

Hawaii Department of Health
Adult Mental Health Division (AMHD)
Request for Information (RFI) Response Summary
RFI No. AMHD 420-5-20
Homeless Case Management Services
Statewide

A Request for Information (RFI) for Homeless Case Management Services was issued on May 13, 2020, to expand services to individuals with less severe mental illness. The AMHD received four responses from the community in response to this RFI. Below is a summary of the responses received through this process as they relate to the questions from the RFI.

1) Respondents were asked: How would you define individuals with less than severe mental illness? Or, how would you distinguish less than severe mental illness from severe mental health?

One respondent used the definition from the National Institute of Mental Health (NIMH) definition as “a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.” This would include anxiety, depression, stress, recent or past trauma, and all recognized mental illnesses ranging from no impairment to mild and moderate impairment.

Another respondent defined less than severe mental illness as experiencing signs and symptoms of mental illness but are at a level of duration, severity, and acuity as such that they do not qualify for existing AMHD case management or DHS CCS funded programs for individuals with severe mental illness.

Another respondent pointed out that the COVID 19 pandemic has caused a new population to recently appear that needs urgent help to prevent them from falling into permanent social isolation and poverty. This population would fall into the definition of less than severe mental health.

2) What recommendations can you make to AMHD about how best to assess and identify individuals with less than severe mental illness? Are there any special considerations that should be noted and included in the RFP?

Respondents recommended that the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition) could be used to establish severity of mental health disorders; and suggested the use of diagnostic tools such as the HAM-D (Hamilton Depression Rating Scale), PHQ-9 (Patient Health Questionnaire-9), C-SSRS (Columbia-Suicide Severity Rating Scale), and VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool).

It was also suggested that a “no wrong door approach” could be utilized where consumers

are routed to all clinical, social, and housing needs simultaneously.

3) How many individuals would you estimate you could serve in a one-month period? How often would you reach out to the individuals? What languages will the consent forms need to be in?

One respondent recommended a staff of seven case workers with an average of 25 clients per person, a caseload of 175 clients would be possible; engaged weekly or every other week, as needed; and consent forms provided in English, Chuukese, Visayan, Ilocano, and Tagalog.

Another responded that a caseload would be 20:1; contacts two times or more per month; and consent forms in English, or with translation from the Department of Human Services.

Another responded 200 or more could be served; at least once a month; with the payment structure within the contract to allow for increased contact as needed; and consent forms in English, Hawaiian, Japanese, Spanish, Korean, Portuguese, American Samoan, and traditional Chinese.

Another responded 150 or more could be served per month; or increased, if needed.

4) How would you provide transportation to assist eligible individuals?

Respondents agreed to link consumers to appropriate transportation services, either from agency staff, or community partners.

One respondent stated they would utilize their existing vehicle fleet, or by partnering with Hawaii County Economic Opportunity Council.

5) What are the anticipated staffing needs (e.g. number of staff, level of education/training, hours)?

One respondent stated seven case managers, a team leader, QMHP time for supervision, addictions counselor, a registered nurse, and APRN-Rx/MD. Staff would be a combination of college graduate staff, field experienced staff, and persons with lived experience in homelessness and recovery from mental illness and substance abuse. Work hours would be seven days a week with daytime hours, as well as nighttime, and holiday hours.

Another respondent felt that non-degreed case managers could be hired, if they were experienced and properly trained using evidenced based practices. It was also suggested that due to the high degree of medical comorbidity with the homeless population, a registered nurse be able to bill for going out and engaging clients with the case manager. This would enable the medical aspect of the treatment to be well-coordinated; which is particularly important due to COVID-19. And finally, having peer specialists on the team

was highly recommended.

A few respondents felt their current staff could handle providing all services needed. Another respondent suggested two to four full-time equivalent (FTE) case managers; one to two FTE Housing Navigators; one team leader; one deputy director; one clinical director; one director of operations; one HMIS (Homeless Management Information System) specialist; and one billing and budgeting specialist.

6) Based on your organization's experience with assisting individuals enroll in Medicaid, please provide AMHD with any suggestions or recommendations that may assist in developing a realistic and reasonable RFP.

One respondent stated all staff would be trained in SSI/SSDI (Supplemental Security Income/Social Security Disability Insurance), Outreach, Access, and Recovery (SOARS); but outside collaboration would be done for Medicaid/CHIP (Children's Health Insurance Program) enrollment assistance.

Two respondents requested the possibility to continue case management services for consumers who are dropped from their insurance after enrollment. One pointed out the importance of having case managers located all over the island to save resources, including time and community knowledge.

One respondent pointed out that case managers should understand the process of how to fast track a Medicaid application.

7) Are there new ideas or technologies that could improve services to AMHD beneficiaries, and if so, how would it be utilized?

One respondent pointed out the efficiency of the AMHD SharePoint, and its usefulness for submitting GPRA (Government Performance and Results Act) data.

Telehealth, video and phone groups was suggested as positive advances for providing services.

Another respondent suggested adequate psychiatry staff. Another suggested welcome baskets, beds, furniture, cooking, and cleaning supplies; move in costs, costs for repairs and maintenance, etc. would improve the trajectory of services to help participants get into housing and end their cycle of homelessness.

8) What kind of payment structure would maximize the number of individuals served and linked to services, particularly, health insurance enrollment?

A respondent recommended a flat monthly fee that covers the cost of the program that is offset by third party payers, so that AMHD becomes a residual payer. Incentive payments should be paid to reward efforts that result in health insurance being established or re-established for each client who is assigned. It was also suggested that if

AMHD incorporates a Medicaid billing component into this program, those funds offset the cost of the program from month to month. This would of course require providers to be impaneled with third party payers as many of the services are likely billable through the Medicaid program.

Fee-for-service was also recommended because capitation often results in less services delivered, and lower quality services.

9) What supports could AMHD offer providers to assist with the GPRA data collection requirements?

Several respondents suggested technical assistance from AMHD and to have the GPRA data submitted in a web-based, fillable form. One respondent stated using a program such as Excel would be more efficient, so data entry, collection, and upload could be in one step. It was noted that this would also reduce payroll costs.

One respondent stated staff training as a priority; tracking completion and communicating with case workers by flagging clients for follow up and tracking completion are important administrative tasks; as well as locating consumers. Supports from AMHD would be providing training in GPRA, and funding needed for administrative and data management activities. Offering incentive funds to consumers who follow through with the interviews was also highly recommended.

10) Would your organization be interested in providing the proposed services? What geographic location(s) would your organization be able to provide the proposed services?

All four respondents said they are interested in providing this service. Three offered to provide them all over Oahu, and one offered to provide services throughout the Honolulu area.

11) Do you anticipate any logistical challenges to be faced by an organization in attempting to provide these services?

One respondent said they would not anticipate any challenges. Another respondent stated they would need four weeks, and a 25% advance payment to defer the start-up costs.

One respondent stated inadequate participant/consumer income; individuals suffering from less than severe mental illnesses finding and securing housing will most probably be persistent obstacles.

The AMHD appreciates the feedback received from the community in response to this RFI. The constructive feedback and recommendations will be reviewed and taken into consideration when developing the scope for this expanded service. An RFP is planned to be issued for this service.