

## **Section 5**

### **Attachments**

- A. Proposal Application Checklist
- B. Sample Table of Contents
- C. Draft Special Conditions
- D. Consumer Rights
- E. Division P & P Regarding Consumer Grievances  
Division P & P Regarding Consumer Appeals
- F. QMHP and Supervision
- G. Division P & P Regarding Warm and Welcoming Approach
- H. Comprehensive Continuous, Integrated System of Care Model  
By Kenneth Minkoff, M.D.
- I. MI/SA Psychopharmacology Guidelines
- J. Level of Care Service Criteria
- K. Division P & P Regarding Continuity of Care (Transitions)
- L. Division P & P Regarding Recovery (Treatment) Planning
- M. Definitions for Case Management Specialist
- N. Certifications
- O. Form SPO-H-205A Instructions
- P. Questions and Answers to RFP 420-5-06

# **Attachment A**

## **Competitive POS Application Checklist**

## Proposal Application Checklist

Applicant: \_\_\_\_\_

RFP No.: HTH 420-1-07

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website References.\*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
<b>General:</b>				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	<b>X</b>	
Proposal Application Checklist	Section 1, RFP	Attachment A	<b>X</b>	
Table of Contents	Section 5, RFP	Section 5, RFP	<b>X</b>	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	<b>X</b>	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5	<b>X</b>	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206B	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206C	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206D	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206E	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206F	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206I	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206J	Section 3, RFP	SPO Website*	<b>X</b>	
<b>Certifications:</b>				
<b>Federal Certifications</b>		Section 5, RFP		
Debarment & Suspension		Section 5, RFP	<b>X</b>	
Drug Free Workplace		Section 5, RFP	<b>X</b>	
Lobbying		Section 5, RFP	<b>X</b>	
Program Fraud Civil Remedies Act		Section 5, RFP	<b>X</b>	
Environmental Tobacco Smoke		Section 5, RFP	<b>X</b>	
<b>Program Specific Requirements:</b>				

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

# **Attachment B**

## **Sample Table of Contents for the POS Proposal Application**

## Proposal Application Table of Contents

<b>I.</b>	<b>Program Overview.....</b>	<b>1</b>
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	A. Necessary Skills .....	2
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	C. Quality Assurance and Evaluation.....	5
	D. Coordination of Services.....	6
	E. Facilities.....	6
<b>III.</b>	<b>Project Organization and Staffing .....</b>	<b>7</b>
	A. Staffing.....	7
	1. Proposed Staffing.....	7
	2. Staff Qualifications .....	9
	B. Project Organization .....	10
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	2. Organization Chart (Program & Organization-wide) (See Attachments for Organization Charts)	
<b>IV.</b>	<b>Service Delivery.....</b>	<b>12</b>
<b>V.</b>	<b>Financial.....</b>	<b>20</b>
	See Attachments for Cost Proposal	
<b>VI.</b>	<b>Litigation.....</b>	<b>20</b>
<b>VII.</b>	<b>Attachments</b>	
	A. Cost Proposal	
	SPO-H-205 Proposal Budget	
	SPO-H-206A Budget Justification - Personnel: Salaries & Wages	
	SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits	
	SPO-H-206C Budget Justification - Travel: Interisland	
	SPO-H-206E Budget Justification - Contractual Services – Administrative	
	B. Other Financial Related Materials	
	Financial Audit for fiscal year ended June 30, 1996	
	C. Organization Chart	
	Program	
	Organization-wide	
	D. Performance and Output Measurement Tables	
	Table A	
	Table B	
	Table C	
	E. Program Specific Requirement	

# **Attachment C**

## **Draft Special Conditions**

## SPECIAL CONDITIONS

1. Time of Performance. The PROVIDER shall provide the services required under this Agreement from \_\_\_\_\_, to and including \_\_\_\_\_, unless this Agreement is extended or sooner terminated as hereinafter provided.
2. Option to Extend Agreement. Unless terminated, this Agreement may be extended by the STATE for specified periods of time not to exceed three (3) years or for not more than three (3) additional twelve (12) month periods, without resolicitation, upon mutual agreement and the execution of a supplemental agreement. This Agreement may be extended provided that the Agreement price shall remain the same or is adjusted per the Agreement Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.
3. Agreement Price Adjustment. The Agreement price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.
4. Audit Requirement. The PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit \_\_\_\_\_ attached hereto and made a part hereof. Failure to comply with the provisions of this paragraph may result in the withholding of payments to the PROVIDER.
5. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

# **Attachment D**

## **Consumer Rights**

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Rights

REFERENCE:

Number: 60.909

Effective Date: 10/29/04

History: New

Page: 1 of 7

APPROVED:

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Title: Chief, AMHD

### PURPOSE

To ensure that specified rights of each consumer are protected.

### POLICY

- A. Each provider shall have a statement designed to protect consumer's rights. The statement shall be:
  - 1. Consistent with Federal and State laws and regulations; and
  - 2. Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness.
- B. Each consumer shall have a consumer rights statement that complies with AMHD consumer rights requirements. The statement shall be:
  - 1. Signed and dated by the consumer prior to treatment; and
  - 2. Maintained in the treatment records of consumers.

### PROCEDURE

- A. The statement given to consumers must include at the minimum the following language:
  - 1. You have rights no matter what your situation is. Adult Mental Health Division (AMHD) and all its providers will uphold these rights. You have these rights regardless of your:

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- Age
  - Race
  - Sex
  - Religion
  - Culture
  - Amount of education
  - Lifestyle
  - Sexual orientation
  - National origin
  - Ability to communicate
  - Language spoken
  - Source of payment for services
  - Physical or mental disability
2. You have the right to be treated with respect and dignity, and to have your right to privacy respected.
  3. You have the right to know about the AMHD and the services available to you. You have the right to know who will provide the services you use, their training, and experience.
  4. You have the right to know as much information about your treatment and service choices as you need so you can give an informed consent or refuse treatment. This information must be told to you in a way you can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each.

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5. You have a right to information about your medications; up to and including your right not to take them, what they are, how to take them, and known side effects.
6. You have a right to be informed of continuing care following discharge from the hospital or outpatient services.
7. You have a right to look at and get an explanation of any bills for non-covered services, regardless of who pays.
8. You have a right to receive emergency services when you, as a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. Payment for emergency services will not be denied in cases when you go for emergency services.
9. You have a right to receive emergency services when traveling outside the State of Hawaii when something unusual prevents you from getting care from an AMHD provider.
10. You have a right to usually have the same provider when you get services.
11. You have a right to an honest discussion with your providers of the options for your treatment, regardless of cost and benefit coverage.
12. You have a right to be advised if a provider wants to include you in experimental care or treatment. You have the right to refuse to be included in such research projects.
13. You have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney or other directive to your providers.
14. You have a right to have any person who has legal responsibility make decisions for you regarding your mental health care. Any person with legal responsibility to make health care decisions for you will have the same rights as you would.
15. You have the right to know all your rights and responsibilities.
16. You have the right to get help from AMHD in understanding your services.
17. You are free to use your rights. Your services will not be changed and you will not be treated differently if you use your rights.

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18. You have the right to receive information and services in a timely way.
19. You have the right to be a part of all choices about your treatment. You have the right to have a copy of your written Individual Service Plan.
20. You have the right to disagree with your treatment or to ask for changes in your Individual Service Plan.
21. You have the right to ask for a different provider or case manager. If you want a different provider or case manager, we will work with you to find another one in the AMHD network. There is no guarantee that you will be provided a new case manager right away, however.
22. You have the right to refuse treatment or medication, or both, to the extent allowed by the law. You are responsible for your actions if you refuse treatment or if you do not follow your providers' advice.
23. You have the right to receive services that are responsive to your racial and ethnic culture including language, histories, traditions, beliefs, and values.
24. You have the right to an interpreter, if needed, to help you speak to AMHD or your providers. You have the right to have an interpreter in the room when your provider sees you.
25. You have the right to ask us to send you mail and call you at the address or telephone number of your choice, in order to protect your privacy. If we cannot honor your request, we will let you know why.
26. You have a right to a second opinion when deciding on treatment.
27. You have the right to expect that your information will be kept private according to the Privacy law.
28. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.

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29. You have the right to be free from being restrained or secluded unless a doctor or psychologist approves, and then only to protect you or others from harm. Seclusion and restraints can never be used to punish you or keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

If you have any questions or concerns about these rights, you can speak to the Rights Advisor at your Community Mental Health Center or call the AMHD Consumer Advisor at (808) 586-4688.

- B. Each consumer must be provided an orientation to the program at a level educationally appropriate for the consumer, communicated in either the consumer's native language or sign language, as is appropriate for the individual. Documentation of the orientation must be kept in the consumer's treatment record and signed and dated by the consumer. If a consumer who received the orientation refuses to sign the form acknowledging that he/she received information regarding his/her rights, the staff shall document on the form that the consumer refuses to sign and the date that the information was provided to the consumer. At a minimum such orientation must include:

1. An explanation of the:
  - a) Rights and responsibilities of the consumer,
  - b) Grievance and appeal procedures
  - c) Ways in which input is given regarding:
    - the quality of care
    - achievement of outcomes
    - satisfaction of the consumer
2. An explanation of the organization's:
  - a) Services and activities
  - b) Expectations
  - c) Hours of operation

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- d) Access to after-hour services
  - e) Code of ethics
  - f) Confidentiality policy
  - g) Requirements for follow-up for the mandated consumer served, regardless of his or her discharge outcome
3. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization
  4. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits
  5. The program's policies regarding:
    - a) Use of seclusion or restraint
    - b) Smoking
    - c) Illicit or licit drugs brought into the program
    - d) Weapons brought into the program
  6. Identification of the person responsible for case management
  7. A copy of the program rules to the consumer, that identifies the following:
    - a) Any restrictions the program may place on the consumer
    - b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer
    - c) Means by which the consumer may regain rights or privileges that have been restricted
  8. Education regarding advance directives, when legally applicable
  9. Identification of the purpose and process of the assessment

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10. A description of how the Individualized Service Plan (ISP) or other plan will be developed and the consumer's participation
11. Information regarding transition criteria and procedures
12. When applicable, an explanation of the organization's services and activities will include:
  - a) Expectations for consistent court appearances
  - b) Identification of therapeutic interventions, including:
    - Sanctions
    - Interventions
    - Incentives
    - Administrative discharge criteria

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]

# **Attachment E**

**Division P&P Regarding  
Consumer Grievances**

**Division P&P Regarding  
Consumer Appeals**

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Grievances

REFERENCE: Consumer Appeals, Consumer Rights,  
Recovery Guide

Number: 60.906

Effective Date: 10/26/04

History: New

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APPROVED:

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Title: Chief, AMHD

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### PURPOSE

To outline the internal process and procedure for reviewing and resolving consumer grievances or any expressions of dissatisfaction.

### POLICY

The grievance process is administered by Adult Mental Health Division's (AMHD) Office of Consumer Affairs.

A description of AMHD's grievance process is included in the Recovery Guide, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing a grievance.

### DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or grievances not acted upon within prescribed timeframes.
- Appeal – A request for review of an action made by AMHD, as “action” is defined. Consumer Appeals are discussed in a separate policy and procedure.

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- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.
- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as “action” is defined.
- Grievance Review – A review process for grievance resolutions. A consumer may request a “grievance review” by AMHD if they do not agree with a provider’s resolution of a grievance.
- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD’s or a provider’s operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

### PROCEDURE

1. Inquiry
  - A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider’s operations, activities, or behavior, or request to change to another provider.
  - B. If during the contact, the consumer expresses dissatisfaction of any kind, the inquiry becomes an expression of dissatisfaction and becomes a Grievance or Appeal (see Grievance and Appeal process below).
2. Grievance
  - A. Consumers may file a grievance to express any dissatisfaction in regards to the following:
    - AMHD or provider’s operations
    - AMHD or provider’s activities
    - AMHD or provider’s failure to respect the consumer’s rights

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- AMHD or provider's behavior
  - Provider or AMHD employee is rude
  - Provider quality of care
  - AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.
- B. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer, may file a grievance orally or in writing.
- (1) For oral filing of grievance, the consumer may call the Office of Consumer Affairs and a Consumer Specialist will assist the consumer in writing the grievance by completing an AMHD Consumer Grievance Form (see Attachment A), however, any AMHD staff may assist the consumer to complete the Grievance Form. The Consumer will be given an option to receive a copy of the written grievance. The form is forwarded to the individual responsible for tracking grievances within the Office of Consumer Affairs who is defined as the Grievance Coordinator.
  - (2) If a provider or an authorized representative on behalf of the consumer files the grievance orally, the consumer must give their written authorization.
  - (3) The Grievance Coordinator directs the grievance to the appropriate individual within AMHD for investigation and resolution of the grievance. That individual forwards the written results of their investigation and resolution to the Grievance Coordinator for data entry and tracking.
  - (4) All written grievances should be submitted to:

Adult Mental Health Division  
Office of Consumer Affairs  
Grievance Coordinator  
P.O. Box 3378  
Honolulu, Hawaii 96801-3378
  - (5) Within five (5) working days of the receipt date, the grievant will be informed by letter that the grievance has been received.

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- (6) Each grievance will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.
  - (7) AMHD will render a resolution of the grievance within thirty (30) calendar days of the receipt date. If the thirtieth (30<sup>th</sup>) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered the next working day. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievant has requested not to be identified, consumer identifying information will be left off other parties' letters.
  - (8) The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- C. The resolution letter includes and describes the following details:
- Nature of the grievance
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures.
  - A statement that AMHD's resolution of the grievance is final, unless the consumer requests an appeal by contacting the Office of Consumer Affairs.
- D. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests an extension or if additional information is needed. In this case, a letter will be sent to the grievant. The content of the notification will include the following details:
- Nature of the grievance
  - Reason for the extension of the decision and how the extension is in the consumer's interest

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### 3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. The appeal process is discussed in a separate policy and procedure.

### 4. Other Requirements

A. The AMHD Grievance Coordinator shall compile an aggregate quarterly grievance report and submit such report to the Quality Improvement Committee in the required format no later than forty-five (45) days from the end of each quarter.

The Aggregate Grievance Report shall at a minimum include the following elements:

- (1) Number of grievances sorted by date, nature of the grievance, county, and provider of services, if applicable;
- (2) Status of Resolution and if resolved, result including feedback, and
- (3) Turn-around times.

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- B. An Aggregate Annual Grievances Report shall be prepared and presented to the Quality Improvement Committee within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis by county, and recommendations for improvement of clinical and service areas.
- C. Privacy of the grievance records is maintained at all times, including the transmittal of medical records.
- D. All grievances and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of grievance.
- E. All grievances that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

**ATTACHMENTS**

Consumer Grievance Form

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]





## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Appeals

#### REFERENCE:

Plan for Community Mental Health Services IV, B, 1, a, i,  
Consumer Grievances, Denial Letter,  
Recovery Guide  
HRS 91

Number: 60.903

Effective Date: 05/01/03  
History: Rev. 10/04, 05/05

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APPROVED:

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Title: Chief, AMHD

### PURPOSE

To outline the process by which a consumer may appeal an action or decision made by Adult Mental Health Division (AMHD).

### POLICY

The consumer appeals process is administered by the Office of Consumer Affairs.

A description of AMHD's appeals process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing an appeal.

Medicaid eligible consumers also have the right to request a Fair Hearing for appeals related to Medicaid reimbursable services provided by AMHD. This process does not require a Medicaid eligible consumer to appeal to AMHD first.

### DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or appeals not acted upon within prescribed timeframes.
- Appeal – A request for review of an action made by AMHD, as “action” is defined.

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- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.
- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as “action” is defined.
- Grievance Review - A review process for grievance resolutions. A consumer may request a “grievance review” by AMHD if they do not agree with a provider’s resolution of a grievance.
- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD’s or a provider’s operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.
- Medicaid – A federal program administered by the Department of Human Services, Med-QUEST Division which provides medical coverage. Medicaid recipients can receive services from the Fee-for-service program or QUEST managed care health plans.

### PROCEDURE

1. Inquiry
  - A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider’s operations, activities, or behavior, or request to change to another provider.
  - B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance (see Grievance and Appeal process below).
2. Grievance
  - A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:
    - AMHD or provider’s operations
    - AMHD or provider’s activities

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- AMHD or provider failure to respect the consumer's rights
  - AMHD or provider's behavior
  - Provider or AMHD employee is rude
  - Provider quality of care
  - AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.
- B. The grievance process is administered by the Office of Consumer Affairs as delineated in the Consumer Grievances Policy and Procedures.
3. Appeals
- A. Consumers may file an appeal for the following actions or decisions made by AMHD:
- Prior authorization for a service is denied or limited
  - The reduction, suspension, or termination of a previously authorized service
  - The denial, in a whole or in part, of payment for a service
  - The denial of eligibility
  - Failure to provide services in a timely manner
  - Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
  - Not satisfied with resolution of grievance
- B. AMHD Utilization Management shall notify consumers about their appeal rights and processes at the time of denial of eligibility or service request. Consumers shall have access to consumer advocacy and AMHD shall assure that any consumer who requests an advocate for this process shall be linked to this assistance.

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### POLICY AND PROCEDURE MANUAL

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- C. Consumers who wish to appeal a decision regarding a Medicaid reimbursable service provided by AMHD and who are Medicaid recipients have the right to ask for a Fair Hearing from the Department of Human Services. These appeals do not have to go through the AMHD appeals process first. Medicaid recipients are directed to contact their Department of Human Services worker for information and assistance.
- D. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer with the consumer's written consent or if documentation is available to demonstrate the consumer is incapacitated, may file an appeal orally or in writing.
- E. For oral filing of appeal, the consumer (or consumer's representative with the written consent of the consumer or if documentation is available to demonstrate the consumer is incapacitated), may call the Office of Consumer Affairs and must also submit a follow-up written appeal.
- F. The designated case manager, or the designated crisis support manager, may appeal on behalf of the consumer without written consent if documentation is available to demonstrate the consumer is incapacitated. The case manager or crisis support manager shall provide specified clinical information to support the appeal request.
- G. An AMHD Consumer Appeal Form (see Attachment A) may also be completed on behalf of the consumer or consumer's representative. In this case, the completed Consumer Appeal Form will be sent to the consumer or the consumer's authorized representative if a written authorization has been received for review and signature.
- H. The consumer or the consumer's authorized representative must submit the follow-up written appeal or return the signed Consumer Appeal Form to the AMHD Office of Consumer Affairs which is designated as the AMHD Consumer Appeals Coordinator within one (1) week from the receipt date of the oral appeal. If the follow-up written appeal or the signed Consumer Appeal form is not received within the allotted timeframe, a follow-up call will be made to the consumer or the consumer's representative. If the consumer requests an extension for the filing deadline of the written appeal, AMHD will grant another one (1) week to submit the written appeal.
- I. If a written follow-up is not received, the appeal will be closed after thirty (30) calendar days without further action or investigation. The consumer will receive written notification of this.

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J. If a provider files a written appeal on behalf of a consumer, it will be initially designated as a Provider Complaint unless accompanied by the consumer's written consent. If the written appeal is filed with the consumer's written consent, AMHD will contact the provider to determine if consent was given. If the written consent is received, AMHD will transfer the Provider Complaint to a Consumer Appeal.

K. All written appeals should be submitted to:

Adult Mental Health Division  
Office of Consumer Affairs  
Consumer Appeal  
P.O. Box 3378  
Honolulu, Hawaii 96801-3378

#### 4. First Level Appeal

- A. The appeal must be filed within thirty (30) days from the date of the initial action or decision made by AMHD. Exceptions to this deadline may be granted if details regarding extenuating circumstances are provided. At no time will an appeal be considered that is 180 days from the date of the initial action or decision made by AMHD.
- B. Within five (5) working days of receipt of the written appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.
- C. The consumer or authorized representative of the consumer may request to examine the consumer's case file, including medical records and any other documents considered during or before the appeal process by contacting the AMHD Consumer Appeals Coordinator in accordance with federal and state privacy regulations.
- D. All appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.
- E. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal.
- F. The AMHD Medical Director shall review the denial and shall make a determination (overturning or ratifying the denial). The AMHD Medical Director has the option of obtaining a second physician opinion prior to rendering an appeal decision.

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- G. AMHD will render a resolution of the appeal within thirty (30) calendar days of the receipt date except in the case of an expedited appeal. If the thirtieth (30<sup>th</sup>) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the provider and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- H. The resolution letter includes and describes the following details:
- Nature of the appeal
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
  - Process for a second level appeal if appeal denied
- I. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests the extension or if additional information is needed. In this case, a letter will be sent to the consumer. The content of the notification will include the following details:
- Nature of the appeal
  - Reason for the extension of the decision and how the extension is in the best interest of the consumer
5. Expedited Appeals
- A. Any AMHD consumer (or provider acting on behalf of the consumer with the consumer's written authorization) may request an expedited appeal.
- B. An expedited appeal may be authorized if the standard review time frame of AMHD's appeal process may:
- Seriously jeopardize the life or health of the consumer

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- Seriously jeopardize the consumer's ability to access services with limited availability with a resulting loss of function
- C. All expedited appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AMHD's policies and procedures.
- D. The AMHD Medical Director will review all expedited appeals.
- E. A decision will be rendered within forty-eight (48) working hours of receipt of the request for an expedited appeal.
- F. The decision will be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.
- G. The resolution letter includes and describes the following details:
- Nature of the appeal
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
  - Process for a second level appeal if appeal denied
6. Second Level Appeal
- A. The consumer or appealing party may proceed with a written second level appeal within thirty (30) calendar days from the date of the first level appeal determination letter.
- B. The second level appeal letter along with any additional clinical information shall be sent to the AMHD Chief who shall obtain all relevant documentation from the AMHD UM Coordinator and the AMHD Medical Director. The second level appeal will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

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- C. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal by the AMHD Chief.
- D. Expedited appeals which result in an expedited second level appeal shall be reviewed and a decision rendered within forty-eight (48) working hours of receipt of the request for an expedited second level appeal if the request has been designated as such. The decision shall be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.
- E. Within five (5) working days of receipt of the written non-expedited second level appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.
- F. AMHD will render a resolution of the appeal for non-expedited appeal within thirty (30) calendar days of the receipt date except in the case of expedited appeal. If the thirtieth (30<sup>th</sup>) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the consumer and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- G. The resolution letter includes and describes the following details:
- Nature of the appeal
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
  - Statement concerning any other avenues of appeal, if any, available to the appellant.
- H. Consumers or their legal representatives who wish to appeal further must follow the Department of Health administrative appeals process, HR91f, or pursue through the legal system.

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7. Other Requirements

- A. The AMHD Consumer Appeals Coordinator shall compile a quarterly aggregate appeal report and submit such report to the AMHD Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

The aggregate Appeals Report shall include at a minimum include the following elements:

- (1) Number of appeals sorted by date, nature of the appeal, county level of appeal, and provider of services, if applicable,
  - (2) Number of decisions upheld,
  - (3) Number of decisions overturned, and
  - (4) Turn-around times.
- B. An aggregate Annual Appeals Report shall be prepared and presented to the AMHD Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis, and recommendations for improvement of clinical and service areas.
  - C. Privacy of the appeal records is maintained at all times, including the transmittal of medical records.
  - D. All appeals and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of appeal.
  - E. All appeals that concern provider organization actions and are proven quality of care matters or non-compliance with the terms and conditions of AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

**ATTACHMENT**

Consumer Appeal Form

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]

**Attachment A**

**Consumer Appeal Form**

Print Name of Consumer:	_____
AMHD ID#:	_____
Mailing Address:	_____
Island:	_____
Phone Number:	_____
Signature of Consumer:	_____ Date Signed: _____
<i>Note to Consumer: By signing this form, you as a consumer are authorizing your provider or any representative (if there's any) to file this appeal on your behalf.</i>	

<b>** Please fill out this section if a provider or a representative is filing the appeal on behalf of the consumer**</b>	
Print Name of Representative:	_____
Relationship to Consumer:	_____
Phone Number:	_____
Mailing Address:	_____
Signature of Representative:	_____ Date Signed: _____

Description of Service: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_



# **Attachment F**

## **QMHP AND SUPERVISION**

## **Definition and Role of the Qualified Mental Health Professional and Mental Health Professional**

### **Qualified Mental Health Professional (QMHP)**

A Qualified Mental Health Professional (“QMHP”) is defined as a Licensed Psychiatrist, Licensed Clinical Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Licensed Advanced Practice Registered Nurse (APRN) in behavioral health currently licensed in the State of Hawaii.

The QMHP shall oversee the development of each consumer’s treatment plan to ensure it meets the requirements stated in the Community Plan 2003 and sign each treatment plan.

The QMHP shall serve as a consultant to the treatment team.

The QMHP shall serve as the LOCUS expert.

The QMHP shall provide oversight and training.

The QMHP shall review and sign each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.

The QMHP shall provide clinical consultation and training to team leaders and/or direct care providers as needed.

Additionally, for Specialized Residential Treatment Programs, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

### **Mental Health Professional (MHP)**

Except for Assertive Community Treatment (“ACT”), the team leader is not required to be a QMHP. Non-QMHP team leaders shall be clinically supervised by a QMHP.

Non-QMHP team leaders are defined as Mental Health Professionals (“MHP”) and shall meet the following minimum requirements:

- Licensed Social Worker (LSW); or
- Master of Science in Nursing (MSN); or
- APRN in a non-behavioral health field; or
- Master’s degree from accredited school in behavioral health field
  - a) Counseling, or
  - b) Human Development, or
  - c) Marriage, or
  - d) Psychology, or
  - e) Psychosocial Rehabilitation, or
  - f) Criminal Justice.

- Master's degree in health related field with two (2) years experience in behavioral health; or
- Licensed Registered Nurse with two (2) years experience in behavioral health.

The MHP may supervise para-professional staff if the MHP is clinically supervised by a QMHP.

The MHP may function as the DIVISION Utilization Management Liaison.

**Supervision:**

Clinical supervision of all staff is ongoing and shall be sufficient to ensure quality services and improve staff clinical skills and is according to community standards, scope of license as applicable, and agency policies and procedures. Treatment team meetings are consumer focused whereas clinical supervision is staff focused. Therefore, treatment team meetings do not need to meet clinical supervision requirements.

One-on-one clinical supervision of MHP team leaders and direct care providers, if there is no MHP team leader, shall be performed by the QMHP at a minimum of once per month. If a MHP is the team leader, the MHP shall provide one-on-one monthly clinical supervision of non-MHP and non-QMHP staff.

The supervision shall be documented in writing, legible, signed and dated by the QMHP or MHP as directed by the provider agency's policies and procedures.

The DIVISION funded PROVIDER shall have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used.

The QMHP and non-QMHP staff does not have to work in the same physical setting but shall have routine meetings as defined in the PROVIDER's policies and procedures.

# **Attachment G**

## **Division P&P Regarding Warm and Welcoming Approach**

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Warm, Welcoming Approach

REFERENCE: Welcoming Section, CO-FIT100,  
Page 8-9

Number: 60.639

Effective Date: 05/13/05

History: New

Page: 1 of 4

APPROVED:

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Title: Chief, AMHD

### PURPOSE

To describe the process for providing a warm, welcoming approach and environment in all AMHD facilities/sites.

### POLICY

All Consumers seeking, or in treatment, with AMHD providers shall have face to face and telephone services which are provided in a warm, welcoming manner, whether or not there is a co-existence of a cross disability along with the mental illness. In such cases, integrated mental health and cross disability services and supports shall be provided according to community healthcare resources and clinically- and consumer-determined need(s).

### DEFINITIONS

#### 1. The Good Reception

- A place of welcome that gives the newcomer his/her first impression of the whole organization.
- The experience of reception and greeting tells you whether or not you matter to the people who are in charge of the facility/program.
- A well-presented Reception tells you that people are properly cared about here and confidentiality is respected.
- Users understand the need for security, but tend to become interested in the need for a sensitive reception.
- A culturally competent invitation to receive services including assistance for those where English is not a first language—use simple language.

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What do you look for at the entrance/the waiting room?

- The place [area] is clean and cared for.
- Magazines/newspapers are up-to-date and in tune with what people normally read. Information [is] available for various mental health disorders and recovery treatments. Group meetings are posted.
- The decor on walls is warm, mellow colors.
- Posters/artwork promotes Hope and Recovery.
- No Us/ [vs.] Them
  - Receptionists [are] friendly and unafraid
  - No screens/glass
  - No cold stares
  - Greeted equally with respect and dignity
  - Non-segregated restrooms
- A decent welcome sign—let the words be backed up by welcoming behavior.

### 2. The Good Building

- It's clean and cared for, its appearance reflects the caring attitude of the people who run it.
- Furniture is clean, good quality, comfortable and ergonomically correct.
- The décor on the walls reflect the beauty of our islands and its people.
- Rooms are available for privacy and conversation.
- All buildings shall provide for reasonable accommodations.
- Plants are present and well cared for.
- Smoking areas are designated away from the entrance of any building.

### 3. The Good Worker

- Listens
- Makes helpful suggestions
- They help carry the weight of decision-making
- They explain things to you
- They give practical help
- They act as an advocate for you, whether or not they agree with you
- They support hope and belief in unlimited potential
- Provide prompt, on time services:
- They offer choices

Further definitions for warm and welcoming shall be determined by a process of engaging consumer participation, establishing standards, implementing, evaluating and improving.

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The establishment of a warm, welcoming service provision shall be established through ongoing process improvement activities, which are systematized by establishing protocols and policies to support it.

### SUGGESTED GUIDELINES

1. Those individuals who are identified as consumers, family members and significant others of consumers shall be welcomed at every AMHD funded program and site. The welcome shall be documented in program brochures that describe services at the site or in any other way the program broadcasts its array of services. This includes ACCESS, AMHD office, Trotter office, AMHD website, Hawaii State Hospital, and Kahi Mohala.
2. All consumers shall be asked if they desire to have family and/or significant other involvement in their treatment.
3. All AMHD Providers shall have a Policy and Procedure regarding how the agency site will create, improve and sustain service delivery in this manner. The policy shall include how staff will [be] oriented and trained in the warm, welcoming approach. The policy shall determine outcomes, the monitoring methodology and the process utilized for performance improvement.
4. All AMHD Providers shall have clinician competencies as a written part of human resource policies that require welcoming attitudes, accepting values, and skills in conveying empathy and hope to consumers with mental health disorders and cross disabilities, and that these competencies need to be demonstrated in practice and by formal assessment. Phone etiquette shall be included as a competency and training held as required.
5. The MD shall discuss and collaborate with the consumer regarding medications and their side effects so that there is [an] informed choice. This discussion shall be documented in the chart each time a prescription is written.
6. Family members and consumers shall be involved in creative group processes whenever possible, i.e., outings, games, role playing, etc.
7. All AMHD Providers shall include as part of their admissions policy specific welcoming language for people with mental health disorders and cross disabilities.

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8. The welcoming response shall convey recognition of the necessity to address treatment of the cross disabilities simultaneously in order to effect the most successful and desirable treatment outcomes.
9. The consumer shall be the head of the treatment team and always present, if possible at Interdisciplinary Treatment Plan Reviews.
10. Appropriate plans and arrangements for the integrated treatment of mental health disorders and cross disabilities conditions shall be evident in clients' clinical records at the program site and available to consumers and carried out in a comprehensive and integrated manner.
11. Henceforward, language reflecting AMHD's commitment to the Continuous, Comprehensive, and Integrated System of Care (CCISC) model shall be incorporated into every AMHD RFP, contract, and extension.
12. Upon finalization of a warm, welcoming policy, all AMHD providers shall submit a copy of their policy to AMHD Performance Management department for approval.
13. All AMHD Providers shall work collaboratively with their consumers to define, design, implement, evaluate and improve the warm, welcoming initiative in each program.

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]

# **Attachment H**

**Comprehensive,  
Continuous, Integrated  
System of Care Model  
by Kenneth Minkoff, M.D.**

# Comprehensive, Continuous, Integrated System of Care Model

By Kenneth Minkoff, M.D.

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating individuals with co-occurring psychiatric and substance disorders (“ICOPSD”) with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.
2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high SA (Quadrant III), high MH – low SA (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High SA individuals are appropriate for receiving episodes of addiction treatment in the SA system, with varying degrees of integration of mental health capability.
3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.
4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a

variety of community based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting
6. *Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)
7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a “job”: to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.
8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in “harm” (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

# **Attachment I**

**MI/SA**

## **Psychopharmacology Guidelines**

**Psychopharmacology Practice Guidelines**  
(Minkoff, 1998; Sowers & Golden, 1999)

**For Adaption and Implementation by COSIG and AMHD MISA Program**

**A. Assessment**

1. Initial psychopharmacologic assessment in mental health settings should not require consumers to be abstinent.
2. Initial psychopharmacologic evaluation in substance disorder treatment should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medications during detoxification and early recovery.
3. Diagnostic assessment of individuals with co-occurring disorders is based ideally on obtaining an integrated, longitudinal, strength-based history, which incorporates a careful chronological description of the individual's functioning, including emphasis on onset, interactions, effects of treatment, and contributions to stability and relapse of both disorders at each point in time. Particular focus is on assessing either disorder during periods of time when the other type of disorder is relatively stable. Obtaining information from family members, previous treaters, and collateral caregivers is extremely important.
4. Diagnostic and treatment decisions regarding psychiatric illness are best made when the comorbid substance disorder is stabilized. Nonetheless, thorough assessment (as described above) usually provides reliable indications for initial diagnosis and psychopharmacologic treatment, even for individuals who are actively using. This is particularly true for individuals with SMI.
5. Diagnostic and treatment decisions regarding substance disorder (including psychopharmacologic decisions) are best made when the comorbid psychiatric disorder is at baseline. Nonetheless, thorough assessment usually provides reliable information about the course and severity of the substance disorder, even for individuals whose mental illness is destabilized.

**B. General Principles of Psychopharmacologic Treatment**

1. Psychopharmacology for people with co-occurring disorders is not an absolute science. It is best performed in the context of an ongoing, empathic, clinical relationship that emphasizes continuous re-evaluation of both diagnosis and medication, and artful utilization of medication strategies to promote better outcome of both disorders.
2. Psychopharmacologic providers need to have ready access to peer review or consultation regarding difficult patients.
3. Some initial evidence of improvements in addictive disorders has been associated with several classes of psychiatric medications (e.g., SSRIs, bupropion, atypical antipsychotics – especially, clozapine – and others). The prescriber may want to consider the potential impact on the substance use disorder when choosing a medication for the psychiatric disorder.

4. In general, psychopharmacologic interventions are designed to maximize outcome of two primary disorders, as follows:

- a. For diagnosed psychiatric illness, the individual receives the most clinically effective psychopharmacologic strategy available, regardless of the status of the comorbid substance disorder.
- b. For diagnosed substance disorder, appropriate psychopharmacologic strategies (e.g., disulfiram, naltrexone, methadone/buprenorphine/LAAM) may be used as ancillary treatments to support a comprehensive program of recovery, regardless of the presence of a comorbid psychiatric disorder (although taking into account the individual's cognitive capacity and disability).

5. In general, psychopharmacologic providers will prioritize the following tasks, in order:

- a. Establish medical and psychiatric safety in acute situations
  - 1) In acutely dangerous behavioral situations, utilize antipsychotics, benzodiazepines, and other sedatives, as necessary, in order to establish rapid behavioral control.
  - 2) In acute withdrawal situations requiring medical detoxification, use detoxification medications for addicted psychiatric patients according to the same protocols as used for patients with addiction only.
- b. Maintain stabilization of severe and/or established psychiatric illness.
  - 1) Provision of necessary non-addictive medication for treatment of psychotic illness and other known serious mental illness must be initiated or maintained regardless of continuing substance use. Administration of depot neuroleptics should not be withheld because of concurrent substance use. Further, ongoing substance use is not a contraindication to use of clozapine, olanzapine, risperidone, quetiapine, or other atypical neuroleptics. Improving psychotic or negative symptoms may promote substance recovery.
  - 2) In patients with active substance dependence, non-addictive medication for established less serious disorders (e.g., panic disorder) may be maintained, provided reasonable historical evidence for the value of the medicine is present.
- c. Use medication strategies to promote or establish sobriety.
  - 1) Utilizing medication (e.g., disulfiram, naltrexone) to help treat addiction should always be presented as an ancillary tool to complement a full recovery program. Communicate clearly that medication will not eliminate the need for the patient to actively work on developing recovery skills.

- 2) Psychotropic medications for comorbid psychiatric disorders should be clearly directed to the treatment of known or probable psychiatric disorders – not to medicate normally occurring and expectable painful feelings.
  - 3) Addicts in early recovery have a great deal of difficulty regulating medication; fixed dose regimes, not prn's, are recommended, except for regulation of psychotic symptoms.
  - 4) In clinical situations where the psychiatric diagnosis and/or the severity of the substance disorder may be unclear, psychotropic medication may be used to treat presumptive diagnoses as part of a strategy to facilitate engagement in treatment and the creation of contingency contracts to promote abstinence.
- d. Diagnose and treat less serious psychiatric disorders (e.g., affective, anxiety, trauma-related, attentional, and/or personality disorders that are not serious or disabling) that may emerge once sobriety is established.
- 1) Once a disorder and an efficacious treatment regime for that disorder have been established, it is recommended to maintain that treatment regime even if substance use recurs.
  - 2) In patients with **active** substance **dependence**, it is not recommended to initiate medication for newly diagnosed non-serious disorders while patients are actively using; it is usually impossible to make an accurate diagnosis and effectively monitor treatment.
  - 3) In patients with substance dependence in very early recovery, however, non-addictive medication for treatment of presumptive primary non-serious psychiatric disorders may be initiated, if there is reasonable indication that such a disorder might be present.
  - 4) It is **not recommended** to establish arbitrary sobriety time periods for initiation of medication. At times, it may be appropriate to initiate psychotropic medication for non-psychotic disorders in the latter stages of detoxification; at other times, it may be appropriate to wait a few weeks, or even longer. With the emergence of newer medications (e.g., SSRI's) with more benign side effect profiles, there is little evidence that prescription of these medications inhibits recovery from substance dependence, and some evidence that such medication may in fact promote successful abstinence.
  - 5) Prescribers need to carefully consider the risks of prescribing potentially addictive medications (Schedule II-IV substances; non-specific sedatives, such as antihistamines, etc.) beyond the detoxification period. Continuing prescription of these medications should generally be avoided for patients with known substance dependence (active or remitted). On the other hand, they should not be withheld for selected patients with well-established abstinence who demonstrate specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for individuals with diagnosed substance dependence is an indication for both (a) careful

discussion of risks and benefits with the patient (and, where indicated, the family) and (b) documentation of expert consultation or peer review with more experienced addiction prescribers if possible.

- 6) For patients with histories of addiction who present for treatment on already established regimes of addictive medication (e.g., benzodiazepines), prescribers should establish an initial treatment contract that connects continued prescription with continued abstinence. In the event of relapse, the prescriber can work with the patient over time to titrate gradual reduction of the benzodiazepine with continued opportunities to establish and maintain abstinence. If it becomes clear that abstinence cannot be maintained, then taper and discontinuation of the benzodiazepines is indicated. A recommended tapering strategy is to switch the patient to equivalent dosing of Phenobarbital, add carbamazepine at a therapeutic dose (valproate or gabapentin may also be used), and then taper the Phenobarbital over 7-10 days.

### C. Diagnosis-Specific Recommendations

1. **Schizophrenic Disorders:** Individuals with active comorbid substance disorder may benefit from addition of atypical neuroleptics. Initial studies indicate that clozapine, in particular, may have direct effect on reduction of substance abuse, in addition to improvement of substance reduction skills through reduction in positive and negative symptoms. (Albanese et al, 1994; Zimmet et al, 2000)

2. **Bipolar Disorders:** Many individuals with co-occurring substance use disorder appear to respond preferentially to second and third generation mood stabilizers, such as valproate and lamotrigine. This is likely to be more due to better efficacy with rapid cycling and atypical mood disorders, as well as broader efficacy with regard to impulsivity, anger, PTSD, and anxiety symptoms, rather than due to a direct effect on substance disorder. (Brady, 1995) Addition of second line mood stabilizers such as gabapentin and topiramate may also be useful. A significant population of individuals, however, will still respond best to lithium.

3. **Depressive Disorders:** No particular category of antidepressant is specifically recommended or contraindicated, although tricyclics are more difficult to use and more sedating. There is data that serotonergic medication may be helpful in certain addicted individuals, particularly those with early-onset alcoholism. Venlafaxine and nefazodone may have more anti-anxiety benefit than conventional SSRIs.

4. **Anxiety Disorders:** Recommendations on how to use benzodiazepines for individuals with addiction have been discussed in the previous section. Medication strategies for panic disorder are otherwise no different than for individuals without substance use disorders. For generalized anxiety, recommendations may include clonidine or guanfacine; venlafaxine, nefazodone, SSRIs, etc.; gabapentin, valproate, topiramate (PTSD symptoms especially); atypical neuroleptics. Buspirone can be effective, but it takes longer to work (months) in higher doses (over 60 mg usually) in individuals with histories of addiction and/or benzodiazepine use. (Tolfson et al)

5. **Attentional Disorders:** Bupropion is often recommended as the first medication in early sobriety (Wilens et al, 2001), proceeding to SSRIs and/or tricyclics. Ordinarily, sobriety should be well-established before initiation of stimulants. Data in both adolescents and adults clearly

support, however, the effectiveness of stimulants, when taken properly in individuals with clearly diagnosed ADHD, in improving outcome for both ADHD and substance disorder.

**Addictive Disorders:** Although medication strategies for treatment of addiction, including opiate maintenance therapy, have not been extensively studied in mentally ill populations, there is no evidence to indicate they are differentially effective in those populations compared to non-mentally ill populations. A few studies have demonstrated effectiveness of tightly monitored disulfiram in severely mentally ill alcoholics, when combined with other substance treatments. (Mueser et al, in press.) Naltrexone, acamprosate, etc. are all apparently effective in mentally ill populations when otherwise indicated. Use of these interventions should be restricted to motivated individuals participating in abstinence-oriented treatment, as an ancillary tool to support recovery. Within such populations, there is not yet clear data to determine who should be treated with psychopharmacologic interventions, and at what point in the treatment process.

# **Attachment J**

## **Level of Care Service Criteria**

**AMHD SERVICE STANDARDS: Targeted Case Management  
SERVICE COMPONENTS**

**COMMUNITY BASED CASE MANAGEMENT (CM)**

**Community-based case management services assists individuals to gain access to necessary medical, nursing social, restorative and rehabilitative services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services include, but are not limited to, maintenance of a supportive relationship to assist with problem solving and development of necessary skills to sustain recovery, regular contact for the purpose of assessing or reassessing needs for planning or monitoring services, contact with collaterals (family and agency) to mobilize services and provide support and education. Additional services include advocacy on behalf of the individual, coordination of services specified in the plan, such as medication management and rehabilitation services, and crisis intervention.**

**The goals of community based case management are:**

- 1. Assisting the consumer in developing recovery management relationships with multi-professional treatment team members that include but are not limited to peer-specialist, RN, case manager and psychiatrist or APRN.**
- 2. Promoting recovery, vocational and personal goals and sustaining hope during periods of relapse.**
- 3. Preventing, reducing or diminishing debilitating symptoms of mental illness and co-occurring substance abuse and medical conditions.**
- 4. Providing rehabilitation and progressive treatment interventions utilizing stages of change, stages of treatment, motivational strategies and stage-wise case management for multiple co-occurring conditions.**
- 5. Improving or establishing new linkages with a variety of community services and mobilizing the involvement of the consumer's support network.**
- 6. Ongoing engagement of the consumer in treatment through relapse and recovery.**
- 7. Promoting crisis prevention and planning, harm reduction, substance reduction, abstinence and recovery skill-building.**
- 8. Teaching symptom monitoring and management skills.**
- 9. Assisting the consumer in improving their responses to community living utilizing multi-professional team members to deliver recovery-oriented treatment in natural environments.**

<b>Level of Care</b>	LOCUS Level 2 or higher
<b>Population Focus</b>	Adults who are registered and eligible for Adult Mental Health Division services who meet the following criteria
<b>Initial Authorization</b>	UM TO DECIDE
<b>Re-Authorization</b>	UM TO DECIDE
<b>Admission Criteria</b>	Meets all of the following: <ol style="list-style-type: none"> <li>1. Consumer is capable of living in the community either in supportive or independent settings.</li> <li>2. Consumer is in need of advocacy, support or any AMHD authorized service.</li> </ol>

	<ol style="list-style-type: none"> <li>3. Moderate or less functional impairment as evidenced by at least one of the following: <ol style="list-style-type: none"> <li>a. Troubled significant relationships but impulsive or abusive behaviors are under control</li> <li>b. Appearance and hygiene are below usual standards on a frequent basis.</li> <li>c. Serious disturbances in vegetative activities but not serious threat to health.</li> <li>d. Neglect or avoidance on some occasions of ability to fulfill social or vocational responsibilities and obligations.</li> <li>e. Deficits in interpersonal relationships but able to engage in socially constructive activities.</li> <li>f. Recent stabilization has been achieved through structured and/or protected setting.</li> </ol> </li> <li>4. Either there is no co-morbidity or, if a medical or substance abuse problem exists, the problem may not adversely affect, or be adversely affected, by the presenting disorder to the extent that it may require medical monitoring.</li> <li>5. Consumer's environment may be moderately stressful with limited or few supports but more intensive intervention is not necessary in order for consumer to access needed services and supports.</li> </ol>
<b>Continued Stay Criteria</b>	<p>Meets all of the following:</p> <ol style="list-style-type: none"> <li>1. In order to maintain current community stability, requires this level of service at least 1 time per month, face-to-face contact with case manager.</li> <li>2. There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, increased environmental supports, and engagement to reasonably conclude that continued services at this level will further stabilize/increase consumer's functioning.</li> </ol>
<b>Discharge Criteria</b>	<p>Meets one of the following:</p> <ol style="list-style-type: none"> <li>1. Service no longer needed due to all of the following: <ol style="list-style-type: none"> <li>a. Functional stability has been maintained in the current community setting in the past 12 months.</li> <li>b. In order to maintain current community stability, requires less than 1 time per month face-to-face contact with a similar service.</li> </ol> </li> <li>2. Consumer is in inpatient facility with expectation of stay to exceed 360 days.</li> <li>3. Consumer is in specialized treatment service that incorporates case management services</li> <li>4. Consumer refuses case management services at this level.</li> </ol>
<b>Service Exclusions</b>	No other case management service would be appropriate while consumer is receiving this service.
<b>Clinical Exclusion</b>	None