AMHD
ADULT MENTAL HEALTH DIVISION

Provider Bulletin

for the Adult Mental Health Division

August 2009

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 Billing & Claims

There have been some additional questions from POS providers about what constitutes a valid diagnosis for the AMHD. The following information is offered to help further clarify the use of diagnosis codes on AMHD service claims. Valid diagnosis codes are used for psychiatric disorders and can be found in both the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) and the International Classification of Diseases 9 (ICD-9). AMHD does not reimburse for "unknown" diagnosis (799.9) or for no diagnosis (v71.09).

Currently, AMHD also reimburses for diagnosis codes that do not appear in DSM-IV or ICD-9, but are very similar to codes found in either of these references. **Effective September 1, 2009** AMHD will deny all service claims that do not meet HIPAA Transaction and Code Set requirements. For more detail on these requirements, please see the AMHD memorandum from Dr. Sheehan titled *"Diagnosis Codes on Service Claims for AMHD Payment"*, dated July 29, 2009.

Hawaii 2009 Adult Community Mental Health Consumer Survey & 2009 Health and Well-Being Survey

The 2009 Annual Consumer Satisfaction Survey was launched June 1, 2009 and the deadline was **extended** through August 31, 2009. As of July 27, 2009 the number and percentage of the surveys received is very small.

Number and Percentage of Consumer Satisfaction Surveys Received - 163 (4%) of 4,450

Number and Percentage of Health & Well-Being Surveys Received - 120 (3%) of 4,450

We understand that many providers are short-staffed and over-worked at this time, but we strongly urge you to turn in the surveys by the deadline. Please contact Steven Wong when your inbox is nearly filled or if there are any concerns or questions. He may be reached at sycwong@hawaii.edu or via phone (808) 735-1811.

AMHD Acting Chief Corner (Dr. William Sheehan)

I thought about our current situation the other day as I was listening to the oldies station and heard David Bowie's 1971 song "Changes", which contains the refrain, "Ch, ch, ch, changes, turn and face the strange".

Ironically, the words of that song, written 38 years ago (yes, I know, many of you weren't even born then!) are relevant today.

There seems to be nothing constant but change. The AMHD, like all areas of state government, our nation, and maybe the world, is going through changes of great proportions.

There are some things that don't change, though, and that's the focus of this month's note. Regardless of the things happening on the large scale level, what we in mental health do ultimately comes down to two people, the person striving for recovery and the person assisting in that process.

It's easy to lose that core relationship in the day to day upheaval of our current economic and social events. But, our job in that partnership is to do the best we can with what we have, no matter how much or how little.

Each of us faces the challenge to remember the primary role we have as helper to another. No matter what amount of money is in the budget, fluctuation is in the economy, or changes in policies, there will always be a relationship between two people at the core of any helping situation. Keep that dyad as the focus, and work with what you have, and the effect of the storms of life around us will be lessened.

Our Duty To Notice and Act, Part 2 (Dr. Rupert Goetz)

Last month, I offered some thoughts on our "clinical duty to notice and act" as it relates to two questions:

1. How can we notice when the usual has become unusual?
2. How can we know when a silent, medical mental status emergency has evolved that should force action?

In the first part, I placed an emphasis on noticing when someone's mental status changed from worrisome or concerning "as usual" to dangerous, such that we would shift gears and take extraordinary steps. I used a case to begin:

> Mary (not her real name) went through a lot growing up, including both psychological and physical trauma. One of her ways of coping when overwhelmed was to flee into drugs, a few years back switching from illicit drugs to prescription medication. As consequence, it was not unusual to see her sedated and slurring her words; since she was homeless, seeing her asleep on a park bench was common. Generally, offering support when she seemed open was what could be done. However, one day, she didn't wake up, even though she had been seen shortly before by one of her providers.

The story produced significant reactions. It is hard, but important to look at clinical encounters that give us pause. There should be no implication that the outcome in this case would have been different; that is useless "Monday morning quarterbacking." However, constant learning honors the client and the sad story by searching for ways to become more skilled.

With this second installment, I hope to contribute to our understanding of medical emergencies signaled by mental status changes.

As mental health specialists, an altered mental status is almost the norm; that's what we deal with every day. However, if we think only in terms of mental health interventions, we might fail to notice when a medical emergency has taken hold. If we were to encounter another "Mary" on the bench, would there be any way for us to check and get a better sense of whether we should call an ambulance or continue to offer support?

Delirium, Stupor and Coma:
Some definitions first: According to DSM IV TR, ***Delirium's*** essential feature is a disturbance of consciousness accompanied by a change in cognition (thinking), not better accounted for by dementia. It generally develops over a short time (hours-days), tends to fluctuate and is the direct consequence of a medical condition. A classic is the Delirium Tremens (DT's) of severe alcohol withdrawal.

The Merck Manual (Home Edition) defines ***Stupor*** as unresponsiveness from which a person can only be aroused by vigorous, physical stimulation. In contrast, ***Coma*** is an unresponsiveness from which a person cannot be aroused. The "Glasgow Coma Scale" (below) is frequently used (for example by EMTs) to describe this, with a normal score of 15 and a dead person scoring 3; Coma is generally defined as ≤8.

	1	2	3	4	5	6
Eyes	Does not open eyes	Opens eyes to painful stimuli	Opens eyes in response to voice	Opens eyes spontaneously	N/A	N/A
Verbal	Makes no sounds	Incomprehensible sounds	Inappropriate words	Confused, disorientated	Oriented, speaks normally	N/A
Motor	Makes no movements	Extension to painful stimuli	Abnormal flexion to painful stimuli	Flexion / Withdrawal to painful stimuli	Localizes painful stimuli	Obeys commands

Numerous medical disorders can lead to severe changes in a person's mental status. Brain disorders (e.g.: seizures, strokes), metabolic abnormalities (e.g.: Hyperglycemia, profound hypothyroidism), accidents (e.g.: head injury, hyperthermia) and substances (e.g.: drugs, carbon monoxide) and many more can be culprits. A gradual, smooth progression from general lethargy to stupor, coma and ultimately death is as possible as the more confusing pathway through delirium, which fluctuates.
Often, part of how the illness presents triggers our understanding that something is different and physically wrong. For example, following a motor vehicle injury a client is suddenly much more confused than he ever was; the history clue makes the need to check for head injury clear.

However, medical problems can emerge as much more silent killers. A classic dilemma we face in mental health is a person suffering from (let's say) schizophrenia, on two neuroleptics (antipsychotics) as well as a benzodiazepine (tranquilizer) and several other medications, drinking alcohol, occasionally taking street drugs and relatively often winding up "pretty out of it". This may be nothing unusual, or it could be the beginning of a medical emergency. It could be "Mary."

The Mental Status Examination:
Are there clues that might warn us when we face a growing medical emergency, not a more benign, cumulative intoxication? While significantly simplified, I here argue that the Mental Status Examination (MSE) presents at least two important opportunities. One is the appearance, the second is cognition.

A brief review of the MSE first: Most of us learned some version. The following is specifically intended to be easy to remember and at the same time to make identification of "medical" problems easier: How does a person Look, Feel, Think and how is the Cognition?

- ***Look:*** First describe the "still photograph" (appearance, etc.), then add movements (activity, etc.) and finally the "sound track" (speech, etc.). *It is in this section that the Glasgow Coma Scale fits.*
- ***Feel:*** Then describe Mood (how the person describes they feel) and Affect (how they look like they feel), as well as Relatedness.
- ***Think:*** Next is Perception (including hallucinations), Thought Content (including delusions, suicidal/homicidal ideations) and Process (stream of thought, logical flow)
- ***Cognition:*** There are lots of possible tests, so let's consider a model that may help remember them.
    - Imagine a person walking into a bar, progressively drinking himself into stupor and coma. What happens along the way?
        - Judgment and Insight usually go first; he shouldn't have been there and he shouldn't take that next drink.
        - Then abstraction diminishes; it's stupid to pick a fight with the big, angry guy.
        - Pretty soon memory fades: "How many drinks have I had?!"
        - Then, attention and concentration goes; he's nodding off.
        - Finally, disorientation begins; when awoken, it's "leave me alone", unaware of time or place.
    - As a test, the reverse order often can be observed when a stuporous person awakes from a severe intoxication:
        - The first question is often: "Where am I?" (Orientation)
        - Soon he's looking around. (Attention and Concentration)

- Then: “What happened?” (Recent Memory)
- Next is often: “Wow, I’m a mess.” (Abstraction)
- Finally: “I guess I shouldn’t have done that.” (Judgment and Insight)

- The point here is that progressive intoxication can become life threatening through progressive brain anesthesia. How many college kids have died from drinking alcohol faster than their bodies can throw it up or break it down? We all know or can imagine mental status changes along the way. This model reminds us how basic a brain function orientation is.

The Action:
If there is a delirium, or if the client is in the stupor-coma continuum, then a medical emergency evaluation and possibly treatment (or at least monitoring) is required. We have to consider calling the paramedics or police. However, we hate to go against a client’s wishes and we don’t want to “cry wolf.” Last month, we looked at how *danger* and signs of *acute mental impairment* need to be considered together when taking over. Today, I suggest Disorientation and the Glasgow Coma Scale as two tools to help we feel more confident when we “declare an emergency.”

Disorientation in my personal opinion is the most neglected part of the mental status examination. I vividly recall an ER resident referring me (as the Psychiatric Attending) an elderly woman with vague behavioral changes. The Evaluation Form said “Ox3” (oriented to time, place and person).
However, when I evaluated her, she thought it was 1975 (it was 1989), she was in San Francisco (it was Portland) and she gave me the name on the form. So, I referred her back to the ER resident as medical emergency, a Delirium (her orientation had fluctuated). Chagrinned, the ER resident confessed that he had “inferred” her orientation as she seemed “so with-it” - he had never asked, yet he completed the form! What ultimately came out was that the woman had long-standing dementia with escalating behavioral problems prompting the nursing facility to ship her to the ER. The point was that checking orientation was critical to understanding her situation. It is one of the last MSE elements to become abnormal when there is deterioration. Psychosis, such as in schizophrenia rarely, if ever, changes orientation. Disorientation, whether walking into closed doors, stumbling over obvious chairs or identified by *asking* a person for time place and name is usually either dementia or delirium; if it not the former, worry about the latter. (By the way, there is a sequence in which dysfunction generally appears. Time: Day often goes first, year generally last; Place: Address often goes first, city and state or even country last; and Person: Name is lost even after the other two dimensions.) In “Mary’s” case, would the outcome have been different if the case manager had tried to wake her and found her disoriented?

Faced with a sleeping or intoxicated client, distinguishing a medical emergency from a self-limiting MSE change can be particularly challenging. Paramedics will generally try to rouse the person. While they are doing this, they will be scoring the Glasgow Coma Scale (CGS, see above), attending to movement (including eyes) and speech. At some point (whether a score of below 10, certainly if below 8), they will take the person to the ER. Anything other than a smooth improvement in the score (fluctuation) raises the worry of Delirium and would be bumped up for emergency medical evaluation. There is no reason you can’t do the same. Look at the scale: Would you be comfortable letting one of your clients stay on the bench if they opened their eyes only to pain, withdrawing from the pain a bit and made only incomprehensible sounds (GCS: E2, V3, M4 =9)?

While unfortunately I cannot guarantee that all emergency personnel will be familiar with the critical importance of Disorientation and the GCS, I can defend that both of these tools are powerful reasons for asking for emergency medical help.

Summary:
Last month, we reviewed how difficult it is to notice when something worsens gradually - the “boiled frog” problem. But we left open *when* to engage in this line of thinking - when a medical emergency might be present, but easy to miss. We did establish that at some point we have to act; combining “danger” and “mental status impairment” helps us see clearer when it might be *our responsibility.* We would then “*declare an emergency*” and call for help, if necessary against the wishes of the client. (An *emergency* in this context is defined by objective danger to life and limb; this is opposed to *crisis* - a perception of being overwhelmed, which may or may not be an emergency. Also, if we acted against the client’s wishes, we must remember the harm this caused the relationship will have to work later to re-establish trust.)

This month, we complete the discussion. Missing was the "thermometer" by which we might know *when* the "frog" in heating water was in mortal danger.

Objective changes in a person's basic cognition and alertness can be such measures for danger - for an emergency. True disorientation or a significant score on the Glasgow Coma Scale are simple to establish and should send a clear message, including to EMTs and ER staff. Remember that Delirium can fluctuate, so if you find real danger signals and while later things seem better, this might be an improvement. However, it might also be a lucid interval before a major worsening.

We knew "Mary" had mental and addictions problems. However, she likely lost her life to a medical problem; she probably slipped from delirium into stupor, coma and death. She often slept on park benches, so it was reasonable to leave her and check again later. However, if we had a suspicion, but weren't sure what to check, we certainly wouldn't have tried to wake her. In these two articles, I hope to have offered some options. Our clients present to us as a whole person and we increasingly have to understand their physical health needs. As mental health providers, we are part of the larger health care system. We want to remember that another "Mary" may need not only our empathy and support, but also our extraordinary action when her life is at risk.

Forensic Program Update

AMHD distributed memorandums regarding the transfer of forensic consumers to Purchase of Service (POS) providers on April 20, 2009 and May 21, 2009. The initiative to have all Conditional Release (CR) consumers serviced by a geographical Community Mental Health Center (CMHC), when feasible, has been occurring in phases. Phase 1: all hospital CR discharges serviced by a POS provider will be serviced by a CMHC with a comprehensive treatment and case management team. Phase II: any foreseeable discharges in the near future such as 3-4 months distant, would be the next consideration so that the new treatment team can establish rapport and assist with transition back to community in a less restrictive environment. Phase III: CR consumers currently in the community receiving Community Based Case Management from a POS provider would be the last to transition over or on a case by case situation. If you have any questions regarding this update, please contact Dr. Keith D. Pedro at (808) 590-9049.

AMHD E-ARCH Program

The current status of our national and local economy has offered an opportunity to take a look at what we do as providers of service. For example, we may have already taken time to self-evaluate our budgets to find ways to maximize resources and to identify ways to save and cut waste. Changing old habits is not always an easy thing to do. We are in a position to see different perspectives perhaps because we have found on a personal level that we may have had to find ways to do more with less and on a professional level, we may have had to assist our consumers in addressing their budget concerns. In any case, your willingness to respond and to prepare are important. Let's continue to identify innovative, creative, and/or recovery-oriented solutions to address the challenges we face. While we cannot control everything that happens in the world we live in, we can certainly do what we can to empower ourselves and our consumers to make positive, healthy decisions.

RSVP now for the 8/28/09 AMHD E-ARCH Provider In-Service Meeting! The topic for August's in-service meeting will focus on the area of day-to-day interaction between E-ARCH staff and consumers. We know that the number of residents living in the E-ARCH almost always outnumbers staff. We also know that E-ARCHs (professional business) are very close in proximity to the E-ARCH staff's immediate family (personal and private). As part of the in-service, AMHD E-ARCH providers will be asked to participate in group learning exercises focused on tying in daily activities with the consumer's medical care plan and Recovery Plan (also know as the psych care plan) as well as identifying where interaction(s) can be strengthened.

Please call Tehani Rawlins at 453-6397 by Thursday, August 27th to RSVP
Friday, August 28, 2009
9:30am – 10:30am
870 Fourth Street, Pearl City

Reminders:

- Attend the 3-day E-ARCH Training in Spring 2010:
  We are now accepting pre-registration for the next 3-day training. Dates of the training will be announced but will likely be around April/May 2010. If you have not attended the training in the last two years, we recommend you/your staff consider attending. Please continue to refer your colleagues, especially those who would like to be an AMHD E-ARCH provider. Please call Tehani at 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/contract 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.

AMHD E-ARCH Program – Fiscal Audit #1 Results: Congratulations to all AMHD E-ARCH providers who were recognized for their exemplary fiscal audit performance. The fiscal audit period was from June 2008 through December 2008. There were two parts to the fiscal audit. First, claims submitted must have been for the correct amount including amount due, units, and dates of service. Second, the amount of room and board paid to the provider must have been for the correct amount as agreed with the consumer/representative payee. The next fiscal audit will be for the period of January 2009 through June 2009. If you have any questions about the fiscal audit process, please call Stacy at 453-6396.

Annual Financial Review for Consumer Room and Board: We apologize for the delay! AMHD is working with case managers, AMHD E-ARCH providers, guardians, and representative payees to identify current income, debt, and expenses for every AMHD E-ARCH consumer. Consumers must pay their share of monthly room and board costs. It is the responsibility of the person managing the consumer's funds to pay the monthly room and board amount in full to the AMHD E-ARCH provider. If an AMHD E-ARCH provider does not receive the monthly room and board amount in full, the provider should contact the OSAA office to report the situation. A confirmation letter will be sent to the consumer's team members indicating the current monthly room and board amount.

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

Peer Benefits Planners (PBP)

AMHD is introducing a new service called Peer Benefits Planners (PBP). Please see the following questions and answers to learn more about this exciting new service.

What is PBP?
Peer Benefits Planning is a service that allows persons with disabilities to learn from their peers how to best balance going back to work while maintaining their disability benefits, such as Welfare, Food Stamps, SSI, SSDI, Medicare and Medicaid, and utilizing work incentives.

Who are PBP?
Peer Benefits Planners are a diverse group of persons with disabilities with extensive experience in both the disability community and the benefits system. Currently, we have 20 recent graduates of an intensive 3-month training jointly provided by the University of Hawaii at Manoa and Cornell University. The training is similar in scope and intensity to the one that Social Security representatives themselves receive from the federal government, who will form the first cadre of certified Peer Benefits Planners.

Where are PBP?
PBP will be independently contracted to provide benefits planning in various locations throughout the state, such as the Community Mental Health Centers and One Stop Employment Centers and wherever needed or requested, such as Homeless Outreach, CBCM, PSR, Clubhouse and Supported Employment programs – serving the islands of Oahu, Maui, Kauai and Big Island.

What do they do?
PBP can provide a range of services, from basic information about benefits work incentives geared toward large groups to intensive one-on-one benefits planning education sessions for individuals or anything in between.

How do I schedule PBP?
PBP services can be scheduled informally on a walk-in basis wherever PBPs are located or you can contact Hire Abilities (www.hireabilitieshawaii.org) to arrange a scheduled PBP session.

What does PBP cost?
This is a FREE service to persons with disabilities who are interested in learning more about work and how it impacts their benefits.

How did this come about?
Currently this is a collaborative project with substantial support from AMHD, the University of Hawaii Center on Disability Studies (CDS) Medicaid Infrastructure Grant Hire Abilities Project, and the Department of Health Mental Health Transformation State Incentive Grant (MHTSIG), with future funding and support to come from the Department of Human Services Vocational Rehabilitation and Service for the Blind Division. We also hope to work with the Department of Labor and Industrial Relations Workforce Development Division and One Stop Employment Centers to build upon the Peer Specialist and Peer Benefits Planner initiatives and create a career pathway in human service professions for persons with disabilities.

Homeless Outreach Reminder

The new contract for Homeless Outreach began August 1, 2009. Providers selected to administer this service include Kalihi Palama Health Care for the Homeless Project (Oahu), Mental Health Kokua (Maui & Kauai) and Office for Social Ministry (Big Island).

AMHD Website

We continue to update our AMHD Website and revisions are underway. If you have any questions regarding the AMHD website information, please contact the AMHD Provider Relations Director at (808) 586-4689 or email at dawn.mendiola@doh.hawaii.gov.

Learning Opportunities & Opportunities for Growth

1. Fundamental Five Non-Profit training series – "Fundraising & Developmental Strategies", by the Grants Central Station, will be held on September 8, 2009 in **Maui** at the Cameron Center. Free. For more information, please visit www.grantscentralstation.org.

2. The US Department of Housing and Urban Development is sponsoring a four-day SOAR "Train-the-Trainer (TTT)" program in **Denver, Colorado** on September 14-17, 2009. Registration is due by August 14, 2009. For more information, contact Dr. Edward Suarez at (808) 453-6941.

3. Ethics and Ethical Thinking for CSACs will be held on September 17, 2009 in **Honolulu**, Kapolei. 6 ADAD CEUs. $15. For more information please call Ana Quintal at 692-7528.

4. Fundamental Five Non-Profit training series – "Volunteer Management", by the Grants Central Station, will be held on October 7th, in **Maui** at the Cameron Center. Free. For more information, please visit www.grantscentralstation.org.

5. Critical Thinking with Mike Taleff, PhD, CSAC, will be held on October 15th, in **Honolulu**, Kapolei. 6 ADAD CEUs. $15. For more information please call Ana Quintal at 692-7528.

6. Fundamental Five Non-Profit training series – "Legal & Insurance Issues", by the Grants Central Station, will be held on November 5th, in **Maui** at the Cameron Center. Free. For more information, please visit www.grantscentralstation.org.

7. Co-Occurring Disorders with Mike Talff, Phd, CSAC will be held on November 12th in **Honolulu**, at the YMCA. 6 ADAD CEUs. $15. For more information please call Ana Quintal at 692-7528

8. Ethical Standards for CSACs will be held on November 19th in **Honolulu**, Kapolei. 6 ADAD CEUs. $15. For more information please call Ana Quintal at 692-7528