

State of Hawaii
Department of Health
Adult Mental Health Division

Addendum 4

September 19, 2011

To

Request for Proposals

**RFP No. HTH 420-1-12
Community-Based Case Management – Recovery
Services Statewide**

**Proposal Deadline
September 30, 2011**

September 19, 2011

ADDENDUM NO. 4

To

REQUEST FOR PROPOSALS
Community-Based Case Management – Recovery Services Statewide
RFP No. HTH 420-1-12

The Department of Health, Adult Mental Health Division is issuing this addendum to RFP No. 420-1-12, Community-Based Case Management – Recovery Services Statewide for the purposes of:

- Responding to questions that arose at the orientation meeting of August 25, 2011 and written questions subsequently submitted in accordance with Section 1-V, of the RFP.
- Amending the RFP.
- Final Revised Proposals

The proposal submittal deadline:

- is amended to <new date>.
- is not amended.
- for Final Revised Proposals is <date>.

Attached is (are):

- A summary of the questions raised and responses for purposes of clarification of the RFP requirements.
- Amendments to the RFP.
- Details of the request for final revised proposals.

If you have any questions, contact:

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Responses to Written Questions Submitted by Applicants
For RFP No. HTH 420-1-12
Community-Based Case Management – Recovery Services Statewide

- 1. Question:**
What is the minimum score to be considered for a contract?

Answer:
There is no minimum score established to be considered for a contract.
- 2. Question:**
Why is BPSR (Biopsychosocial Rehabilitation) an optional service? What are the units? Caps?

Answer:
The availability of a BPSR billing code gives providers the option of providing relevant skill building sessions in a group training format, following the DIVISION's current utilization criteria and process.
- 3. Question:**
Is there a cap on services that case managers can provide?

Answer:
The DIVISION authorizes services based on its current utilization criteria and process.
- 4. Question:**
Will the DIVISION still be the responsible party to provide MRO (Medicaid Rehabilitation Option) services certification?

Answer:
Yes. The provider shall submit an application to the DIVISION within one (1) month of contract award to be certified as an MRO provider and the DIVISION shall issue the certification within six (6) months of the contract award. For additional information, please refer to page 2-10.
- 5. Question:**
What are the DIVISION's required screening tools and assessment tools referenced on page 2-16, #D?

Answer:
Examples of current DIVISION-required tools include several Trauma Informed Care Initiative (TIC IT) Screening Tools which will become available on the DIVISION's website. The DIVISION may add or subtract tools during the contract period for this service.
- 6. Question:**
Is there a cap on psychiatric services that are billed to Medicaid? Medicare?

Answer:

When billing to any third-party payors, providers shall follow the rules and regulations of those payers. Any limits on psychiatric services that providers bill to Medicaid/Medicare would be set by Medicaid/Medicare and not the DIVISION.

7. Question:

What is DIVISION's policy/protocol for discharge? Where can it be found in the RFP? How do we determine if a consumer is no longer eligible for CBCM-RS services?

Answer:

Discharge and transfer of consumers must follow the current DIVISION policy and protocol for discharge. Please refer to page 2-23.e. Discharge planning is part of each consumer's recovery plan, and should be developed at the time of admission into your program. Please refer to AMHD Policy and Procedure No. 60.638 on the Continuity of Care (Transitions), which is attached as Attachment M. It was not included in the RFP. To determine consumer eligibility, please refer to the DIVISION's Policy and Procedure No. 60.601, Eligibility, which is attached as Attachment N.

8. Question:

How frequently should the QMHP provide supervision to the case manager?

Answer:

At a minimum, providers shall follow all applicable DIVISION policies/directives, including the guideline listed in the DIVISION minimum qualifications attachment related to the case manager qualifications.

9. Question:

Are there specific units associated with family psychotherapy, group psychotherapy, therapeutic, prophylactic or diagnostic injection? Addendum 1 replaces CPT code 96372 (therapeutic injection) with 90862 (med. management). Is this intentional to drop injection reimbursement? On page 2-27 e. It states that the RN ratio should not exceed 1:150. Are they required to administer shots, if so, is it within the 14 unit cap? Therapeutic injections are sometimes given by RN/LPN specialties that are non-credentialed providers with third party payers; can the service be billed to the DIVISION?

Answer:

Please refer to the amended chart of service codes in Addendum 4, which includes codes for therapeutic injections and medication management. RN administered shots, if clinically required, would be included within the DIVISION's current utilization criteria and process. No, RN/LPNs do not have to be credentialed with third party payers, but they can still bill the administration of injections directly to the insurance, but not to the DIVISION.

10. Question:

On page 2-32, j.2) it states the provider shall ensure that all case managers and team leaders obtain, at a minimum, sixteen (16) hours of continuing education and training units each year. Is this requirement limited to certified continuing education units (CEU) or general education training?

Answer:

This requirement is not limited to certified CEU and is inclusive of agency and other trainings relevant to serving the target population.

11. Question:

On page 2-34, 2)c) it states the provider shall complete at least one (1) annual Continuous Quality Improvement (CQI) activity approved by the DIVISION and one (1) additional annual CQI activity per three hundred (300) consumers served during the preceding year, approved by the DIVISION.

- a. Is this activity different than the indicators (efficiency, effectiveness, access, satisfaction) & annual trends/reports that we already do? Or is AMHD asking for a specific CQI activity in addition to our regular QA duties?
- b. Please give an example of a CQI activity?

Answer:

- a. The CQI activity is different from the indicators, but may arise out of a provider's analysis of the indicators/trends.
- b. As an example, if data were to suggest that the consumers served have a high rate of crisis services (CBCM-RS services outside of scheduled hours, extra crisis units, and/or CMO services), the provider would drill down on that data using CQI tools, for example, by examining the elements that differentiate the consumers that use crisis services from those who do not. The provider might also map out the clinical processes involved.

Based on that drill down, the provider would develop interventions intended to lower the rate of crisis service use. Such interventions might include: changing timing of when and how frequently risk information is gathered, staff training, incorporating additional elements into supervision activities, development of a communication book or clinical alert system, or other activities.

The DIVISION would look for such activities that:

- Apply to either a significant portion of your DIVISION caseload or a significant portion of a DIVISION consumer cohort targeted for intervention,
- Apply to a specific clinical area rather than solely an administrative area (e.g. billing, funding),
- Is significant in that it creates a new process or significantly enhances an existing process,
- By the end of a year will have been implemented broadly as measured by implementation in consumer cases,
- By the end of a year is sustainable, and
- Utilizes a full PDCA/PDSA cycle.

The DIVISION will provide more detail in regards to CQI activities as part of contract orientation.

12. **Question:**
Because there are very limited numbers of psychiatrists and APRNs (Advanced Practice Registered Nurse) to make psycho-therapy groups possible, would AMHD allow MSW, MA, LSW, and LCSW to facilitate groups with regular supervision from psychiatrist/APRN?

Answer:

No. However, this does not prevent providers from utilizing different credentialed staff to conduct their psycho-therapy groups, which would be billed to private insurances.

13. **Question:**
Would AMHD allow the use of a modified Denver Acuity scale to fit the needs of our unique setting? Will you be providing clarification on the DIVISION's use and parameters of the very limited Denver scale, in relation to guidelines for level of service expected for the five (5) different levels of acuity?

Answer:

All providers must use the same version of the Denver Acuity scale or another DIVISION-approved tool. No, the DIVISION will not be providing clarification at this time. The DIVISION plans to gather data from providers on the use of the Denver Acuity Scale prior to developing and implementing guidelines for levels of service based on different levels of acuity.

14. **Question:**
On Page 2-30.c., How shall an agency "demonstrate" a shortage of qualified psychiatrist?

Answer:

An agency shall demonstrate a shortage of qualified psychiatrists by documenting their unsuccessful recruitment efforts, which would include advertised position announcements and communications with members of the psychiatry community, etc.

15. **Question:**
On page 2-3, F. Probable funding amounts, source, and period of availability.

- a. What is the total amount that the DIVISION has budgeted for CBCM POS services? For State FY 2012 (2011 – 2012) and FY 2013 (2012-2013)
- b. If CBCM POS services exceeds the budgeted amount, how does the DIVISION plan to address this?
- c. The Governor's office recently announced \$50 million in cuts from state budget over FY 12 and FY 13, which includes \$1.2 million in cuts for AMHD POS outpatient services. Do these budget cuts impact CBCM POS services?

Answer:

- a. The DIVISION carefully reviewed the budget allocated to this contract and wrote the scope of services to be within that budget.
- b. Applicants should submit a proposal that is within the budget requirements outlined in the RFP.

- c. There have been no decisions made regarding any possible affects of the FY2012 and FY2013 budgets on CBCM-RS services.

16. Question:
Are the RN shot services required, therefore inclusive with case management services?

Answer:
RN services billed to the DIVISION shall fall within the DIVISION's current utilization criteria and process.

17. Question:
Does "medication management" LOC (Level of Care) apply? If so, do these clients count within the 30:1 ratio?

Answer:
All assigned consumers count within the 30:1 ratio.

18. Question:
On page 2-14, there is no billing code for physical outreach. Do we assume all outreach is done by phone and billed under "collateral" service and there is no more physical outreach?

Answer:
No, outreach should not be billed under "collateral" contact. A collateral contact is made after the outreach has been completed, the consumer was admitted into your program, and the agency is communicating with other individuals on the consumer's behalf. Providers may do physical outreach, but this is no longer a service that the DIVISION reimburses.

19. Question:
Can a HCPS (Hawaii Certified Peer Specialist), who qualifies as a mental health worker (MHW) carry a caseload and still satisfy the HCPS requirement?

Answer:
No. An HCPS has a distinct role from a MHW/case manager and cannot perform both jobs simultaneously.

20. Question:
Should the QMHP (Qualified Mental Health Professional (QMHP) description still include "Locus Expert" as referenced in Attachment G, QMHP and Supervision?

Answer:
No, the "Locus Expert" shall be deleted from the roles and responsibility for a QMHP, please refer to the Attachment G, "Revised QMHP and Supervision."

21. Question:
Does the MHA (Mental Health Assistant) bill using the same codes (in general) as the MHW

(Mental Health Worker)?

Answer:

Yes.

22. Question:

On page 2-33, 4). Does this mean the provider must deliver services without utilization management authorization?

Answer:

This statement means that providers must avail themselves of all possibilities for obtaining an authorization, if services are clinically indicated.

23. Question:

Is the registered nurse (RN) assessments still required to be completed within seventy two (72) hours of initial contact?

Answer:

No. For teams required to have an RN, an RN assessment of medical needs is required to be completed within 30 days of admission and forms part of the Integrated Intake Assessment package.

24. Question:

Is the RN assessments still part of the intake assessment?

Answer:

Yes.

25. Question:

Please clarify the role of the RN as required on page 2-30.d.

Answer:

The roles of the RN is to perform duties described as described in Section 3 on page 2-19 of the RFP and as appropriate to the scope of his/her RN licensure.

26. Question:

Are AMHD's CMHC (Community Mental Health Centers) required to submit proposals in response to this RFP in order to provide such services?

Answer:

Only State Operated CMHC's are not required to submit a proposal in response to this RFP.

27. Question:

Is the LMHC (Licensed Mental Health Counselor) considered a QMHP (Qualified Mental Health Professional)?

Answer:
Yes.

- 28. Question:**
Can non-degreed case managers be a Q (Qualified Mental Health Professional) Is that acceptable?

Answer:
No, please refer to the QMHP minimum qualifications in Section 5, Attachment G.

- 29. Question:**
Is Psychosocial Rehabilitation (PSR) reimbursement limited under CBCM unit cap?

Answer:
Biopsychosocial Rehabilitation services is included within the DIVISION's current utilization criteria and process.

- 30. Question:**
Is accreditation required for Psychosocial Rehabilitation (PSR) since it's considered an MRO service?

Answer:
Yes, accreditation is required in order for the DIVISION to certify providers as MRO providers.

- 31. Question:**
Has the LOCUS, been replaced by the Denver Acuity Scale and if so why is the LOCUS still in the RFP under page 3-5 QM Policies and Procedures and in Attachment G, QMHP and Supervision.

Answer:
Yes, please refer to the revised definition and role of the QMHP in Attachment G, Revised QMHP and Supervision.

- 32. Question:**
Does the QMHP have to sign all assessments?

Answer:
Yes, the QMHP has to sign all assessments billed as 90801.

- 33. Question:**
If a provider is pending credentialing with third party payers, can the provider bill the DIVISION for psychiatrist codes until the credentialing is completed?

Answer:
No, psychiatrists are required to be credentialed with the third party payers before they provide

any services to consumers.

34. Question:

Will PI (Performance Improvement) be modifying their monitoring tool to reflect the new contract provisions (i.e. decrease in team meetings, supervision etc.)?

Answer:

Yes, the parts of the Performance Improvement monitoring tools that have their basis in contract provisions will be modified accordingly.

35. Question:

Is the RFP suggesting splitting the two (2) Peer Support Workers per team, suggesting four (4) positions per team? Can nineteen (19) hour part-time positions suffice?

Answer:

Yes, the Peer Support Worker position may be split into two part-time (19 or 20 hour per week) positions.

36. Question:

In the RFP Peer Specialists (MHA) are suggested to provide PSR groups, however, the program is also required to provide evidence based groups such as Seeking Safety, Illness Management and Recovery (IMR), are Peer Specialists considered trained to facilitate such groups?

Answer:

Peer Specialists may be qualified but not necessarily trained to provide such evidence-based groups upon hire. The basic training from the DIVISION will focus on basic peer supports and Wellness Recovery Action Planning.

37. Question:

Page 3-3 is missing Letter B or is it mis-labeled?

Answer:

Letter B was inadvertently omitted, and Addendum 1 addresses this omission.

38. Question:

Can an LPN be used on the CBCM team in the nurse role?

Answer:

No, an LPN cannot be used on the CBCM team in the RN role. However, an LPN may serve on the CBCM as a case manager.

39. Question:

Can the HCPS position remain cost reimbursement, verses transitioning it to fee-for-service in the near future? If the position does transition to fee-for-service, will the units used by the HCPS be expected to fall within the unit cap per consumer?

Answer:

No, the HCPS position cannot remain on a cost reimbursement basis. At this time, the DIVISION plans to keep the HCPS position outside the DIVISION's current policy and procedure for authorizations, but this may change during the tenure of the contract. The DIVISION reserves the right to change its policies and procedures for authorizations.

40. Question:

On page 2-26, c., it states that fees for the Psychiatrist and APRN should be billed directly to Medicaid. Do we know if these fees would be covered by QEXA (which should remain unchanged) or by the Quest Adult plan which will be changing (including several reductions in coverage) in early 2012?

Answer:

No, it's the provider's responsibility to determine third party payment arrangements and ensure that the DIVISION is the payor of last resort.

41. Question:

On page 2-28, under "Coordination" it talks about the team meeting as often as necessary to coordinate services for high acuity consumers. We need additional clarification on this. Does the whole team need to actually meet, or if it would be acceptable for the Team Leader and Psychiatrist to be available for case managers to coordinate services for those consumers?

Answer:

It is up to the provider to determine the appropriate team size and frequency of meetings necessary to coordinate services for all consumers, including high acuity consumers effectively.

42. Question:

Does the current fourteen (14) unit cap/month/consumer still apply for this new RFP or is the DIVISION asking providers to propose their own unit needs? There are no real specifics in the RFP, or any guidelines from the DIVISION in terms of expected levels of service for each acuity level. The only specific guideline given is that one (1) time per month is sufficient for those consumers who have demonstrated stability.

Answer:

No, the DIVISION is not asking providers to propose their own unit needs. Providers are required to follow the DIVISION's current utilization criteria and process.

43. Question:

Please provide more specifics regarding MHP supervision for MHWs.

Answer:

At a minimum, providers should follow all applicable DIVISION policies/directives including the guidelines listed in Section 5, Attachment I, the DIVISION minimum qualifications and supervision requirements for the MHW.

- 44. Question:**
Will case manager responding to crisis calls in collaboration with CMO involvement be able to bill for coordination provided such as arranging for transportation, de-escalation interventions, etc?
- Answer:**
This is an issue that needs to be resolved between the case manager and CMO responder because both providers cannot bill the DIVISION for services provided at the same time for the same consumer.
- 45. Question:**
In regards to recovery planning, a QMHP is required for the treatment meeting; would a MHP (team leader) be sufficient enough for signing off the initial recovery plan and six (6) month updates?
- Answer:**
No, a QMHP is required to sign recovery plans and updates.
- 46. Question:**
There are billing codes for “Trauma Informed Care Initiative”. What is the purpose of these codes? There is not a reference to the service in the RFP.
- Answer:**
The Trauma Informed Care Initiative (TIC IT) is a federal funding opportunity to transform the existing public mental health services into an improved system of care. All providers will be provided with an opportunity to be trained and reimbursed by the DIVISION to provide a one-time TIC IT screening/assessment service, which is in addition to the CBCM-RS. Additional billing codes were included in this RFP in the event that future funding opportunities will allow for other reimbursable activities.
- 47. Question:**
In regards to the TIC IT billing codes, once a consumer completes the TIC IT assessment and has been identified as “trauma”, do we use the TIC IT (SE) codes for all services to include case management and psychiatric services in place of the regular billing codes for all future services?
- Answer:**
No, once the TIC IT screening/assessment has been completed and a consumer has been identified as needing specific trauma treatment, the provider may request specific TIC IT-funded trauma services from the DIVISION, such as Seeking Safety, but shall continue to provide CBCM-RS services under its usual third-party payment arrangements.
- 48. Question:**
Can we submit questions on the RFP via email?
- Answer:**
No. Email inquiries are not part of this RFP procurement and will be deleted upon receipt. Inquiries may be made via telephone, facsimile, or by mail.

49. Question

Is it possible to increase the number of pages available for attachments and supporting documents? The RFP initially stated that there would be 200 pages to cover job descriptions, copies of MOUs, etc.

Answer

The DIVISION has received many requests from potential applicants, to increase/decrease the amount of pages to be required in this RFP. The DIVISION compromise was released in Addendum 2: 75 pages for the main text of the application; 175 pages for supporting documentation.

50. Question

What is the page limit for the body of the proposal and the entire proposal?

Answer:

The Proposal Application shall not exceed 75 pages of main text, not including appendices, attachments, identification form (and/or title page), required forms, and table of contents. Appendices, attachments, identification form (and/or title page), required forms, and table of contents shall not exceed 175 pages. Please refer to Addendum 2.

RFP No. HTH 420-1-12, Community-Based Case Management – Recovery Services, Statewide is amended as follows:

<i>Subsection</i>		<i>Page</i>	
Section 1, Administrative Overview			
No Changes			
Section 2, Service Specifications			
	III. Scope of Work A. Service Activities		
	1. Clinical Services:	2-18	Subparagraph 1.c.2)a) has been revised to read as follows: “1.c.2)a) The provider shall provide treatment in a manner consistent with the most current DIVISION Practice Philosophies and implement treatment models consistent with the Continuous, Comprehensive Integrated System of Care included in Section 5, Attachment E. Additionally, prescribing staff shall adhere to the AMHD Practice Guidelines and Psychopharmacology Practice Guidelines presented in Section 5, Attachment F.” Please refer to Attachment I.
		2-23	Subparagraph 1.e.1) has been revised to read as follows: “1.e.1) Discharges and transfers must follow the most current DIVISION policy or protocol for discharge. Please refer to the DIVISION’s Policy and Procedure No. 60.638, Continuity of Care (Transitions), to be included in Section 5, Attachment M.” Please refer to Attachment II.
	2. Services for coding and billing.	2-24- 2-26	Subparagraph 2.b. has been revised to read as follows: “2.b. The specific services to be procured under this agreement are limited to those in the following table.” Please refer to Attachment III, dated 09/19/11.
	B. Management Requirements 1. Program Operations	2-26	Subparagraphs 1.a.1)c) has been revised to read as follows: “1.a.1)c) Providers shall have the capacity for the Psychiatrist or APRN-RX to be able to see each assigned consumer once a month, for a minimum of fifteen (15) minutes of face-to-face contact. Providers may apply the capacity in a flexible manner to accommodate the changing clinical needs of consumers, but at no time should the capacity be less than the capacity cited in the sentence above.”

Section 3, Proposal Application Instructions		
	No Changes	
Section 4, Proposal Evaluation		
	No Changes	
Section 5, Attachments		
	Cover, Attachments Section	Section 5 Attachments Cover page was revised. Please refer to Attachment IV.
	Attachment G	Attachment G, QMHP and Supervision, has been replaced by Attachment G, Revised QMHP and Supervision. Please refer to Attachment V.
	Attachment N	Attachment N has been added, DIVISION Policy and Procedure, No. 60-601, Eligibility. Please refer to Attachment VI.

Attachment I

Revised
Attachment F
AMHD Practice
&
Psychopharmacology Practice
Guidelines

AMHD Practice Guidelines:

1. Employ a Recovery Perspective

- a. People with mental illness can and do overcome the barriers and obstacles that confront them.
- b. Recovery is a long term process which is self-directed by the consumer, who defines his or her life goals and designs a unique path towards these goals.
- c. The role of the worker is to facilitate and support the consumer in their recovery and encourage the consumer to participate in all decisions that would affect his or her life.

2. Consumer Engagement

- a. Engage the consumer in a warm, empathic manner.
- b. Include trained peer support, when appropriate.
- c. Partner with the consumer by attending to their strengths, needs, treatment preferences, experiences, and cultural background.

3. Cultural Competency

- a. In the building of a therapeutic alliance, recognize that culture (which includes gender, ethnicity, sexual orientation, religion, language, etc) plays a significant role in enhancing engagement. Engagement influences how comfortable consumers are with seeking help, who they seek help from, what types of help they seek, what coping styles and social supports they have. This influences how they view the problem and solutions, and how much stigma they attach to mental illness.

4. Service Provision

- a. Where available, services should be based on evidence based practices, best practices and recognized consensus panel recommendations
- b. Assessments should be timely and include a comprehensive and holistic approach.
- c. Treatment should be informed by the assessment and customized according to consumer preferences, needs, stage of change, and other factors, such as legal, spiritual, cultural, etc.
- d. Treatment is a team process. It is dynamic and constantly shifting. No one should feel solely responsible or isolated in the process. All members of the team interact and mutually collaborate in providing inter-disciplinary interventions for the benefit of the consumer.
- e. Individuals are inherently complex and multi-dimensional. Therefore treatment should be tailored to expect Co-Occurring Conditions (substance use, trauma etc). Understanding and support of influencing vital dimensions is necessary in providing effective intervention.
- f. Teams should identify and contact other providers currently or previously providing services to the consumer, and use that information to better inform the current plan.
- g. Treatment is not a linear progression (i.e., hospitalization to specialized residential to 24 hr. group home to supported housing). Rather, they are all options, which can be tailored to best "fit" the consumer's situation.

- h. Teams should include, whenever possible, the natural supports. Strengthening the consumers family and significant others may strengthen the consumers recovery.
- i. Teams should teach, implement, and monitor (in accordance with standard fidelity measures, if applicable) evidence based practice, best practices, and/or promising practices.
- j. Teams must consider and address safety concerns throughout treatment and ensure that pre-crisis interventions are documented and in place.

5. Continuity of Care

- a. Caseworkers must ensure proper follow through and not leave it up to the consumer or the “other system”. The key for the case worker is to stay involved in the process and to provide key information such as medication updates, what worked in the past, contact information, etc.
 - i. For example, with regard to crisis, did the consumer make it to the emergency room? If so, what was the disposition? Another example could be arranging for the consumer to attend a Clubhouse interview. What would the consumer need to attend the interview? Transportation? Bus instructions? Prompting on how to ask for services, etc.
- b. In referring to other programs, the caseworker must continue active involvement and function as an integral part of the team.
- c. Workers should obtain support and consultation whenever needed (who to ask? how to contact? who serves as back up? etc)

6. Documentation

- a. Documentation must be recovery focused by using person first language and avoiding generalizations that are judgmental (e.g., “non-compliant”, “resistant”). This language style tends to reinforce beliefs that the consumer needs to do what we want them to do rather than viewing ourselves as partners.
- b. Use descriptions that focus on conveying clinically useful information. For example, instead of the term “medication non-compliance”, consider descriptions such as, “Consumer often forgets to take their medication”, “Consumer does not use the medication because of uncomfortable side-effects”, etc.
- c. Documentation effectiveness can be enhanced when stages and stage appropriate interventions are utilized. (e.g. “Individual is pre-contemplative in acceptance of illness, however is in action stage in taking their meds. Therefore will work on increasing their understanding of the medications and proper administration.” In this case, they don’t necessarily have to accept that they have a mental illness to effectively take their medications.

7. Crisis

- a. The goal of crisis intervention is to decrease self-harm or dangerousness and movement toward self-regulation.
- b. The QMHP should be actively involved throughout the process by, a) being consulted during and at the resolution of the situation; b) reviewing and

approving the outcomes of the interventions; and c) ensuring appropriate debriefing to improve the process and support those involved.

- c. Documentation of consultations are an effective way of establishing community standards of practice and mediating risk.
- d. Documentation should include the nature of the crisis (e.g. crisis antecedents), the assessment of the risks, interventions used, and the rationale for final disposition (e.g., "Hospitalization was considered, however the consumer included his family in the intervention of which the family agreed to provide 24 hour supervision and will call Dr. K for assistance, if needed").
- e. The caseworker should ensure proper follow-up, which is documented and including in the consumers record (e.g., where is the consumer now? What can we do the next time to prevent a crisis? What can the consumer do?).

8. Co-Occurring Disorders

- a. Dual diagnosis is an expectation, not an exception
- b. 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.
- c. 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.
- d. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting
- e. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended
- f. 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
- g. 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.
- h. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.

9. Supervision

- a. Clinical supervision teams should routinely review cases.
- b. In addition to "as needed supervision", caseworkers should have access to timely, routine supervision, and opportunities for continued skill development.

- c. Supervisors should establish agreed upon competencies with each supervisee and routinely document supervision outcomes as part of the quality improvement process.

10. Psychopharmacology

Prescribing clinicians will adhere to the most recent version of the MISA Psychopharmacology Guidelines. (see attached)

Reference:

SAMHSA Treatment Improvement Protocol (TIP) 42 chapter five

CCISC Model: Dr. Kenneth Minkoff, 2001

Psychopharmacology Practice Guidelines (Minkoff, 1998; Sowers & Golden, 1999) Lettich 2006

Psychopharmacology Practice Guidelines For Individuals With Co-Occurring Substance Abuse (SA) And Serious Mental Illness (SMI)

Overview

The results of the most recent national household survey found that there are:

- 17 1/2 million people with serious mental illness (SMI) in the United States, or
- 8.3% of the population (SAMHSA, 2002). Of these:
 - 5 million or, 28.9% of the SMI, had used an illicit drug in the previous year
 - SMI use illicit drugs at more than twice the rate of non-SMI
 - Four million, or 22.2% of all SMI, had a substance use disorder
 - 11.1 were heavy alcohol users (compared to 8.1% of non-SMI)
 - Adults with nicotine dependence were 1.5 times as likely to have SMI
- Of people in the general population with a substance use disorder, 20.4% were SMI.

In Hawaii, the Adult Mental Health Division has found that approximately 53% of the population it has screened has experienced problems as a result of substance use.

The comorbidity of schizophrenia and SA is of particular concern. While relatively infrequent prior to 1960, there is now a 70-80% lifetime incidence of a substance use disorder in people with schizophrenia.

In summary, there is a high rate of comorbidity between SMI and SA.

General principles of treatment in a drug abusing, seriously mentally ill population:

Issues Related to Screening and Diagnosis

- 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 providers, and collateral caregivers is important.
- Initial psychopharmacologic assessment in mental health settings does not require consumers to be abstinent. It should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medications during detoxification and early recovery.
- Substance abusers will often deny their substance abuse problems and blame their symptoms on the mental illness. Bipolar disorder in particular may be over diagnosed in a substance abusing population due to the fact that mental status can appear to cycle as a result of intermittent substance abuse. For example, stimulant (cocaine and methamphetamine) abuse can mimic manic episodes, and the "crash" that occurs when a stimulant effect ends can mimic depression.
- Families often blame psychotic symptoms on substance abuse when none is present. Families may not want to accept that their relative has a chronic psychosis. Furthermore,

patients can be delusional about their substance use, reporting using drugs, or being drugged, when this has not occurred.

- Abuse of more than one substance is common.
- Because of the high rate of comorbidity, the evaluator should maintain concern and vigilance when working with an individual with SMI. Urine drug analysis (UDA) may be useful. UDAs are not used as an intrusive or punitive tool, but rather to develop psychotherapeutic intervention/approaches. Examples are:
 - As a tool for ongoing monitoring and feedback and use of motivational techniques to increase readiness for change
 - To encourage and/or reinforce reduction in use or abstinence (i.e. rewarding clean UDAs)
 - Tailoring the treatment approach
 - Diagnostic purposes which would impact on course of illness/treatment

Issues Related to Treatment

- Psychopharmacology alone is inferior to combined psychopharmacologic and psychosocial therapies.
- Motivational enhancement approaches have been shown to be more effective than confrontational or punitive approaches, and are preferred when combining psychotherapy with psychopharmacology.
- Abusers may attempt to abuse any medication including anti-psychotic, anti-anxiety, and anti-depressant medications. Thus, medication adherence is a significant issue during times of substance abuse.
- For diagnosed psychiatric illness, the individual should receive the most clinically effective psychopharmacologic strategy available, regardless of the status of the comorbid substance disorder.
- Substance abusers are less likely to adhere to antipsychotic regimens. Depot neuroleptic medications are used more often in the SA/SMI population, likely due to adherence issues. For patients who do adhere to antipsychotic medications, there is evidence that substance abuse is lessened.
- Treatment of the severely mentally ill with dependency producing drugs is risky, especially in the long-term. Whenever possible, it is best to avoid the use of:
 - Opioids and muscle relaxants for chronic pain
 - Stimulants for attention deficit disorder
 - Benzodiazepines for bipolar disorder or anxiety
 - Barbiturates for chronic headaches
- If an outside physician persists in prescribing dependency-producing drugs to your consumer with mental illness, consultation with an addiction specialist may help in negotiating with the outside physician. (See below for consultation resources)
- Any consideration or consumer attempts to reduce substance use or achieve/maintain abstinence should be encouraged. Illicit drug use should not be condoned or minimized.

Psychopharmacologic treatment principles:

1. **Acute intoxication:** in general, it is best to let the effects of the intoxicating drugs wear off rather than manage these effects with another drug. If the patient is behaviorally out of control, it may be necessary to send the patients to an emergency room for treatment.
2. Treatment of dependence for ***opioids, sedatives, alcohol, and stimulants*** requires ***detoxification***. Social detoxification is the treatment of choice for stimulants and may be satisfactory for the other classes of substances listed here. For significant levels of dependence however, detoxification can occur safely and comfortably using medication for sedative, alcohol, and opioid dependence if the proper structured environment is available. For high levels of sedative and alcohol dependence, withdrawal can be dangerous. A higher level of care other than outpatient (e.g. acute care, LCRS or partial hospital) may need to be considered. Consultation with an addiction specialist is recommended when evaluating for and performing medical detoxification.
3. A number of treatments are available to minimize and prevent substance abuse. Some treatment considerations are:
 - **Opioid Dependence:** The treatment of opioid dependence, either with detoxification or maintenance therapy, in the past has only been allowed by specially licensed treatment programs such as methadone maintenance clinics for outpatients. Now it is possible for any physician who holds a special narcotics license to use the new sublingual formulation of buprenorphine (Suboxone) to treat opioid dependence. Buprenorphine is a partial agonist with very high affinity for the mu opioid receptor. Because of its ceiling effect, it is relatively safe in overdose, and it can detoxify faster than methadone with milder withdrawal symptoms. The patient must be on the equivalent of 30 mg methadone or less, however, before taking it or it may cause withdrawal symptoms because it will replace the offending opioid on the mu receptor without stimulating it as much. The American Academy of Addiction Psychiatrists offers information about buprenorphine and an online course at: "<http://www.aaap.org/buprenorphine/buprenorphine.htm>"
The American Psychiatric Association also offers this information at:
http://www.psych.org/edu/bup_training.cfm
 - **Alcohol :** The medication most used with the SMI population is disulfiram (Antabuse). A retrospective review showed that treatment with 250 mg daily appears to be effective and well tolerated and associated with reasonable compliance. Reports of disulfiram induced psychosis exist and but they appear to be rare in the United States and are associated with high doses. The theoretical exacerbation of psychosis does not appear to occur. Naltrexone (Revia) maintenance is the other treatment for which there is evidence of effectiveness in the SMI population. There appears to be no evidence that the use of disulfiram and naltrexone together improves efficacy. At present, there is no evidence that acamprosate (Campral) is effective in the SMI population. This is understandable, since this drug is much more difficult to take, requiring three times per day dosing. However, side effects and interaction risks with other medications are minimal.
 - **Cocaine and amphetamine** (including methamphetamine) dependent patients are particularly problematic since use of these drugs typically exacerbates psychosis. Psychopharmacologic treatment of the schizophrenia or schizoaffective disorder is indicated along with psychosocial treatments for stimulant dependence. SAMHSA has published a curriculum titled, "Matrix Intensive Outpatient Treatment for People with

Stimulant Use Disorders”, specifically for treatment of stimulant abusers. Information for obtaining this can be found below.

- **Marijuana** use is associated with more mental illness than occurs in non-users. A study of 14-16 year-olds who smoked marijuana found that they were more likely to ultimately develop a psychotic disorder than controls. While there is no good evidence for a “cannabis psychosis,” people diagnosed with schizophrenia are at higher risk for psychotic episodes. Cannabis is also more associated with positive rather than negative symptoms of schizophrenia. Bipolar patients may be at risk for lengthier affective episodes and rapid cycling. On the web, there are testimonials that marijuana helps bipolar disorder, but the scientific evidence is the opposite.

For non-psychotic individuals, there may be the perception that marijuana is a benign drug. However, emergency room visits associated with marijuana abuse have been rising and this is thought to be related to the increased potency of marijuana in recent years (SAMHSA). There is no specific pharmacologic treatment for marijuana dependence.

- **Nicotine:** Treatment of nicotine dependence should be attempted. Discussion of treatment options and health consequences when done in an empathic and a non-coercive way often helps the therapeutic relationship because the patient can see that the doctor is really interested in his or her health and not in blaming him or her for using drugs. The new drug, varenicline (Chantix), appears to be more helpful than nicotine replacement therapy. It is a partial agonist at the nicotine receptor. In theory, it may offer cognitive benefits in schizophrenia, although this has not been tested.

Addiction psychiatry consultation may be obtained from:

- Jon Streltzer, M.D. 586-7427
- Louise Lettich, M.D. 266-9937
- David Friar, M.D. 233-3775

Selected references:

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Shi L, Ascher-Svanum H, Zhu B, Faries D, Montgomery W, Marder SR. Characteristics and use patterns of patients taking first-generation depot antipsychotics or oral antipsychotics for schizophrenia. *Psychiatr Serv.* 2007 Apr;58(4):482-8.

Westermeyer, J. Comorbid schizophrenia and substance abuse: a review of epidemiology and course. *American Journal on Addictions*;15:345-355, 2006.

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Resources:

Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders can be obtained at no cost from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. See links below for ordering or downloading:

Counselors Manual: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17441>

Family Handbook: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17442>

Client's Handbook: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17443>

Client's Treatment Companion:

<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17444>

Brief Counseling for Marijuana Dependence-A Manual for Treating Adults

<http://www.kap.samhsa.gov/products/brochures/pdfs/bmdc.pdf>

Attachment II

Attachment M

Policy & Procedure No. 60.638 Continuity of Care (Transitions)

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Continuity of Care (Transitions)

REFERENCE: American Association of Community Psychiatrists (AACP) Continuity of Care Guidelines; :
Plan for Community Mental Health Service IV,B,1,b

Number: 60.638

Effective Date: 10/26/04

History: New

Page: 1 of 4

APPROVED:


Title: Chief, AMHD

PURPOSE

To establish standards for the transition of care between levels of care and between providers of services.

POLICY

Adult Mental Health Division (AMHD) shall adopt the transition guidelines and outcome indicators established by the American Association of Community Psychiatrists (AACP) to assure that consumers who are moving between levels of care or between service providers are given adequate support and structure to assure a positive transition through the use of the following principles that are detailed in the AACP Continuity of Care Standards:

- Prioritization
- Comprehensiveness
- Coordination
- Continuity
- Service User Participation
- Support System Involvement
- Service User Choice
- Cultural Sensitivity

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- Prevention
- Resource Utilization
- Timing
- Designation of Responsibility
- Accountability
- Special Needs
 - o Addictions
 - o Geriatrics
 - o Forensics
 - o Child and Adolescence

DEFINITIONS

Transition:

The movement between levels of care or between providers of services. According to AACCP guidelines:

- “Transition implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change.
- Transition implies collaboration among providers, which is required for a successful progression through the continuum.”

Designated Case Manager:

The case manager who is designated as the primary person responsible for the development and updates of the Individualized Service Plans (ISPs).

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PROCEDURE

AMHD shall adhere to the following procedures:

1. The Level of Care for Utilization Systems (LOCUS) shall be the primary clinical tool used in determining when a change in level of care is needed. The designated case manager shall be responsible for the completion of the LOCUS.
2. Consumer involvement and choice shall guide the development of transition planning and provider selection. Transition planning shall include the consumer, the consumer's case manager, the consumer's support systems, and both the current and new provider(s).
3. The Individual Service Plan (ISP) shall incorporate transition planning and the new provider shall "incorporate relevant elements of any preexisting treatment plan" into the new ISP.
4. Transition plans that involve movement to a lower level of care shall include relapse prevention planning.
5. Transition planning shall detail specific timelines and responsibilities of all parties involved in the transition period.
6. The existing provider shall maintain responsibility for the service being provided to the consumer until the time that the consumer is adequately ready for transfer to another provider.
7. AMHD shall establish a payment schedule for transition services for the new provider at the beginning of the transition and for the old provider at the end of the transition.
8. Transition periods shall be limited and shall be based upon the individual needs of the consumer and not the convenience of any provider.
9. In cases where a consumer moves to a higher level of care due to safety or functional reasons and a transition period cannot occur, the previous provider and the new provider shall cooperate with the consumer's case manager in providing information and supports to assure a smooth transition to the higher level of care.

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10. The following services and conditions constitute Transitions and require the above detailed planning to occur:
- a. Between any level of Case Management or change in Case Management provider
 - b. Between Specialized Residential services and all other community services
 - c. Between levels of Housing
 - d. Between Day Services (Intensive Outpatient Hospital, Psychosocial Rehabilitation, Clubhouse, Day Treatment for Dual) or change in providers of these services
11. AMHD Quality Management (QM) shall include transition standards in their monitoring process based on the Outcome Indicators established by the AACP.

ATTACHMENT

AACP CONTINUITY OF CARE GUIDELINES

Date of Review: / / ; / / ; / / ; / /

Initials: [] [] [] []

AACP CONTINUITY OF CARE GUIDELINES

Best Practices for Managing Transitions Between Levels of Care

INTRODUCTION

Continuing engagement with treatment and recovery services is one of the most important aspects of addressing an episode of illness or ongoing disabilities associated with severe behavioral health problems. Interruption of care, for whatever reason, is among the most significant obstacles to establishing a stable recovery. It is in response to these circumstances that the AACP has prepared these guidelines to assist providers and planners in establishing standards for the management of transitions between levels of care.

A Progressive Conceptualization of the Service Continuum

With the development of LOCUS and CALOCUS, the AACP developed a structure of variable intensity service arrays that incorporate evolving concepts of "Levels of Care". In contrast to traditional concepts, overlapping and integrated levels of resource intensity are described, more conducive to providing true linkages between the phases of treatment for a given episode of illness. It is from this perspective that we have elaborated these guidelines for transition management.

Critique of Traditional Terminology

The traditional terminology of "discharge" planning is usually counterproductive in establishing continuity of care as it reinforces the notion of discreet, independent treatment programs operating in a fragmented system of care. Consequently, "discharge" terminology implies:

- Termination of service rather than a *transformation* of service variables and continuation of service in another setting.
- Recovery is sufficiently established and stable that services are no longer required.
- The *complete* termination of one provider's responsibility and the *equally complete* assumption of responsibility by another provider.

These concepts associated with discharge often lead to conflict between providers and the development of cracks in the service continuum through which many consumers readily fall.

Transition Rather Than Discharge

"Transition" planning better captures the concept of continuing care (not aftercare) throughout the episode of illness or service need.

- Transition implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change.
- Transition implies collaboration among providers, which is required for a successful progression through the continuum.

Although this concept of fully integrated service systems still remains idealistic in most cases, the articulation of this ideal is an important element in the reform process. In this document we will use the traditional terminology in parallel with the more progressive "transition" terminology described here, recognizing that reality and idealism must rub shoulders during the process of change.

Applications of the Guidelines

These guidelines are intended to be more than a simple statement of principles. Rather, they are intended to provide a quality management framework by which systems of any type can continuously monitor and improve their processes for managing client transitions. For this to occur, it is essential that these organizations not only endorse these principles in theory, but also create methods to measure their implementation in practice. With this thought in mind, a sample outcome indicator is attached to each of the principles elaborated in the guidelines. Indicators of this type, customized and quantified to reflect the specific circumstances of the organization developing them, would allow for the measurement of the adherence to these principles.

These guidelines, along with their companion documents for special populations, will continue to evolve. We hope that these guidelines will be useful in their present form to all elements of the service system.

- Governmental agencies and other purchasers can use them for developing standards for contracts.
- Regulatory agencies can use them in practice guidelines and standard development.
- Program managers and quality managers can use them for developing program standards and quality indicators.
- Clinicians can use them in elaborating transition plans.

Continuity of Care Guidelines for Behavioral Health Service Systems

The following are general principles for developing transition plans for persons using behavioral health services moving from one level of care to another. They offer a synopsis of elements common to this process regardless of the setting or the population that is being served. Specific needs and issues related to special populations are elaborated in a series of companion documents, which will only be summarized here. Continuity of Care Guidelines can only offer a framework to facilitate transitions and plans which incorporate them must be adapted for each individual. They may provide a template for developing standards regarding transitions in specific circumstances throughout a service system.

Implementation of any set of guidelines is subject to the availability of resources. Community resources should be conceived of as an array of services and mutual supports which will operate as a unified system of care. If community resources are limited, the transition plan should make the most effective use of the resources that are available and reflect the most important priorities for the patient in question. Realistic determinations should be made on a case-by-case basis. Ideally, transitions between levels of care will be based on clear criteria such as those contained in the AACAP's LOCUS or ASAM's PPC2. Only with an integrated, client driven, community based system of care will the ideal planning for level of care transitions be achieved.

Principles for Transition of Care Between Levels of Service

1. **Prioritization:** Transition or discharge planning should begin at the time of admission to any level of care and should be a part of the treatment plan. Identification of transition needs and the coordination of services required to meet them will be most urgent at the most intense levels of care.

Outcome Indicator: Treatment plans, assessments and progress documentation will demonstrate activities relevant to issues likely to be encountered in anticipated transitions in treatment setting or providers.

2. **Comprehensiveness:** Transition plans should include all aspects of an individual's service needs. These would typically include continuing treatment, supportive services such as case management or child care, residential stabilization, treatment of co-morbid health issues, realistic financial supports, and mutual support networking. In some cases interface with the legal system or child protection/family service agencies will be required.

Outcome Indicator: All aspects of a service user's needs, as identified in completed assessments, will be adequately addressed in the transition plan.

3. **Coordination:** Coordination of and collaboration between elements of the service system which are involved with the client on either side of the transition should occur as part of the treatment plan such that a sense of continuity is achieved while the transition evolves. Whenever possible, information regarding the most recent experience should be provided to the agency where the client will be continuing care. Appropriate incentives for providers are an essential consideration in efforts to achieve this objective.

Outcome Indicator: Significant communication and coordination between all involved service providers is evident through service user's experience and relevant documentation.

4. **Continuity:** Transitions, either upward or downward in the continuum of services, should incorporate relevant elements of any preexisting treatment plan. Treatment plans should be relevant to the entire course of an episode of illness/disability so that they can provide a degree of continuity in the context of change if properly elaborated and utilized.

Outcome Indicator: Treatment plans incorporate significant aspects of previous treatment plans and build on prior treatment initiatives.

5. **Service User Participation:** Extensive participation of the service user in the formulation of transition planning is critical to success. Efforts should be made to elicit the service user's perspective on the specific difficulties they anticipate in making the transition and their preferences for services, and to address these issues in the elaboration of the plan.

Outcome Indicator: Documentation of the service user's perspective on the transition and his or her preferences for services is available.

6. **Support System Involvement:** Client and family involvement in the elaboration of the discharge/transition plan is essential from the time of admission at any level of care. The degree of family involvement will generally be dictated by the client's and the family's willingness to engage in the process. Other persons providing support in the community should be included as well if a client indicates a desire for their participation.

Outcome Indicator: Significant members of the service user's support system are consulted in the formulation of the transition plan or an effort to obtain their participation is evident.

7. **Service User Choice:** Transition/Discharge plans must reflect reality and address client needs in the most practical way possible. This will require recognition of the phase of illness and/or recovery of the client for which services are being planned. In many cases, clients may choose to leave treatment early or they may have had marginal investment in the service they are departing from. Regardless of the circumstances of their departure or the likelihood of their continuing in treatment, a comprehensive plan should be elaborated in a manner that is as inclusive of client wishes as possible.

Outcome Indicator: Service users will be offered comprehensive attention to their transition needs even when their choices do not coincide the service provider's.

8. **Cultural Sensitivity:** Transitions should be managed in a culturally sensitive manner. Considering this in its broadest sense, an individual's beliefs, customs, and social context must be considered when making transitions upward (to more intensive levels of service) or downward (to less intensive levels of service).

Outcome Indicator: Cultural issues relevant to the transition of services are identified and adequately addressed in the transition plan.

9. **Prevention:** Discharge planning from highly structured settings to loosely structured settings should include comprehensive relapse prevention planning. Strategies to avoid re-initiating old, dysfunctional patterns of behavior should be identified, as well as available community supports and treatment programming. Financial supports should be arranged in such a manner as to avoid undue potential to misuse funds in detrimental ways.

Outcome Indicator: Factors contributing to exacerbation of illness or disability have been identified and transition plan has included attention to strategies to minimize their impact.

10. **Resource Utilization:** The transition/discharge plan should be designed to maximize the resources available to the client for continuing care. This includes efforts to secure benefits for which the client is eligible with the active participation of the client. Planning should foster self-reliance while recognizing that significant support may be required in the early stages of recovery.

Outcome Indicator: Resources necessary for the support of the service user in the transition environment are identified and arrangements have been completed to meet those needs.

11. **Timing:** Whenever possible, transitions should take place gradually, titrated according to an individual's ability to adapt to changing roles and expectations.

Outcome Indicator: Opportunities to experience transition situations partially prior to termination of referring entities involvement are available and used.

12. **Designation of Responsibility:** Systems should develop clear protocols delineating responsibility for care of clients in transition periods. In most cases responsibilities should incorporate redundancies between the referring and receiving entities. These concurrent responsibilities will be more likely to ensure a smooth transition and prevent some of the discontinuations commonly observed in systems that do not contain overlaps between levels of care. Reimbursement arrangements should incentivize processes that incorporate concurrent responsibilities where appropriate, for the following transition functions:

- Assuring the service user's awareness of location, time, and contact person for next scheduled treatment session.

- Assuring that the service user has access to prescribed medication and that a sufficient quantity is available to allow uninterrupted use between physician contacts.
- Assuring that the service user is aware of the person(s) to contact should there be any difficulties with either obtaining or using medication during the transition period or with any other aspects of required services.
- Assuring that the service user can identify contact persons for arranging alterations in the original discharge plan should such changes become necessary.
- Assuring that the service user is aware of the tracking plan and the process that will be initiated to re-engage him/her should unplanned alterations in the plan occur.

Outcome Indicator: Contacts during transition period are clearly identified and service user was well informed and able to use specified arrangements.

13. **Accountability:** A mechanism for monitoring outcomes of transition plans and identifying opportunities to improve the process should be in place.
- Appropriate quality indicators should be established with realistic benchmarks that can be easily measured.
 - A mechanism for establishing corrective action plans for systems unable to meet those expectations should be elaborated.
 - Documentation should clearly indicate that all responsibilities delineated above occur and that they do so within appropriate time frames.
 - Oversight of the quality management process should include all stakeholders in the system, including persons in recovery.
 - Standards established should be incorporated into contracts with Managed Care Organizations to assure proper incentives in reimbursement.

Outcome Indicator: A quality improvement process is in place and is comprehensive.

14. **Special Needs:** Recognition of the needs of special populations and their incorporation into the transition plan is an essential element of the process. Specific guidelines have been elaborated for each of the populations considered below. The following points regarding transition planning for these populations are brief summaries of some of the unique aspects of this process for these people.

Addictions:

- **Confrontation of disparities between a substance user's wishes and his/her needs to maintain abstinence are critical. The distinction between engagement and enabling is frequently a fine one, and transition efforts must attempt to maximize the former while attempting to minimize the latter.**
- **Recognizing that co-occurring psychiatric and medical problems are expected to be present in this population, transition plans should be particularly vigilant in assuring that identified needs are met.**
- **Plans should emphasize fluidity in the treatment continuum and acknowledge the continuing availability of services at any required level of care should the initial transition attempt be unsuccessful. Awareness of an individual's readiness for change will guide the types of transitions that might be recommended.**
- **Confidentiality is given particular emphasis in this population due to the stigma associated with it. Careful consideration must be given to the transfer of information between substance use treatment providers and must be done with the full consent and knowledge of the service user.**
- **Family members are often involved in the dynamic that contributes to the maintenance of addictions and therefore their participation in the transition plan and continuing treatment is a critical priority whenever it is possible.**
- **Mutual support programs, such as the twelve steps, have traditionally been an important component of the recovery process and have played a crucial role in relapse prevention plans. Transition plans should always attempt to acknowledge and incorporate the tradition of mutual support, while emphasizing the rationale for concurrent treatment.**

Geriatrics:

- **Involvement of the support system is an essential aspect of care. A primary caregiver should be identified and supported to the greatest extent possible by other service providers. Early establishment of this person as one who can make decisions in cases where the service user is unable to make informed choices is essential.**
- **The service user's participation in transition planning will vary according to cognitive capacities, but efforts must be made to assure that the elderly person is not assumed to have limited capacity when this is not so, and that their ability to make self-determined choices are maximized by clear communication and cognitively appropriate education.**
- **Interface with providers of physical health care is particularly important for the elderly. It must be established early and attention to these needs must be well integrated in the transition plan.**

- Assessment of needs in all spheres of function must be obtained in order to insure a comprehensive transition plan. Multi-agency cooperation and communication will often be necessary to meet multiple needs.
- Insurance status may be a significant issue for many elderly clients, particularly with regard to prescription medication, as Medicare does not currently have provisions to cover these expenses.

Forensic:

- Post release planning may be avoided altogether if efforts to divert persons with mental illness from incarceration are successful.
- Post release planning cannot occur if persons with mental illness and substance use problems are not identified and engaged in treatment during the period of their incarceration.
- Residential components of the plan will be of particular importance, particularly for those persons who are homeless. This part of the plan may well be the difference between recidivism and successful community adjustment, and liaisons with community based housing resources are essential.
- Establishment or resumption of health insurance benefits will be a critical element in the post release plan.
- Interface with probation and parole supervision is vital to reducing repetition of illegal behaviors in the future.
- Facilitation of transitions may be enhanced through opportunities for inmates to meet with community providers prior to release. This is more difficult in a highly secured setting, but developing this capacity can have significant benefits with regard to service use.

Child and Adolescent:

- Multi-agency involvement in the provision of C&A Services require mutual engagement throughout periods of treatment.
- Parental responsibility or guardianship/custody must be established as quickly as possible in the course of treatment, and those who will be responsible must be involved actively in the planning process. Extended family should be included as well, unless specifically prohibited.
- Developmental level and capabilities will determine the extent of the child's participation in the planning process, but efforts should be made to maximize their role.

- Families or other responsible parties will be responsible for engagement of the child with the receiving agencies, and it will be critical to address their concerns as well as allowing for opportunities for them to interface with community providers prior to transition.
- Integration of treatment needs and educational needs should be an important aspect of transition planning and schools and teachers must be part of the planning process.
- Transitions from adolescent to adult systems of care are particularly difficult and will require special vigilance and coordination to be successfully completed. Gradual, titrated transitions will usually be required.

Attachment III

Revised 9/19/11

AMHD Service	Billing Code	Unit	Rate
Intensive Case Management / Community Based Case Management, face-to-face contact	H2015	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, case assessment	H2015 - U1	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, treatment planning	H2015 - U2	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, collateral contact with no consumer contact	H2015 - U3	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, telephone consultation with consumer	H2015 - U5	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, telephone treatment planning with Hawaii State Hospital / Kahi Mohala	H2015 - HT	15 minutes	\$20.25
Psychosocial Rehabilitation	H2017	15 minutes	\$3.30
AMHD Licensed Psychiatrist Services	Billing Code	Unit	Rate
Initial Evaluation	90801	60 minutes	\$104.43
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	90804	30 minutes	\$46.62
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	90805	30 minutes	\$52.02
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	90806	50 minutes	\$75.00
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	90807	50 minutes	\$78.00
Family Psychotherapy (without the patient present)	90846	60 minutes	\$71.55
Family Psychotherapy (conjoint psychotherapy) (with patient present)	90847	60 minutes	\$82.73
Group Psychotherapy (multiple-family group)	90849	60 minutes	\$25.38
Group Psychotherapy (other than of a multiple-family group)	90853	60 minutes	\$27.20
Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	96372	n/a	\$13.87
Medication Management	90862	n/a	\$38.28

AMHD Licensed Advance Practice Registered Nurse in Behavioral Health Services	Billing Code	Unit	Rate
Initial Evaluation	90801	60 minutes	\$78.32
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	90804	30 minutes	\$34.97
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	90805	30 minutes	\$39.01
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	90806	50 minutes	\$56.25
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	90807	50 minutes	\$58.50
Family Psychotherapy (without the patient present)	90846	60 minutes	\$53.66
Family Psychotherapy (conjoint psychotherapy) (with patient present)	90847	60 minutes	\$62.05
Group Psychotherapy (multiple-family group)	90849	60 minutes	\$19.03
Group psychotherapy (other than of a multiple-family group)	90853	60 minutes	\$20.40
Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	96372	n/a	\$10.40
Medication Management	90862	n/a	\$28.71
Trauma Informed Care Initiative (TIC IT)			
Intensive Case Management / Community Based Case Management, face-to-face contact	H2015 SE	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, case assessment	H2015 SE - U1	15 minutes	\$20.25
Mental Health Assessment, by non-physician	H0031 SE	per session	\$162.00
Intensive Case Management / Community Based Case Management, treatment planning	H2015 SE - U2	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, collateral contact with no consumer contact	H2015 SE - U3	15 minutes	\$20.25
Intensive Case Management / Community Based Case Management, telephone consultation with consumer	H2015 SE - U5	15 minutes	\$20.25
Self-Help/Peer Specialist	H0038 SE	15 minutes	\$13.75
TIC IT Licensed Psychiatrist			
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30	90804 SE	30 minutes	\$46.62

minutes face-to-face with the patient			
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	90805 SE	30 minutes	\$52.02
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	90806 SE	50 minutes	\$75.00
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	90807 SE	50 minutes	\$78.00
Group Psychotherapy (other than of a multiple-family group)	90853 SE	60 minutes	\$27.20
TIC IT Licensed APRN-Rx			
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	90804 SE	30 minutes	\$34.97
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	90805 SE	30 minutes	\$39.01
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	90806 SE	50 minutes	\$56.25
Individual Psychotherapy Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	90807 SE	50 minutes	\$58.50
Group psychotherapy (other than of a multiple-family group)	90853 SE	60 minutes	\$20.40

Attachment IV

Revised Section 5

Attachments

- A. Revised Proposal Application Checklist
- B. Sample Table of Contents for the POS Proposal Application
- C. Draft of Special Conditions
- D. Denver Acuity Scale
- E. Comprehensive Continuous, Integrated System of Care Model by Kenneth Minkoff, M.D.
- F. Revised AMHD Practice and Psychopharmacology Practice Guidelines
- G. Revised QMHP and Supervision
- H. Mental Health Professional
- I. Mental Health Worker
- J. Mental Health Assistant
- K. Certifications
- L. Form SPO-H-205A Instructions
- M. Policy & Procedure No. 60.638, Continuity of Care (Transitions)
- N. Policy and Procedure No. 60-601, Eligibility

Attachment V

Attachment G

Revised QMHP and Supervision

Definition and Role of the Qualified Mental Health Professional

The requirements established below are **minimum requirements** that the Department of Health Adult Mental Health Division (“AMHD”) has set for this position. Individual services may have additional academic or experience requirements depending on the intensity of the service. Any additional service specific requirements beyond these minimum requirements will be stated in the Request for Proposal and/or in the contract.

Definition / Role and Activities:

The Qualified Mental Health Professional (“QMHP”) in the AMHD service delivery system is the individual generally responsible for clinical oversight and development of the service. A QMHP may provide a wide range of service and support including, but not limited to the following:

- Oversees the development of each consumer’s treatment plan to ensure it meets the requirements stated of applicable funding streams and sign each treatment plan.
- Serves as a consultant to the treatment team.
- Provides oversight and training.
- Reviews and signs each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.
- Provides clinical supervision.
- Provides therapy.
- Provides clinical consultation and training to team leaders and/or direct care providers as needed.

Additionally, for Specialized Treatment Programs such as Intensive Out-Patient Hospital and Specialized Residential Services, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

QMHP Minimum Requirements:

A QMHP is required to have an advanced degree and is licensed to practice in Hawaii as a:

- Licensed Psychiatrist,
- Licensed Psychologist (“Ph.D.” or “Psy.D.”),
- Licensed Clinical Social Worker (“LCSW”),
- Licensed Mental Health Counselor (“LMHC”)
- Licensed Marriage and Family Therapist (“LMFT”), or
- Licensed Advanced Practice Registered Nurse (“APRN” or “APRN-Rx”) in behavioral health currently licensed in the State of Hawaii.

Attachment VI

Attachment N

Policy and Procedure No. 60-601 Eligibility

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Eligibility

REFERENCE: AMHD Level of Care Criteria

Number: 60.601

Effective Date: 07/03/93

History: Rev. 9/93, 9/95, 7/98, 11/98,
5/04, 7/09

Page: 1 of 8

APPROVED:



Title: Acting Chief, AMHD

PURPOSE

The purpose of this Policy and Procedure is to establish the criteria used to determine an individual's eligibility to receive services funded by the Adult Mental Health Division (AMHD).

POLICY

The AMHD determines the eligibility of an individual requesting service based on the criteria described in this Policy and Procedure. The three (3) categories of services available for individuals determined to be eligible to receive AMHD services are:

- **CATEGORY I: CONTINUING SERVICES**
- **CATEGORY II: TIME LIMITED SERVICES**
- **CATEGORY III: DISASTER SERVICES**

The AMHD is the safety-net provider and the payer of last resort for individuals who do not have access to other available services and resources. Individuals who have access to other mental health services will be assisted to access and use them. Eligibility for enrollment as a consumer of AMHD does not guarantee any specific service provision. Eligibility for specific services is based on an individual's need which must meet medical necessity criteria and contractual scope of service standards, as appropriate, as determined by AMHD Utilization Management (UM). All services shall be subject to availability of resources.

Eligibility criteria for the categories of AMHD services are described below:

Category I: Continuing Services

AMHD continuing services are designed to provide safety-net supports for individuals who meet these criteria. The population focus is on individuals with a qualifying severe and persistent mental illness with accompanying severe functional impairment who do not have access to other

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appropriate mental health services. The population served includes individuals who have been diagnosed with a severe and persistent mental illness, who have co-occurring mental and substance use disorders, and those who are legally encumbered.

A. Eligibility Criteria for Consumers Who Participate Voluntarily In Services: To be eligible for AMHD services under Category I.A, the individual must meet the following criteria:

1. **Age:** Eighteen (18) years or older;
2. **Eligibility Assessment:** Has participated in an AMHD approved clinical eligibility assessment sufficient to establish an eligible diagnosis of severe and persistent mental illness and severe functional impairment;
3. **Eligible Diagnosis:** The individual must be assessed as having one (1) of the following qualifying diagnoses, as found in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders:
 - a. 295.xx Schizophrenia
 - i. 295.10 Disorganized Type
 - ii. 295.20 Catatonic Type
 - iii. 295.30 Paranoid Type
 - iv. 295.60 Residual Type
 - v. 295.90 Undifferentiated Type
 - b. 295.70 Schizoaffective Disorder
 - c. 296.24 Major Depression, Single Episode Severe, with Psychotic Features
 - d. 296.33 Major Depression, Recurrent Type, Severe without Psychotic Features
 - e. 296.34 Major Depression, Recurrent Type, Severe with Psychotic Features
 - f. 296.xx Bipolar Disorder
 - i. 296.0x Single Manic Episode
 - ii. 296.4x Most Recent Episode Manic
 - iii. 296.5x Most Recent Episode Depressed
 - iv. 296.6x Most Recent Episode Mixed
 - v. 296.7 Most Recent Episode Unspecified
 - g. 296.89 Bipolar II Disorder
 - h. 297.1 Delusional Disorder;
4. **Duration:** The individual must have demonstrated the presence of the disorder for the last 12 months, or is expected to demonstrate the disorder for the next 12 months;

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5. **Functional Impairment:** The individual must demonstrate functional impairment that seriously limits their ability to function independently in an appropriate and effective manner. This impairment is documented by an assigned Global Assessment of Functioning (GAF) score of 50 or lower at the time of the eligibility assessment. The factors which were considered in determining the GAF are documented in the eligibility assessment;
6. **Insurance Coverage:** AMHD services are intended for individuals with no available means of obtaining mental health care. Individuals who are determined to have access to mental health services through other means will be referred to those resources and will not receive AMHD services;
7. **Means and Assets:** AMHD is the safety-net provider of mental health services and as such will determine if an individual requesting services possesses the means or assets to obtain services privately. If it is determined that an individual has the resources to obtain mental health services by other means, the individual will be referred to those resources and will not receive AMHD services; and
8. **Residency Status:** The individual must live in Hawaii and be a citizen of or have permanent resident status in the United States of America.

Individuals with a co-occurring substance use disorder will be deemed eligible for AMHD funded services if the other criteria for eligibility under this policy are met.

Individuals with a diagnosis of Mild Mental Retardation (DSM 317) will be deemed eligible for AMHD funded services if the other criteria for eligibility under this policy are met. Other developmental disability and/or mental retardation diagnoses are not eligible for AMHD funded services.

- B. **Eligibility Criteria for Adults Detained or Committed Criminal State Courts:** To be eligible for AMHD services under Category I.B, the individual must meet the following criteria: Individuals, age eighteen (18) or older, who are detained by Hawaii Courts for forensic examination, or committed to certain psychiatric facilities under the care and custody of the Department of Health Director for appropriate placement. Courts include the Family Courts, District Courts, and Circuit Courts. Detention may be for evaluation and commitment as part of criminal court proceedings.
- C. **Eligibility for Adults Placed on Conditional Release or Released on Conditions:** To be eligible for AMHD services under Category I.C, the individual must meet the following criteria: Individuals placed on Conditional Release or Released on Conditions by a judge in Hawaii Courts.

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- D. Eligibility for Adults Placed in Mental Health Court or Jail Diversion:** To be eligible for AMHD services under Category I.D, an individual is considered eligible for AMHD services if he or she is involved in Mental Health Court or a Jail Diversion program.

Category II: Time Limited Services

AMHD Time Limited Services are intensive and focused services designed to assess, stabilize and provide linkage to treatment and other community supports, as appropriate. Time Limited Services are intended for individuals in Mental Health Crisis or Situational Crisis and not already qualified under Category I.

The population focus for this level of service includes individuals in need of emergent (within 24 hours) or urgent (within 24-72 hours) intervention who are: (1) exhibiting symptoms of a mental health crisis, or (2) individuals suspected of having a primary mental illness with an associated situational crisis such loss of residence or arrest.

A. Eligibility Criteria for Mental Health Crisis:

1. **Age:** Eighteen (18) years or older;
2. **Eligibility Assessment:** A brief telephone or face-to-face screening assessment to determine immediacy of needs is necessary;
3. **Diagnosis:** Exhibiting symptoms of significant psychological or behavioral distress;
4. **Duration:** No durational requirement; and
5. **Functional Level:** Significant degree of functional impairment in the areas of self protection, impulse control, or social judgment, and/or high risk of harm to self or others.

B. Eligibility Criteria for Situational Crisis:

1. **Age:** Eighteen (18) years or older;
2. **Eligibility Assessment:** A brief telephone or face-to-face screening assessment to determine immediacy of needs is necessary;
3. **Diagnosis:** Suspected of having primary mental illness and exhibiting symptoms of significant clinical distress;

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4. **Duration:** No durational requirement; and
5. **Functional Level:** Some degree of functional impairment expected to worsen because of the situation.

Category III: Disaster Services

AMHD Disaster Services may include post-trauma counseling, debriefing or education intended to relieve or minimize the development of psychological distress or dysfunction in persons who have experienced stress from a disaster.

A disaster is an event that has been officially declared by the State of Hawaii or the United States, or the AMHD Chief has received and approved a request for disaster services from legitimate community leadership such as a school administrator, state or county official, or religious, social or business organization.

The population focus is adults who have experienced a disaster. They are identified as part of a community or social system which has recently undergone an event of significant community impact that is outside the range of usual human experience and that would be markedly distressing to almost anyone, provoking, or expected to provoke intense fear, terror, or helplessness such as serious threat to life or physical integrity, or sudden destruction of home or community infrastructure.

Individuals who meet these criteria include direct or indirect victims of one or more of the following:

1. Hurricane, flood, or other storm or weather related disaster;
2. Volcanic eruption, earthquake, landslide, or tsunami;
3. Forest, brush, or other wildfire;
4. Toxic or radioactive contamination, biohazard, bioterrorism, epidemic, other environmental or public health disaster;
5. Building fire, or structural collapse;
6. Shipwreck, airline crash, or other mass transportation disaster;
7. Kidnapping, hostage taking, multiple homicide, or terrorism;

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8. Major business failure or economic collapse.

Eligibility Criteria for Persons after Disasters:

1. Age: Eighteen (18) year or older;
2. Eligibility Assessment: A screening has been completed and indicates that the individual is a member of the identified and designated community or social system;
3. Diagnosis: No mental health diagnosis is required, only the presence or risk of significant distress or dysfunction;
4. Duration: Individuals will be eligible for services for up to 60 days after initiation of those services; and
5. Functional Impairment: Not required.

PROCEDURE TO ACCESS CATEGORIES I, II & III

A. To Access Category I – Continuing AMHD Funded Services:

1. Eligibility assessments are scheduled through AMHD ACCESS Line. The Policy and Procedure for Eligibility Assessment is detailed in a separate policy.
2. Individuals have the right to appeal denial of eligibility and use the existing AMHD UM Appeals Process.
3. The AMHD Chief, or designee, has the ability to administratively determine eligibility. AMHD UM is notified of these cases, either through the AMHD Appeals Process or through review of authorization requests and consults with the AMHD Chief, or designee, regarding administrative eligibility decisions.
4. When an individual is determined to be eligible for AMHD services, this eligibility follows the consumer throughout the state provider system. If a consumer transfers to another provider and the new provider questions the consumer's eligibility, the provider contacts AMHD UM with any specific concerns. The provider accepts eligibility decisions as determined by AMHD.

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5. Individuals discharged from AMHD services who wish to resume services within one (1) year of the discharge date are not required to be re-assessed for eligibility if they were found eligible in Category I as detailed in this policy. However, assessment for other purposes may be needed (such as risk assessment, assessment of need based on financial assets, or health insurance coverage). Requests for readmission to AMHD funded services shall be received and processed by the AMHD ACCESS Line.
6. Individuals requesting resumption of AMHD services more than one (1) year after discharge are screened by AMHD ACCESS Line to determine if a new eligibility assessment is appropriate.
7. Individuals who have been determined to be not eligible for AMHD Category I services may request an appeal to this decision according to the AMHD Appeals Policy.
8. Eligibility assessment does not replace the need for clinical/treatment assessment to occur as part of treatment and service planning.
9. Individuals who are determined to be not eligible for AMHD Category I services may apply for another eligibility assessment 12 months after a final determination (initial determination plus any appeals) of ineligibility is made.

B. To Access Category II – Time Limited AMHD Funded Services:

1. An individual, advocate or homeless outreach worker contacts AMHD ACCESS Line;
 - a. If the individual is in crisis, AMHD ACCESS Line screens for and may authorize crisis services which may include Crisis Mobile Outreach, Crisis Support Management, or Licensed Crisis Residential Services; or
 - b. If the individual is homeless and suspected to have a severe and persistent mental illness, but not in crisis, the individual is presumed eligible for Category II services and registered through AMHD ACCESS Line.
2. Under presumptive eligibility, the individual is eligible for homeless outreach, Community Mental Health Center (CMHC) urgent care and medication management services.
3. CMHC urgent care services are accessible by walking into a CMHC and requesting the service.

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4. The Homeless Outreach worker or the Crisis worker arranges through AMHD ACCESS Line an eligibility assessment appointment for the consumer to determine eligibility for Category I.A Continuing Services.
5. If the eligibility assessment finds an individual ineligible for AMHD funded services, the individual is transitioned to their health plan or other community services within five (5) days of the determination.

C. To Access Category III – Disaster Services:

1. The AMHD Chief, or designee, approves a request for disaster services.
2. Individuals call AMHD ACCESS Line, or are contacted by any outreach efforts conducted by or supported by the AMHD.
3. A screening is completed and indicates that the individual is a member of the designated community or social system.
4. The individual meeting criteria as a member of the designated community or social system is offered services for up to 60 days after the designation is made by the AMHD Chief, or designee.

DEFINITIONS

Situational Crisis: For persons suspected of having a primary mental illness, acute situations that substantially increases risk of homelessness or arrest.

Presumptive Eligibility: Persons suspected of having a primary mental illness who are experiencing a clinical or situation crisis shall be presumed to be eligible for AMHD crisis services under Category II (Time Limited Services).

Date of Review: ___/___/___; ___/___/___; ___/___/___; ___/___/___

Initials: [] [] [] []

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