:

- There were no program admissions and one program discharge in February (as of 02/19/10).
- There are several AMHD E-ARCH consumers who are waiting to be accepted for AMHD E-ARCH placement (majority are males). If you have an open E-ARCH bed and would like to schedule a screening appointment, please call Stacy Haitsuka.
- A list of program activities for calendar year 2010 was sent to you. Your feedback on these program activities is valuable to the success of the program.

AMHD Administrative Updates:

- AMHD furlough days for the month of March 2010 is Friday, 3/5/10 and Friday, 3/12/10.
- We continue to monitor the status of timely claims payment. If you are experiencing a payment delay and have questions, please call Stacy Haitsuka.

Topic of the Month: "Safety in the Home"

Safety in the home is a significant component of providing licensed, professional services in your E-ARCH. Rather than waiting for an incident to occur such as slipping, falling, or property damage, let's be proactive and take time to inspect everyday, common use items.

For example, ensure there is a process in place to disinfect, wipe, clean, and dry walking areas as well as railings, tables, and chairs on a routine basis. Be on the look out for wobbly equipment that needs to be tightened or replaced such as loose floor tiles, an off-balanced table leg, toilet seats, shower curtains, door knobs, and appliance handles.

Looking out for safety in the home needs to be a priority. It is true that as safe as you are, accidents can happen. When an accident occurs, please be quick to respond making sure to assess the person(s) involved and calling for help or further examination.

Being able to determine to potential causes for the accident is part of the investigation process. Was the accident due to slipping alone? Or, perhaps the resident was not wearing non-skid socks which are part of their recommended foot care. Was the accident due to the weather? Or was the railing in need of maintenance that hasn't yet been performed?

Document the incident and contact the resident's case managers. If needed, please ask to debrief about the incident with the resident's treatment team to evaluate what can be done in the future to prevent a repeat occurrence.

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.

- Going on Vacation?
  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. If you prefer to fax a copy, our fax number is 453-6399.

- 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. PCGs are responsible for keeping a current copy in the chart. Recovery Plans are updated every six months. RN case managers are responsible for attaching the Recovery Plan to the medical care plan. 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.

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

Upcoming State Procurement Office (SPO) Workshop For your information, there is an upcoming SPO workshop for providers on April 14, 2010 at 1:30 p.m. The title of the workshop is "Doing Business with the State: An Informational Session for Private Health and Human Service. HRS Chapter 103F." Providers may register at the following website:
http://www4.hawaii.gov/spoh/tng/wkshpRegistration04.asp)

FREE Tax Help for those who qualify through the Hawaii Alliance for Community Based Economic Development. I volunteer to do taxes through this agency and for more information, see www.hawaiitaxhelp.org or call 211.

Personal Care Aid (PCA) Training Classes for 2010 are underway. 1st class session started 2/17 to 2/21, 2nd class session is from March 10 – March 14, 2010. For more information see www.etc.hawaii.edu/cna.

SAVE THE DATE! Mental Health Awareness Day at the Capitol
March 25 2010, 3rd & 4th Fl. Balcony at the State Capital, Honolulu, 11:00 am to 1:30 pm.
Public, Consumers, Families, Professionals, and Legislators are invited to view educational exhibits from various mental health related organizations. This is an event sponsored by the DOH, MHT SIG and CF&Y Alliance.

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.