

Hawaii Department of Health  
Adult Mental Health Division  
**Request for Information (RFI)**  
**RFI No. AMHD 420-1-17**  
**Community-Based Case Management Services – Statewide**

A Request for Information for Community-Based Case Management Services (CBCM) for adults with severe and persistent mental illness, statewide, was issued on July 1, 2016. Written feedback was received from six (6) organizations. Below is a summary of the responses received through this process as they relate to the questions from the RFI.

The respondents proposed the following innovative practices and/or partnerships to better deliver/sustain CBCM services:

1. More intensive case management (ICM) plus teams.
2. Holistic approaches: Integrated medical and psychological care.
3. Recovery support services such as tobacco cessation, computer classes, and SNAP (supplemental nutrition assistance program) food preparation workshops.

Respondents stated that an annual budget is difficult to project without knowing the number of assigned Adult Mental Health Division (AMHD) consumers that would be serviced. Responses came in from agencies that do not currently provide CBCM services, to agencies that currently provide services to nearly 500 AMHD consumers. In all responses, respondents stated that the current units authorized of 3½ hours per month for each consumer is not enough. Considering the acuity and the constant changes in the lives of the AMHD consumers, the providers want an increase in the minimum units. Each respondent stated that Peer Support and Psychosocial Rehabilitation Services (PSR) should NOT come out of the case management units.

Respondents provided the following suggestions on how the Department of Health could achieve better data collection to determine CBCM service outcomes:

1. Coordination with the Hawaii State Hospital, Department of Public Safety, Psychiatric Hospitals and Drug Treatment Centers for data sharing would be helpful.
2. A coordinated entry system with electronic health records (EHR) systems like the Department's Alcohol and Drug Addiction Division's WITS System.
3. The Quality of Life Inventory appears to provide an overview of where an individual is at a given time. However, it is lengthy and consumers often lose interest in answering the questions. It may be more manageable to focus on five indicators such as need for hospitalization, homelessness, employment, health and socialization.
4. An important consideration with the severe mental illness population is connecting and keeping the lines of communication open. Gathering information through face-to-face interviews or phone interviews with consumers is important. If consumers miss appointments, a survey with a return envelope can be mailed to the address provided. Information can be documented in a progress note or survey.

Respondents provided the following suggestions when asked to suggest ways the AMHD could achieve higher quality CBCM services:

1. Community-based office location.

2. University trained staff, at a master's degree of education.
3. Professional rate of pay.
4. Offer licensed supervision.
5. ACT like teams.
6. 24-hour access to a judge.
7. Require providers to have offices in the community, open 5 days per week.
8. More housing and levels of care.
9. Increase the units for case management.
10. Provide units for skill building.

A respondent also stated that much more emphasis is needed on the care that Case Managers provide for consumers, especially in the areas of working on a multi-disciplinary team, substance abuse, multiple chronic illnesses, informal partnerships (engaging the family, other providers, friends, natural supports, etc.), and shared decision making (working with an empowerment and recovery model).

Four respondents stated that they currently provide CBCM services. Two respondents do not provide CBCM services.

When asked if their organization would be interested in providing CBCM services in the State of Hawaii, five respondents were interested in providing services on Oahu; five on the island of Kauai, three on the island of Maui, and two on the island of Hawaii.

When asked if their organization was interested in providing CBCM services for a specific geographic area only, one respondent was interested in providing services for all geographic areas, one responded for all geographic areas on Oahu and Kauai; one responded for all geographic areas except Maui, Molokai and Lanai; one responded for only the West/East Honolulu and Waipahu/Ewa areas on the island of Oahu; and one responded for only the Waianae Coast area on the island of Oahu.

Respondents identified the following challenges to creating a CBCM program:

1. Finding qualified staff to support the program.
2. Providing supervision on the neighbor islands, with master's level training.
3. Establishing new payment systems, involving collaborative provider teams to help prevent medical and social consequences. These collaborative teams for integrated care involve treatment agencies well versed in mental illness, substance use disorders, and medical conditions. The model will need to involve primary care & shift from an episodic acute model (address remission/relapse) into a chronic care model (CCM). Funding issues for a CCM model include training for improving providers knowledge and skills for multiple chronic conditions involving mental illness, substance use disorders, and physical medical conditions; educating as well as engaging consumers to improve self-efficacy & adherence to treatment plans; emphasizing multi-disciplinary team service at the organizational level for follow-up; and leveraging health information technology such as consumer disease specific registry and electronic health records to support the above points.

To maintain a sufficient number of psychiatrists and/or APRN-Rx clinicians to provide 24-hour coverage in their geographic regions, the Respondents identified the following provisions:

1. Partner with health centers to see their consumers and then hire a psychiatrist after they attain 50+ clients.
2. Maintain psychiatrists by providing them with an office space, access to their consumers, and the handling of their credentials and billing.

Respondents were asked to describe how a CBCM program would best utilize Hawaii Certified Peer Specialists (HCPS) in their services and the following responses were provided:

1. HCPS provide valuable insight for consumers entering the system. HCPS have been very helpful with waiting room activities such as greeting and handling various receptionist duties. Discussing the needs of the consumers with consumers as they enter the building has been proven to be very helpful with the CBCM program.
2. HCPS are great opportunities for consumers to re-enter the employment market and are valuable assets to the treatment team. The HCPS assists consumers in the development of their WRAP (wellness recovery action plan) which helps them to focus on their goals. During this process, the HCPS uses personal experiences to assist the consumer in processing their path to recovery.
3. The HCPS provides a level of expertise that professional training cannot replicate. HCPS should be fully integrated team members, who provide highly individualized services in the community and promote client self-determination and decision making. They will complete WRAP services and help assist with high acuity clients that need extra care. Some Providers plan to create “agreed upon matches” to assist consumers to achieve & maintain productive & meaningful recovery.

The AMHD is interested in learning what specific outcomes and data gathering/tracking/reporting methodologies CBCM providers use or propose to use in order to best manage its CBCM services for the purposes of maximizing positive consumer outcomes. Respondents were asked to describe specific consumer outcomes and to identify, gather, track, and report these key consumer outcomes that would demonstrate the effectiveness of their CBCM services.

Respondents that currently provide CBCM for AMHD, utilize the Quality of Life Inventory (QOLI) to track data. Each QOLI is entered into their internal data base and the information is used for quarterly reporting to Quality Assurance Committees.

When asked to describe how their organizations relevant plans, policies and procedures could be used/enhanced to effectively manage consumers’ changing acuity/risk and to allocate CBCM resources effectively and efficiently, without increased demand on external resources such as emergency/crisis services and inpatient hospitalization, the respondents stated they do this through their risk assessments. Risk assessments are required for consumers in all levels of care. Case managers would meet with consumers to develop a crisis plan, which addresses prevention and intervention, and is updated every 6 months, prior to discharge from services and after every crisis event.

When asked how their organization defines what it considers to be appropriate case management services to be billed to AMHD, the respondents stated that they would utilize AMHD guidelines

for appropriate billing for consumers, follow evidenced-based best practices, and adhere to contract requirements.

The AMHD is concerned with the high rates of tobacco use within the mental health population. Respondents were asked to describe how their agency coordinates the identification of consumer tobacco use and/or tobacco exposure, referrals to community-based tobacco cessation resources, and the follow-up with consumers for tobacco cessation support. While not all respondents addressed these questions thoroughly, they responded as follows:

1. Consumer tobacco use is identified during the screening and admissions process.
2. Some respondents provide smoking cessation classes, sometimes in-house, and at other times, referrals are made to outside sources.
3. Some respondents stated that if funded, would make tobacco cessation a key component of education and make refers to tobacco cessation programs.
4. Some case managers perform follow-up with consumers on any referrals made.

When asked how their agency would provide language access to consumers who do not speak English as their primary language, respondents stated that they currently employ, or intend to employ, bilingual case managers to provide consumers with access to services and supports. Agencies shared that they have/would contract with other agencies for bilingual services they could not provide and/or would use Medicaid services. Agencies also stated that they are experienced with consumers who speak little to no English, offering alternative forms of communication including oral communication as opposed to written. One agency has program materials written at the fourth grade reading level. Additionally, an agency proposed interpreter services, where possible, be a shared cost between applicable insurers, available government agencies and providers.

When asked how their agency would support consumer's interest in Supported Education and Supported Employment, agencies reported an interest in these areas, but were concerned about how they would be supported by AMHD financially to provide such services. Some of the agencies partner and refer to State Vocational Rehabilitation Counselors to find supported/independent education/employment opportunities. Some consumers attend Clubhouses which have a pre-vocational and vocational component. Providers also mentioned accessing the State of Hawaii Workforce Development Division supportive employment services.

When asked to share how their agency would address cultural considerations for consumers, respondents indicated that:

1. They take cultural considerations quite seriously, and it often serves as a foundation for their services.
2. Respect for consumers, understanding of nuances and incorporating cultural values into program structure were mentioned.
3. Agency staff tend to be representative of communities and clients served.
4. Treatment planning identifies and incorporates the cultural values/preferences and natural supports available to consumers and their families/significant others.
5. Staff are trained on cultural sensitivity and will consult or contract to obtain training on cultural considerations. Cultural competency issues will be reviewed/processed regularly during both individual and group staff supervisions.

**Overall themes and barriers:**

1. 3½ hours of case management is not enough as a baseline number of units per month.
2. PSR services (individual or group) are not currently being provided by CBCM providers due to billing/funding and services are needed.
3. Supported education and supported employment will not be added to the current CBCM expectations without more funding.
4. Peer Specialists are an invaluable service to the array of CBCM services. Agencies need assistance in getting their units paid for.

**Suggestion:** AMHD needs to provide services similar to CCS, especially consumers that are forensically involved.

The AMHD appreciates the level of interest and the observations made regarding the RFI for the CBCM services. These observations and recommendations will be reviewed and taken into consideration when drafting the Scope of Service for the program. An RFP is planned to be issued for this program.