DEPARTMENT OF HEALTH

Special Action Team Report
To the Governor
On
Revitalization of the
Adult Mental Health System
And Effective Management of the
Hawaii State Hospital Census

October 2012

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The current rate of admissions to the Hawaii State Hospital (HSH) resulted in a census in excess of its licensed capacity during the fourth quarter of FY 2012. When HSH operates in excess of its licensed capacity, patient care may be compromised, program integrity may be lost, staffing costs rise, and exposure to external review from agencies such as the United States Department of Justice (DOJ) and the State of Hawaii Office of Health Care Assurance (OHCA) increases.

Virtually all admissions to HSH are forensic admissions, in which individuals are committed to the custody of the Department of Health (DOH) by state courts and sent to the hospital. Due to the increased rate of admissions, HSH incurred significant additional costs due to increased overtime for staffing and increasing the number of contracted overflow beds at another facility. The projection is that HSH will accumulate an operating deficit of approximately $4,800,000 in FY 2013.

Many of the individuals hospitalized at HSH either do not require inpatient psychiatric services, do not have a bona fide mental illness, or remain in HSH much longer than is clinically necessary. Individuals are committed to HSH due to problems including dementia, acquired and traumatic brain injuries, developmental delays, substance abuse, and general medical conditions, primarily because courts either cannot require or cannot identify a more appropriate placement. HSH patients experience significant inequities compared to people without mental illness in gaining access to long term care beds, medically necessary physical health care, and housing compared to individuals without psychiatric illness or those not committed to DOH.

In response to this situation, Governor Neil Abercrombie convened a Special Action Team (SAT) on the census at HSH. The SAT was initiated through a Governor's Executive Memorandum (Attachment 1). The SAT accomplished its work over 5 weeks of intensive efforts from July 17, 2012 through August 21, 2012; and, as directed, focused on areas to recommend for action and consideration by the Administration for the 2013 Legislative session and the biennium budget.

The full SAT met three times (Attachment 4), and was composed of three subcommittees (Attachment 4). Each of the subcommittees met twice (Attachment 4). The membership of the SAT and the subcommittees was expanded in subsequent meetings to include additional important stakeholders from outside of state government, including the neighbor islands, the four counties, and special groups including Police Departments, Prosecuting Attorneys, the State Council on Mental Health, veterans and homeless affairs, and private hospitals for the duration of the project. Each subcommittee was composed of a subset of participants of the full SAT and others, whose participation was specific to the subcommittee.

The 3 subcommittees were named according to their areas of focus, as follows:

Subcommittee 1: Personnel/Finance/Procurement

Subcommittee 2: Program Capacity/Clinical Operations

Subcommittee 3: Legal/Judicial

The goal of each subcommittee was to use the collective input from the participants to analyze causes and identify ideas to address the systemic factors that contribute to the increased rate of admissions as well as factors that increase the length of stay and, through consensus, suggest a number of recommendations.

The systemic factors identified were the use of HSH to provide the majority of inpatient psychiatric treatment in the state (unlike most of the other states), the very high forensic utilization of HSH (unlike most of the other states), and the currently unexplained increase in the rate of forensic evaluations ordered by Hawaii courts during FY 2012. In general, the recommendations focused on the development of community resources (more cost effective than inpatient hospitalization) and making the forensic evaluation process more efficient and effective.

The goal of the SAT committee of the whole was to review, refine, and finalize the subcommittee recommendations to be included in the final report to the Governor. Recommendations were divided into two groups: Short Term (those that can be substantially implemented in FY 2013); and Long Term (those that can be implemented in FY 2014 and beyond).

Using the consensus methodology, the following are the Short Term and Long Term recommendations from each subcommittee, with estimated costs (where applicable):

SUBCOMMITTEE RECOMMENDATIONS

Subcommittee 1: Personnel/Finance/Procurement Recommendations

Short Term:

1. Current human resources are not deployed effectively because of excessive or continuing staff vacancies in critical roles.
   a. Identify vacant HSH and AMHD positions that (1) may impact the census (either directly or indirectly) and (2) provide diversion services. Work to obtain administrative approval to fill the positions that will have the most impact. (DOH and Department of Human Resources Development (DHRD))
   b. Continue the agreement that allows DOH employees to assist DHRD in screening HSH applications and extend it to include to other critical positions. (DOH and DHRD)

Long Term:

1. Human resources are not deployed efficiently
   a. In collective bargaining, negotiate changes to the current contract terms to result in the reduction of the following: overtime, compensatory time off, other unanticipated leaves, and implementation of time and attendance systems. (DOH, DHRD, and the Office of Collective Bargaining (OCB)) (Note: A multi Departmental task force has already been convened to begin looking at factors driving overtime).
2. Sick leave usage is high for some workers due to high employee stress and low morale.
   a. Devote resources to an employee wellness program (DHRD, DOH, OCB, and Budget and Finance (B&F))

Subcommittee 2: Program Capacity/Clinical Operations Recommendations

(Note: Funding for Subcommittee 2 recommendations will be from current DOH budgetary resources; no requests for additional funding are planned.)

Short Term:

1. Increase options and capacity will divert persons with mental illness from the Criminal Justice System and commitment to HSH
   a. Expand crisis services programs. (DOH) (Cost is approximately $1.1 million/year).
   b. Revitalize pre- and post-booking jail diversion programs. (DOH)
   c. Expand current state-county partnerships to provide arrest diversion programs statewide, potentially to include the Department of Public Safety (PSD). (DOH, PSD, counties).(Estimated cost is approximately $465,000/year to provide police psychologist positions and pay for on-call services after current Federal Grant funding for this project concludes this year).
2. The community services currently available are challenged to respond to the increasing demand; increasing types and quantities of services will provide alternatives to placement at HSH.
   a. Increase the amount of case management services available under current contracts. (DOH) (Cost is approximately $3.5 million dollars/year, a 25% increase from current levels).
   b. Create a special inter-agency service model to respond to the highest utilizers of services. (DOH, PSD, and Department of Human Services (DHS).
   c. Develop plans for new combinations of intensive case management and housing services. (DOH, DHS).
3. Decreasing the gaps in services or financing of services will decrease the risk of hospitalization or shorten stays at the HSH.
   a. Study the feasibility of increasing rates paid under current Adult Mental Health Division (AMHD) contracts. (DOH).
   b. Study new ways to expedite eligibility determinations for DHS benefits (DOH, DHS).
   c. Develop a plan to implement behavioral health services in long term care facilities (DOH, DHS, and Hawaii Health Systems Corporation (HHSC).

4. There are opportunities to understand patterns of usage across systems and agencies through data use and integration to more effectively deliver services
    a. Share data between agencies and track outcomes of high utilizers. (DOH, DHS, and PSD).
    b. Determine the appropriate number of beds needed for publicly funded inpatient psychiatric hospitals. (DOH, DHS).

Long Term:

1. Increasing options and capacity will divert persons with mental illness from the Criminal Justice System and commitment to HSH.
    a. Create and contract for new types of intensive case management services to provide effective early intervention. (DOH) (Cost is approximately $500,000/year).
    b. Develop alternative placements to jail or emergency departments. (DOH) (Cost is approximately $438,000/year).
    c. Develop and implement a Crisis Stabilization Center. (DOH) (Operational cost approximately $2.9 million/year based on 16 beds at a rate of $500/day; if there is a DHS/FMAP match of 50%, this will be $1.45 million/year).
2. The community services currently available are challenged to respond to the increasing demand; increasing types and quantities of services will provide alternatives to placement at HSH.
    a. Formalize interagency partnerships for housing and case management services. (DOH, DHS).
    b. Create new housing types for those who require individual living rather than group living. (DOH) (cost is approximately $192,000/year).
3. Decreasing the gaps in services or financing of services will decrease the risk of hospitalization or shorten stays at the HSH.
    a. Explore options for possible increases in Medicaid rates (DOH, DHS).
    b. Develop long term care facilities as viable placements for individuals with mental illness. (DOH, DHS, HHSC) (Cost is approximately $5.4 million dollars/year, based on $300/day/person of supplemental mental health services for 50 persons; if there is a FMAP/DHS match, it would be $2.7 million per year net state funds).
4. There are opportunities to understand patterns of usage across systems and agencies through data use and integration to more effectively deliver service.
    a. Create interagency partnerships for data sharing. (DOH, DHS, PSD).
    b. Add performance and outcome metrics to new AMHD contracts. (DOH).

Subcommittee 3: Legal/Judicial Recommendations

Short Term:

1. Expediting the forensic examinations process will shorten many patients' length of stay at HSH.
    a. Revise court orders with respect to Hawaii Revised Statutes (HRS) chapter 704 mental health cases to contain an order that public agencies turn over their records about the defendant to adult probation. (Judiciary)

b. Provide reports to Adult Probation on defendants (inmates) in the correctional facilities for whom fitness evaluations have been ordered by the Court. Provide updated reports to Adult Probation regarding the fitness of these individuals if their clinical status changes during the period of incarceration. (PSD, Judiciary)
c. Propose a Resolution for the 2013 Hawaii Legislature asking for the Legislative Reference Bureau (LRB) to study the National Model for Competency Evaluations, and how it might be applied to Hawaii. (DOH, Department of the Attorney General (AG))

2. In order to avoid unnecessary delays, court orders should be clear and accompany the defendant at the time of admissions to HSH.
   a. Move toward creating standard orders to be used by all of the courts for HRS chapter 704 mental health calendars. (Judiciary)
   b. Strive to expedite completion of all HRS chapter 704 orders. (Judiciary)
3. Placement in Hawaii State Hospital is the only option for placement currently available under law for persons on conditional release who violate the conditions of their conditional release.
   a. Propose legislation to amend HRS §704-411(1) (b)[1] regarding conditional release timeframes. (DOH, AG)

Long Term:

1. Expediting the forensic examinations process will shorten many patients' length of stay at HSH.
   a. Review the results of the LRB's study of the National Model for Competency Evaluations and consider adopting its recommendations for implementation, which would include statutory changes. If three evaluations were not required for all defendants charged with felonies for each evaluation, stays in HSH will be shorter. (Legal/Judicial Subcommittee members)

As the methodology used in this process was decision by consensus, it is acknowledged that some members of these groups had dissenting opinions. The recommendations made by the SAT represent the consensus of the group.

It is the opinion of the facilitator of the SAT that these recommendations represent the core group of actions the membership of the team believe are appropriate and necessary to make a definitive change to the current situation. The Governor's consideration and the implementation of these recommendations are respectfully requested to achieve a broad revitalization of the public mental health system and impact the census at the Hawaii State Hospital.

Ms. Kate Stanley
Senior Policy Advisor to the Governor
Office of the Governor

[1] Further detail on this proposal is found in body of the report

I. Background - The SAT was convened to address the following:

The Hawaii State Hospital (HSH)[2] reached full, and on several occasions went over, its licensed capacity of 202 beds, in May of 2012, due to an accelerated rate of admissions in the previous six months. HSH operated above its licensed capacity during the entire month of June 2012.

The Department of Health (DOH) initiated what it believes were diligent actions to lower the census by all means available internally (e.g., aggressive treatment, internal Utilization Management (UM), increased discharge planning, purchasing the additional inpatient capacity available through community hospitals, and requesting assistance from community stakeholders).

Despite the actions taken by DOH, the rate of admissions, and as a consequence the hospital census, did not decrease substantially. Additionally, DOH learned there is little additional incremental capacity for community inpatient hospital bed space available for purchase or contract.

Consultation and guidance was requested from the Governor's Office, which determined the best course of action was to convene a SAT. The charge of the SAT was to review the causes of the situation, consider possible solutions, and make recommendations to the Governor in time to be considered by the Governor and the Legislature during the 2013 Legislative session and Fiscal Year 2014-2015 budget cycle.

A. Short Term History: Fiscal Year 2012

For the first five (5) months of FY 2012, the rate of admissions to HSH slightly increased. However, discharges nearly kept pace, resulting in an increased but manageable number of patients in the hospital. In November and December of 2011 (before and after Asian Pacific Economic Cooperative (APEC) meeting), the HSH census began to climb due to an increase in the rate of admissions. The Chief of Adult Mental Health Division (AMHD) initiated a twice weekly Divisional Operations planning meeting to review the census and discharge status of the HSH, the State Operated Specialized Residential Program (a special treatment facility on the grounds of the state hospital), Hale Imua (a 24 hour a day staffed group home on the grounds of the state hospital), and to determine available community placements. The result of this

[2] The Adult Mental Health Division (AMHD) of DOH provides services to about 11,000 individuals each year. AMHD has 4 components: HSH, licensed for 202 beds and budgeted for 168; the Community Mental Health Centers (CMHCs), providing case management and other services to about 2,000 people; Purchase of Service providers, providing crisis services, case management, housing, and rehabilitation services to about 8,500 people; and the Central Office, providing utilization management, performance improvement, personnel, contracting, and fiscal services to the Division.

activity has been that available bed capacity in AMHD community programs has been utilized at full capacity during the second half of fiscal year 2012.

By March 2012, even with community resources utilization at full capacity, the HSH census continued to remain at or near its licensed capacity. That same month, HSH expanded its contract with Kahi Mohala, a private psychiatric facility in Ewa Beach, to accommodate the additional patients being ordered into the custody of DOH. That contract, which had been for 16 beds, was increased to 24 beds in March-April, 32 beds in May-June, and then to 40 beds in July 2012; DOH is contracted for 40 beds at Kahi Mohala at this time. Kahi Mohala does not have additional capacity beyond the current number of beds contracted.

AMHD also has a contract with each the four Hawaii Health Systems Corporation (HHSC) hospitals to pay for beds in HHSC facilities that have inpatient psychiatric units so they may accept DOH court ordered patients. HHSC facilities have not had sufficient bed space available for DOH consumers. HHSC facilities total average daily census of DOH patients under the contract has been less than 5.

Additional available community outpatient capacity will have a direct effect on the HSH census. There are 8 additional beds of contracted specialized residential program beds opening shortly, once licensure from the Office of Health Care Assurance (OHCA) is completed. This will result in a one-time reduction to the HSH census as those beds will be filled after licensure. A new community based case management contract was awarded in April 2012, which includes increased case management services and a new service, peer specialists, an evidence based practice in which AMHD pays for trained individuals who are in recovery from mental illness to support and guide other consumers as they enter services and participate in treatment. This new service may help reduce readmissions to HSH.

As DOH analyzed the factors contributing to the accelerated rate of admissions, it was learned that the number of forensic examinations conducted by the Courts and Corrections Branch of AMHD pursuant to orders from courts statewide increased by 28% in FY 2012 compared to FY 2011. Of note, the number of admissions to HSH in FY 2012 was 24% higher than in FY 2011, roughly proportional to the increased number of forensic examinations.

Queen's Medical Center reported the number of times in which Honolulu Police brought an individual to the Emergency Department with a mental illness almost doubled, with about 800 visits in FY 2011 and close to 1600 in FY 2012. Queen's, which is licensed by the Office of Healthcare Assurance (OHCA) for 63 inpatient psychiatric beds, has decreased its inpatient adult capacity to 16 beds at the present time, and reports capacity is planned to be reduced further to 12 beds by October 2012,[3] Castle, licensed for 55 beds, currently has 28 open and will

[3] Queen's Medical Center has 63 licensed psychiatric beds. As of the date of this report they have 36 in operation (16 adult & 20 child/adolescent). Planned construction has been delayed so QMC anticipates in December, 2012 adult inpatient will go to 12 beds and the child/adolescent will go to 24. Therefore, 36 beds will still be in operation.

decrease capacity by 50% over the next year while renovations to their units are completed. While the statewide total inpatient psychiatric capacity other than HSH is 274, according to the numbers on file at the OHCA, the available capacity at this time is approximately 204, an available capacity 34% less than the total licensed capacity statewide other than HSH.

As FY 2012 ended, DOH assessed that current services under its direct control were essentially operating at maximum capacity. However, with the HSH census at licensed capacity, the situation remained critical. A determination was made that soliciting the input, consultation, and assistance of other Branches of government (Judiciary), other Executive Branch Departments, including the Attorney General (AG), Department of Human Resources Development (DHRD), Department of Human Services (DHS), Department of Public Safety (PSD), Department of Accounting and General Services (DAGS), Department of Budget and Finance (B & F), the Office of Collective Bargaining (OCB), and the Office of Healthcare Transformation), and key affiliated government stakeholders (Hawaii Health Systems Corporation (HHSC), the Office of the Prosecutor, and the Office of the Public Defender), and other community stakeholders (Police Departments, Healthcare Association of Hawaii), was necessary. DOH then approached the Governor's office, which resulted in the creation of the Special Action Team.

B. Other Relevant History: Fiscal year 2006 through fiscal year 2011

In FY 2007 (November 2006) the United States Department of Justice Lawsuit against the State of Hawaii for conditions at HSH, and services provided by DOH, was formally dismissed, with prejudice. Resolving that Federal lawsuit took almost 20 years and substantial expenditures of state funds.

In FY 2008, the State of Hawaii, along with the rest of the country, began to experience a significant economic downturn which impacted departmental budgets and programs and furloughs of state employees began.

At the beginning of FY 2009, as a result of the persistent inability of programs to provide contracted levels of service, AMHD discontinued its Assertive Community Treatment (ACT) contracts. There were approximately 400 consumers in this service, who were transitioned out of ACT programs and into community based case management services.

At the beginning of FY 2010, AMHD experienced a reduction in force and lost 58 staff members from the Community Mental Health Centers (CMHCs), HSH, and Division Central Office. Later in the same fiscal year, in response to continued budgetary constraints, resources available for the following services were restricted or reduced: specialized residential treatment beds; group home beds; case management; homeless outreach; peer services; respite care; and bilingual case management.

During FY 2011 additional restrictions were received, and these were absorbed without further reduction of amounts of services.

In 2011, DOH's legislative proposal passed as Act 53. Act 53 amended the criminal mental health law, Hawaii Revised Statutes (HRS) Chapter 704, to provide that when defendants are charged with a non-violent petty misdemeanor or a misdemeanor and are found "unfit to proceed," the length of time that they can either be committed to HSH or released to the community on conditions, is limited to 60 days and 120 days, respectively. Another DOH legislative proposal passed in 2011 as Act 99, however this passed in a form which included a typographical mistake that rendered it virtually useless. DOH's intent when introducing this bill was to limit a person's conditional release to one year when a person is acquitted of a petty misdemeanor or misdemeanor by reason of physical or mental disease, disorder or defect, and eventually placed on conditional release. However, the language for the limitation was restricted to the paragraph pertaining to situations in which a defendant is placed on conditional release as soon as the defendant is acquitted. This rarely happens; defendants acquitted by reason of physical or mental disease, disorder or defect usually is committed to HSH first and then later placed on conditional release. When that occurs, the one year limitation would not apply. The DOH plans to propose a remedy to this mistake during the 2013 legislative session.

II. Analysis of Possible Causes

Why does Hawaii have to have a State Hospital?

There are two main reasons –
1. To provide for the inpatient clinical (mental health or psychiatric) treatment of individuals (adults and children) where there is no other willing provider (the state functions as treatment provider of last resort). This is similar to the State's role with respect to HHSC.

2. To receive court ordered forensic commitments of individuals ordered into the custody of the Director of Health.

Although there is some degree of overlap of these reasons, during Fiscal 2012 HSH received only forensic commitments; no civil admissions occurred.

The Director of Health has the authority to designate another facility, via the contracting process, to receive and treat these patients. The DOH assessment is that there is little, if any, additional available inpatient capacity for purchase and there do not appear to be other providers willing to assume the clinical responsibility and liability for providing these services. Other suitable facilities would have to provide forensic services including access to courts, defense attorneys, forensic examiners, specialized programming to address the legal issues, and community reintegration opportunities, must be accredited and licensed, have the ability to integrate mental and physical health treatment, meet applicable forensic requirements (e.g. detention), and be able to deliver services consistent with state and federal law.

If Hawaii has to provide inpatient hospital services – What is the right number of beds?

There is an inverse relationship between state operated or funded inpatient beds and the availability of community inpatient psychiatric beds. In other words, to the degree more inpatient and other levels of care are available in the community, there is less demand for state operated inpatient placements; when less community capacity is available, the demand for state placements increases. During the course of FY 2012, a number of individuals were committed to HSH who had acute medical or long term care needs; they were committed to HSH because there was no other available place to provide for their physical health or long term care in the community. The utilization of beds at the HSH is decreased when there is availability and willingness of other inpatient and long term care settings to admit these individuals. In the absence of adequate community capacity, demand for state hospital beds is higher.

The question has been raised as to whether Hawaii has an adequate number of all types of inpatient beds. The State Health Planning and Development Agency (SHPDA) reported that Hawaii has 16 % fewer acute beds than the US average (2.3 per 1000 for Hawaii, compared to 2.7 per 1000 nationally). This report was completed before the bankruptcy and closure of Hawaii Medical Center in January 2012.

The question has also been raised as to whether Hawaii has an adequate number of long term care beds. According to a 2006 SHPDA report, which is the most recent comparison of Hawaii to national data available, Hawaii ranks 48th among the states in number of long term care beds. Both HSH and Healthcare Association of Hawaii (HAH) members report discharge delays due to lack of available bed for the placement of individuals in acute hospitals who require long term care; it is known that a number of admissions to HSH are related to the limited availability of long term care for patients with dementia or other medical conditions requiring long term care.

Is there truly inadequate capacity at HSH? If it is at licensed capacity, does that mean there are too few beds?

The observation that many people currently in HSH do not require an inpatient level of care does not necessarily mean that Hawaii has enough inpatient capacity. It is possible there are a cohort of potential patients who are not currently referred (for instance, because HSH does not take civil admits or civil transfers) who would be appropriate referral candidates for transfer if HSH had space available for civil patients who would be more effectively treated there than in community facilities.

What are the methods for determining the correct size for the State Hospital for Psychiatric Services?

A number of authors have proposed benchmarks to be used in calculating the appropriate amount of public sector, inpatient psychiatric capacity needed for state operated hospitals. These benchmarks range from 14 (beds)/100,000 adult population to 50/100,000. Some

benchmarks are empirical; for example, these represent the average of current capacity found across the United States. Some benchmarks make explicit assumptions about potentially offsetting factors (e.g. publicly financed inpatient treatment available in private, private not for profit, or community hospitals; numbers of individuals with severe mental illnesses in jails) and others do not. Drawing conclusions based upon these benchmarks without a clear understanding of the assumptions may lead to incorrect assessments of needed capacity. This analysis is primarily intended to describe methods for calculating the "optimal" size of the public sector provided inpatient capacity. The scope of the SAT is for Hawaii's adult population, although the methods may be useful in estimating the optimal size of public sector capacity needed for children and adolescents.

Definitions

Optimal size – the level above or below which some significant over utilization, underutilization, or other cost is incurred. The costs incurred could be calculated (cost difference between a hospital and community residential bed) or estimated (e.g. increased probability of a negative outcome associated with inability to hospitalize a person, quantifying risk).

Factors

A. Population factors (i.e., the higher number of adults at risk of admission, the higher the number of beds needed at the optimal level). This is relatively straightforward to measure.

B. Socioeconomic Status (SES) adjustment to population (i.e., a lower SES is correlated with an increased risk of having a Severe and Persistent Mental Illness (SPMI), and a higher risk of hospitalization).

   There is no reason to believe that prevalence of SPMI is any different in Hawaii than in the rest of the US, after adjusting for SES. There is no reason to believe that the individuals who require hospitalization at HSH present with fundamentally different assessment or treatment challenges than in the rest of the United States.

C. Availability of private sector, community based inpatient services (i.e., a greater availability of community inpatient services is associated with a reduced need for public sector inpatient services).

D. Availability of private sector, community based outpatient services (i.e., a greater availability of community outpatient services is associated with a reduced need for public sector inpatient capacity).

While HSH and state funded adult inpatient utilization are at full capacity, private sector and HHSC adult inpatient psychiatric utilization are underutilized relative to available licensed capacity. It is possible, or even likely, that a bigger share of the inpatient services provided to adults is at Hawaii's state operated facility, relative to other states.

Options for action which would improve the situation are available. A number of factors combine to have a direct impact on the use, length of stay, and ultimately the amount of inpatient capacity required to meet the need.

III. Subcommittee Summaries of Discussions on Options to Address the Causes and a Priority List of Recommendations

The summaries below are comprised of the broad array of the problems identified by the subcommittees formed from the SAT, and the information shared and discussion generated by the members during the meetings. Using the consensus process, the wider discussion was narrowed down to a number of recommendations included in the SAT Executive Summary. Where applicable, estimated costs for recommendations were determined and included in the Executive Summary.

Subcommittee 1: Personnel/Finance/Procurement

Background: The budget of Hawaii State Hospital is approximately $52,000,000 per year. This is 100% state appropriation[4]. Approximately two-thirds of HSH budget is the direct cost of the state employee staff, including compensation for sick time, ordinary overtime, holiday pay, other differentials. The recent increase in census has resulted in an approximate doubling of the amount of ordinary overtime. With about 667 permanent and temporary positions there is always turnover, but unfilled vacancies also result in increased staff expense, as some of the vacant shifts have to be covered through use of either overtime or agency staffing. The other expenses in the HSH budget are contract costs (Security, Pharmacy, and Supplemental Agency staff), utilities, food, the Kahi Mohala overflow unit contract, and medical services rendered outside of the facility. External medical service costs amounts to several hundred thousand dollars per fiscal year.

Problem A: The existing allocation of Human Resources are not deployed for maximal efficient use, there are continuing staff vacancies which increase overtime or compromise accomplishment of programmatic goals.

Short Term

Work together with DOH Human Resources Office (HRO) and Administrative Services Office (ASO), DHRD, and others, to prioritize for recruitment all positions which have impact on diversion from admissions, increase options for discharge, and shorten the length of stay. This may include non-direct care administrative positions or even positions in other

[4] There is a Medicare D program through HSH which offsets medication costs for the approximately 33% of patients who qualify for Medicare and who have been enrolled. This program provided approximately $750,000 in reimbursement for medicine to HSH patients in FY 2011; without this program that expense would be paid from HSH's appropriation.

departments; if filling these other positions will impact positively on diverting individuals from hospitalization.

Problem B. *Work rules seem to limit the effective utilization of Human Resources.*

Long term

Work with DHRD, B&F, DOH, OCB, and others around negotiated modifications to collective bargaining agreements as they relate to the use of sick leave, payment for overtime, time and attendance systems, and other areas, with the goal of improved efficiency in the utilization of human resources.

Problem C. *State procurement process must be adhered to, which limits expansion of existing programs or implementation of new programmatic models.*

Short Term:

DAGS and others are available to provide technical assistance on procurement related to the expansion of existing service lines or new services (AMHD)

Problem D. *HSH is 100% funded through state appropriation.*

Long Term:

HSH could improve its budgetary bottom line (or at least, the net cost to the state) and achieve a more efficient utilization of resources, if it received revenue for the billable medically necessary services which it provides. This initiative involves three significant steps: Implementation of modified Hawaii Administrative Rules; approval from Centers for Medicare and Medicaid Services (CMS or its agent) through certification of HSH as a Medicare provider; and the establishment of administrative and clinical billing infrastructure.

Problem E. *Given current and projected utilization of HSH and its overflow program, what are the budgetary consequences?*

Short Term:

Budget Conclusion– Three months into FY 2013, there appears to be no change in fundamental facts such as would materially influence census and staffing, and therefore, expenses for this Fiscal Year. DOH and other stakeholders should prepare for an approximate $ 4.8 million deficit for HSH in FY 2013. This is attributable to an estimated $720,000.00 in additional overtime expenses associated with the high census and an increase in contract costs of $4,000,000 associated with the expansion of the contract with Kahi Mohala for overflow beds.

Subcommittee 2: Program Capacity and Clinical Operations

Background: Program Capacity and Clinical Operations at AMHD serve core functions related to the HSH. AMHD funds programs to individuals involved in the Criminal Justice System from the time they are incarcerated to their admittance to HSH. In addition, some AMHD services received by those committed to HSH before and after their hospitalization are currently neither provided nor funded by DOH These include the Honolulu Police Department Psychologist project; primary care services and medication, provided by a private entity; financing for services from the DHS Med Quest programs, General Assistance, or Long Term Care Divisions.

Problem A. Increasing options and capacity will divert persons with mental illness from the Criminal Justice System and commitment to HSH

Short Term:

a. Expand crisis services programs. (DOH) (cost is approximately $1.1 million/year).
b. Revitalize pre- and post-booking jail diversion programs. (DOH)
c. Expand current state-county partnerships to provide arrest diversion programs statewide, potentially to include the Department of Public Safety (PSD). (DOH, PSD, counties).(Estimated cost is approximately $465,000/year to provide police psychologist positions and pay for on-call services after current Federal Grant funding for this project concludes this year).

Long Term:

a. Create and contract for new types of intensive case management services to provide effective early intervention. (DOH) (cost is approximately $500,000/year).
b. Develop alternative placements to jail or emergency departments. (DOH) (cost is approximately $438,000/year).
c. Develop and implement a Crisis Stabilization Center. (DOH) (operational cost approximately $2.9 million/year based on 16 beds at a rate of $500/day; if there is a DHS/FMAP match of 50%, this will be $1.45 million/year.).

Problem B. The community services currently available are challenged to respond to the increasing demand. Increasing types and quantities of services will provide alternatives to placement at HSH.

Short Term:

a. Increase the amount of case management services available under current contracts. (DOH) (cost is approximately $3.5 million dollars/year, a 25% increase from current levels).
b. Create a special inter-agency service model to respond to the highest utilizers of services. (DOH, PSD, and Department of Human Services (DHS)).
c. Develop plans for new combinations of intensive case management and housing services. (DOH, DHS).

Long Term:

a. Formalize interagency partnerships for housing and case management services. (DOH, DHS).
b. Create new housing types for those who require individual living rather than group living. (DOH) (cost is approximately $192,000/year).

Problem C. Decreasing the gaps in services or financing of services will decrease the risk of hospitalization or shorten stays at the HSH.

Short Term:

a. Study the feasibility of increasing rates paid under current Adult Mental Health Division (AMHD) contracts. (DOH).
b. Study new ways to expedite eligibility determinations for DHS benefits (DOH, DHS).
c. Develop a plan to implement behavioral health services in long term care facilities (DOH, DHS, and Hawaii Health Systems Corporation (HHSC).

Long Term:

a. Explore options for possible increases in Medicaid rates (DOH, DHS).
b. Develop long term care facilities as viable placements for individuals with mental illness. (DOH, DHS, HHSC) (cost is approximately $5.4 million dollars/year, based on $300/day/person of supplemental mental health services for 50 persons; if there is a FMAP/DHS match, it would be $2.7 million per year net state funds).

Problem D. There are opportunities to understand patterns of usage across systems and agencies through data use and integration to more effectively deliver service.

Short Term:

a. Share data between agencies and track outcomes of high-utilizers. (DOH, DHS, and PSD).
b. Determine the appropriate number of beds needed for publicly funded inpatient psychiatric hospitals. (DOH, DHS).

Long Term:

a. Create interagency partnerships for data sharing. (DOH, DHS, PSD).
b. Add performance and outcome metrics to new AMHD contracts. (DOH).

Subcommittee 3: Legal/Judicial Recommendations

Problem A. *Expediting the forensic examinations process will shorten many patients' length of stay at HSH.*

Background: Hawaii Revised Statutes §704-404 provides that when a judge concludes that "the physical or mental disease, disorder, or defect of the defendant will or has become an issue in the case, the court may immediately suspend all further proceedings in the prosecution" and order that the defendant participate in three evaluations if the charges include a felony, or one

evaluation if the charges are non-felonies (forensic evaluations). There are two issues that the evaluators can address. One is whether the defendant is fit to stand trial, which means that the defendant has the capacity to understand the proceedings against him/her and is able to assist in his/her own defense. The other issue is "the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law was impaired at the time of the conduct alleged." Once the proceedings are suspended, the judge has the discretion to send the defendant back to jail, release the defendant into the community with conditions ("released on conditions") to attend the evaluations as they are scheduled, or order the defendant to HSH pending the evaluations. When forensic evaluations are ordered, the court, through adult probation, gathers "all existing medical, mental health, social, police . . . and other pertinent records in the custody of public agencies . . . and make such records available for inspection by the examiners."

Many defendants are ordered to HSH for forensic evaluations for various reasons. The majority of those are eventually found fit to stand trial. Because of the length of time it takes adult probation to obtain the medical and other reports for the evaluators, and because the examiners are very busy (especially the employees of DOH), it takes prolonged periods of time to complete the evaluations, especially in felony cases that require three evaluations. This often results in delays of thirty to ninety days.

Short Term

a. Revise Judicial orders with respect to HRS chapter 704 mental health cases to contain an order requiring public agencies are to turn over their records about the defendant to adult probation. Adult probation is required by statute to gather all the relevant records on a defendant who is going to be evaluated to turn over to the evaluator; however, without consent or a court order, many public agencies cannot turn over their documents that contain confidential health information (Judiciary).
b. PSD to provide Reports to Adult Probation on defendants (inmates) in the correctional facilities for whom fitness evaluations have been ordered by the Court. Also, PSD is to provide updated reports to Adult Probation regarding the fitness of these individuals if their clinical status changes during the period of incarceration. The reports will give the evaluator observations of the defendants from a recent but longer period of observation than an hour or two evaluator's interview can provide. Providing these reports should assist evaluators to determine whether the defendant is malingering (feigning mental illness) in order to be found unfit and sent to the Hospital (PSD and Judiciary).
c. Propose a Resolution for the 2013 Legislature asking for the Legislative Reference Bureau (LRB) to study the National Model for Competency Evaluations, and how it might be applied to Hawaii. The Model proposes single evaluator forensic evaluations for all defendants, even those charged with felonies. DOH research reveals that Hawaii appears to be the only state that requires three evaluations each time an evaluation is needed for a defendant charged with a felony. If single evaluations were permitted in

felony cases, the length of stay at HSH for those defendants charged with felonies would be much shorter (DOH, with the AG).

Long Term:

Review and discuss the results of the LRB's study of the National Model for Competency Evaluations. Consider adopting its recommendations for implementation, which would include statutory changes. If three evaluations are no longer required for all defendants charged with felonies each time they require evaluation, their stays in HSH will be much shorter (Members of the Legal/Judicial subcommittee).

As a consequence of the structure of state and Federal law (related to the processes of Hawaii courts, the availability of attorneys, expert witnesses and others) this area greatly affects the likelihood of hospitalization (commitment to DOH) and the length of that hospitalization. This includes the many individuals who ultimately become committed to HSH along the continuum from arrest to post-adjudication monitoring and tracking (e.g. individuals on Conditional Release).

Problem B. *In order to avoid unnecessary delays, court orders should be clear and accompany the defendant at the time of admission to HSH.*

Short Term

a. Subject to input from neighbor island circuits, the Judiciary will create standard orders to be used by all of the courts for HRS chapter 704 mental health calendars (Judiciary).
b. The Judiciary will strive to expedite completion of all HRS chapter 704 orders.

Problem C. *Placement in Hawaii State Hospital is the only option for placement currently available under law for persons on conditional release who violate the conditions of their conditional release.*

Background: When a person is acquitted by reason of physical or mental disease, disorder, or defect excluding responsibility, pursuant to section 704-411, the court may order that the person be committed to the detention, care, and custody of the Director of Health to be placed at HSH. However, HRS§704-413 provides that a person can also be granted conditional release with conditions as the court deems appropriate, if the person can be controlled adequately and given proper care, supervision, and treatment in the community. Once released, if the person's mental health provider believes that the person is not complying with the terms and conditions of the person's release, or there is other evidence that hospitalization is appropriate, the provider shall notify the probation officer assigned to the person. The probation officer may then order the person to be hospitalized at HSH "for a period not to exceed 72 hours". This is commonly known as a "72-hour hold". However, this hold can be extended under certain circumstances beyond 72 hours, for up to one year, or the court can revoke the person's conditional release and commit the person to the detention, care, and custody of the Director of Health to be placed at HSH. It often takes six months to a year before the person is released on conditions again.

Persons charged with non-felonies but acquitted by reason of physical or mental disease, disorder, or defect excluding responsibility, but granted conditional release, often stay on conditional release for many years. Therefore, they can be deemed noncompliant with their conditions years after the acquittal, and placed back at HSH for a long time, without having committed another criminal offense. If the person had been convicted of the non-felony, they would have spent no longer than one year in jail or on probation. Most states do not use conditional release for non-felony defendants. There is not a clear rationale as to the reason persons acquitted of crimes due to mental illness should be treated differently than those who are convicted of the same crimes who do not have a mental illness.

Short Term:

Propose legislation to amend HRS §704-411(1) (b) to provide that all defendants granted conditional release when acquitted of a non-felony shall have their conditional release limited to one year (rather than those ordered on conditional release only at the same hearing when they are acquitted by reason of mental disease, disorder or defect). The proposal shall also include language to clarify that if a person on a 1-year limited conditional release is placed back in HSH on a 72-hour hold pursuant to HRS §704-413(1), the 1-year period will be tolled during that placement, and the clock will resume ticking upon that person's release from HSH. Further, the proposal shall provide that if a person on a 1-year limited conditional release has conditional release revoked pursuant to HRS §704-413(4), and then, subsequently, is ordered back on conditional release based upon the same non-felony charge, the 1-year timeframe will begin anew (DOH, with the assistance of the AG).

IV. Conclusions

(1) The phenomenon of the increased rate of admissions to the HSH appears to be primarily due to systemic factors rather than operational procedures at the facility.

(2) The Special Action Team has successfully brought together the key stakeholders involved directly and indirectly in the increased rate of admissions to the Hawaii State Hospital. The Team engaged in broad discussions, proposed a number of solutions to the problem, and used consensus to narrow the list down to a number of actionable items for implementation on both a short and longer term basis.

(3) There are changes which could be made in 3 specific areas (Personnel/Finance/Procurement; Program Capacity/Clinical Operations; Legal/Judicial) that could provide significant potential impact on the rate of admissions to the HSH, length of stay, or efficiency of its operations; the greatest likelihood of impact is next fiscal year and beyond.

(4) Assistance and collaboration from other stakeholder agencies will continue to be crucial to successfully address the systemic factors involved in the increased rate of admissions.

V. Recommendations

(1) The Governor request that DOH, other state agencies, the Judiciary and other stakeholders work toward implementing the short term recommendations. Budget requests are to be refined and prioritized, to be included in the Departments' current fiscal year and next Biennium budget requests for consideration by Budget and Finance and the Governor.

(2) The Governor continues the SAT, requesting the SAT to meet regularly to monitor progress.

VI. Appendices

Appendix A: Proposals from Legal/Judicial Subcommittee which Did Not Achieve Consensus
Appendix B: Charges and Commitments Section, All Admissions to HSH FY 2012 (Updated)
Appendix C: Comments received after final SAT meeting

VII. Attachments

1. Governor's Executive Memorandum
2. White paper and Table
3. Presentation
4. Sub group descriptions, proposed membership and tentative schedules
5. Sub Group Summaries, Attendance Lists

APPENDIX A: Proposals from Legal/Judicial Subcommittee which did not Achieve Consensus

Subcommittee #3 Legal/Judicial:

1. Implement a "courtroom clinic" model or expand AMHD's court-based clinician program to Honolulu Circuit Court and to Neighbor Island Courts.

- Clinicians could assist the Court with determining whether the defendant should be detained at HSH pending forensic evaluations, remain in PSD custody, or be safely released to the community under conditions.

2. Consider using private examiners rather than Courts and Corrections Branch examiners for HRS §704-404(2) non felony evaluations.

- What entity would pay for this?
- Will this violate civil service laws (Konno v. County of Hawaii, 937 P.2d 397, 85 Haw. 61 (1997))?

3. Separate evaluations for fitness from evaluations for penal responsibility.

- Do not require diagnosis for fitness exams.
- Change "shall" to "may" in HRS §704-404(4):

(4) The report of the examination ~~shall~~ may include the following:
(a) A description of the nature of the examination;
(b) A diagnosis of the physical or mental condition of the defendant;
(c) An opinion as to the defendant's capacity to understand the proceedings against the defendant and to assist in the defendant's own defense;
(d) An opinion as to the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law was impaired at the time of the conduct alleged;
(e) When directed by the court, an opinion as to the capacity of the defendant to have a particular state of mind that is required to establish an element of the offense charged; and
(f) Where more than one examiner is appointed, a statement that the diagnosis and opinion rendered were arrived at independently of any other examiner, unless there is a showing to the court of a clear need for communication between or among the examiners for clarification. A description of the communication shall be included in the report. After all reports are submitted to the court, examiners may confer without restriction.

APPENDIX B: Charges and Commitments Section, all Admissions to HSH, FY 2012 (Updated)

	404	406	411(1)(a)	413(1)	413(4)	706-607	MH-9	Vol	Total	%
Total Felons	**10**	**42**	**14**	**51**	**3**	**1**			**121**	**44%**
Felony A		**6**	**2**	**9**					**17**	
offense against another		*6*	*2*	*8*					*16*	
offense not against another				*1*					*1*	
Felony B	**3**	**6**	**6**	**8**					**23**	
offense against another	*1*	*3*	*3*	*3*					*10*	
offense not against another	*2*	*3*	*3*	*5*					*13*	
Felony C	**7**	**30**	**6**	**34**	**3**	**1**			**81**	
offense against another	*3*	*15*	*5*	*19*	*2*	*1*			*45*	
offense not against another	*4*	*15*	*1*	*15*	*1*	*1*			*36*	
Total Misdemeanants	**30**	**62**	**4**	**32**	**2**	**3**			**133**	**48%**
Misdemeanors	**21**	**34**	**3**	**21**	**2**				**81**	
offense against another	*16*	*24*	*2*	*14*	*2*				*58*	
offense not against another	*5*	*10*	*1*	*7*					*23*	
Petty Misdemeanors	**9**	**28**	**1**	**11**		**3**			**52**	
offense against another	*3*	*8*		*5*		*2*			*18*	
offense not against another	*6*	*20*	*1*	*6*		*1*			*34*	
Violation - *offense not against another*	**1**	**1**							**2**	**<1%**
Unrecognized - *offense not against another*	**4**	**13**							**17**	**6%**
No criminal charge							**3**	**1**	**4**	**1%**
Total	**45**	**118**	**18**	**83**	**5**	**4**	**3**	**1**	**277**	**100%**
Percent	16%	43%	6%	30%	2%	1%	1%	<1%	100%	*

Admissions by Circuit									**Total**	**%**	% of pop*
Oahu	**19**	**82**	**9**	**47**	**4**	**4**			**165**	**60%**	70
Hawaii	**10**	**25**	**6**	**22**	**1**				**64**	**23%**	14
Hilo	*5*	*16*	*4*	*18*					*43*		
Kona	*5*	*9*	*2*	*4*	*1*				*21*		
Maui	**16**	**3**	**3**	**3**					**25**	**11%**	11
Kauai		**8**		**11**					**19**	**5%**	5
No criminal charge							**3**	**1**	**4**	**1%**	

*based on 2010 US census estimate

404= Evaluation of Fitness 406- Unfit, pending restoration 411(1) a= Not Guilty by Reason of Physical or Mental Defect 413(1) = Conditional Release, 72 hour hold
413(4) = Conditional Release Revoked 706-607= Civil Commitment in Lieu of Prosecution MH 9= Prisoner in Need of Treatment

AMHD Confidential **8/13/2012**

APPENDIX C: Additional Comments Received After Final SAT Meeting

Received from **Patricia McManaman, Director**
Department of Human Services (DHS)

Subcommittee 2: Program Capacity and Clinical Operations:

a. One missed opportunity to divert individuals from the criminal justice system may be the inability of consumers to meaningfully access the DOH's ACCESS Line. I've been advised by consumers that the ACCESS Line message refers them to 911 if there is a crisis or to 211 if they have general questions. The message does direct callers with questions about eligibility to leave a message. Perhaps if DOH obtained funding to fully staff and operate the ACCESS Line, the DOH would be in a better position to offer appropriate, timely advice and counseling that may divert its clients from referral to the criminal justice system.

b. I was recently advised by a hospital based physician that they are unable to access Medicaid funding where individuals with SMI refuse or decline to sign the MedQuest application after being civilly committed. The refusal was characterized as product of the SMI. This places hospitals in a difficult positions and, I'm advised, contributes to the reduction in beds Statewide by facilities no longer wishing to take on the financial burden or additional "charity care." Clearly, we need to build capacity, not reduce it. Federal law prohibits MedQuest from accepting applications which are not signed by the individual seeking services, designated family members or individuals with duly authorized legal authority. I'm advised Family Court does not believe it has the jurisdiction to authorize a temporary limited guardianship for these purposes. Perhaps DOH might consider looking at the civil commitment statute to determine whether an appropriate remedy exists. As you know, it takes months to obtain a permanent guardianship order. Additionally, the costs to a hospital to obtain guardianship, whether temporary or permanent are also costly. This could be a quick fix if a bill was passed this Session.

c. Access to timely, comprehensive case management services is of ongoing importance to the SMI community. We have had multiple meetings with mental health consumers, advocates, and providers regarding case management. These individuals report that the current system is fragmented and, as a result, inaccessible. The DHS believes that we can eliminate the fragmentation and close the gap in case management services by placing all Medicaid eligible adults with SMI - whether Quest or Quest Expanded Access clients - into one system for case management services. The DHS looks forward to its continuing discussions with the DOH on this issue and stands by its offer to provide these services to all Medicaid clients. The fragmentation is simply not working for providers or clients who are uncertain about whom to call for services and other issues. This small step will make it easier to access services when needed, enhance

stabilization, and provide greater continuity of care. This may result in fewer referrals to the criminal justice system.

Thank you for the opportunity to comment on the SAT plan.

Received from **Kenneth Fink, M.D., Med Quest Administrator**
Department of Human Services (DHS)

Subcommittee 2: Program Capacity/Clinical Operations Recommendations

Short term
3. There are gaps in services or financing of services which increase risk of hospitalization or prolong it.
a. Study the feasibility of increasing rates paid under current Adult Mental Health Division (AMHD) contracts.
b. Study mechanisms to expedite eligibility determinations for Department of Human Services benefits

The impetus for the SATs was the census of HSH. It is unclear how Medicaid eligibility determinations are contributing to HSH's census. Treating individuals in an outpatient setting is less expensive than treating in an inpatient one, so patients who can be cared for in an outpatient setting should be discharged to receive such care, both for the patient's being cared for in the more appropriate setting and for fiscal savings.

Discharging patients to receive services in AMHD is not contingent upon Medicaid eligibility. Because Medicaid eligibility is retroactive to the date of eligibility, completing an application upon discharge will still allow optimization of federal funds because services provided by AMHD during the period between application submission and eligibility determination would be able to receive Medicaid reimbursement.

Medicaid makes timely eligibility determinations compliant with Hawaii Administrative Rules and federal requirements. In addition, MQD has an existing MOU with HSH such that for HSH patients who have a known discharge date, MQD will accept and process an application so that the patient has Medicaid coverage at the time of discharge.

Creating a single behavioral health organization to provide behavioral health services for Medicaid beneficiaries and the uninsured would facilitate discharge from HSH (or other institutions such as prison) by having a single entity responsible for service provision and allowing for back-end reconciliation of funding sources. This patient-centric approach would

eliminate barriers created by the organizational fragmentation of behavioral health service delivery by multiple state agencies.

The impact of this solution on the problem of HSH's census is unclear.

c. Implement behavioral health services in long term care facilities

MQD offered to review HSH patients believed to need long-term care placement, but this offer was not accepted. By report HSH staff completed assessments (1147) finding few of them would meet Medicaid's nursing facility level of care. Assuming that it is less expensive to care for an individual in a nursing facility compared to the state hospital, AMHD could add a service of long-term care for SMI individuals. For Medicaid beneficiaries, MQD has previously communicated that AMHD services could be provided in nursing facilities.

No data have been provided that quantifies the number of individuals in private hospital psychiatric beds who meet Medicaid eligibility, SMI criteria, and nursing facility level of care. While there may be individuals covered by Medicare with aggressive dementia awaiting long-term care placement, this has not been shown to be contributing to HSH's census. MQD will be working with NF providers to make indicated changes to its acuity adjustment methodology.

The impact of this solution on the problem of HSH's census is unclear.

Long term
3. There are gaps in services or financing of services which increase risk of hospitalization or prolong it
a. Explore options for Department of Human Services (DHS) to increase rates

With a new appropriation, MQD could increase its reimbursement rates for SMI services. This would likely require a fee schedule change, which once increased is difficult to later decrease.

b. Develop long term care facilities as viable placements for individuals with mental illness

MQD has implemented a nursing facility tax that increases payment to nursing facilities by nearly $10 million. If the nursing facilities do not accept more complex patients, the State could consider more closely tying supplemental payments to increased acuity. As previously mentioned, AMHD services provided to Medicaid recipients meeting SMI criteria and nursing facility level of care are eligible to receive Medicaid covered AMHD services provided in a nursing facility.

Department of Human Services (DHS)/Medicaid:
DHS could modify Hawaii Administrative Rules to allow insurance coverage for medically necessary treatment to individuals who would otherwise qualify for Medicaid while they are inpatients at HSH. Expedited eligibility determination for individuals at time of their discharge from HSH would provide for potentially improved continuity of care and improved access the health services while in the community. Additionally, DHS could activate the Memorandum of Agreement on eligibility, allowing presumptive eligibility for HSH discharged patients; address key reimbursement rate issues (e.g., community based inpatient and long term care) for providers; and create a psychiatric Intermediate Care Facility rate for long term care facilities.

Services provided to individuals institutionalized in a prison or mental hospital is not eligible for Medicaid coverage. This is a federal regulation and not modifiable through a HAR change. Please see previous comments about ability for HSH to submit applications prior to discharge under an existing MOU; this MOU is in place and does not need to be "activated." It does not involve presumptive eligibility but instead planning and application submission in advance of discharge. See previous comments about ability to discharge to AMHD without a Medicaid determination. In addition, rather than creating new complexities and workarounds, the benefit of a single unified approach to providing outpatient behavioral health services to Medicaid beneficiaries and uninsured individuals with SMI should be considered. Payment to long-term care facilities is covered only if the individual meets nursing facility level of care. Nursing facilities are receiving increased payment through the nursing facility tax and supplements, and we are working to revise the acuity adjustment methodology.

C. Problem: There are apparent gaps in the community service continuum or in the financing of services which result in heightened risk of hospitalization or prolong hospital stay.
Short Term:
1-Resume having DHS eligibility workers rotated to hospitals to expedite Medicaid eligibility

Hospitals receive payment from DHS to fund outstation eligibility workers, who help ensure the accurate completion of an application. Eligibility determinations cannot be made outside of the eligibility system, HAWI, which is not accessible from hospitals. Please provide the data on Medicaid eligibility determination untimeliness that is contributing to HSH's census. Eligibility for long-term care services involves the federally required 5 year retrospective transfer of assets review including review of relevant documentation. Applicants' production of the necessary documentation is often delayed.

2- Add AMHD services to long-term care facilities-explore LTC facilities becoming AMHD providers.

AMHD services can already be provided to eligible individuals in nursing facilities. Adding nursing facilities as AMHD providers is an AMHD issue.

3- Increase rates paid to vendors by AMHD contracts for priority services.

AMHD can increase reimbursement above Medicaid rates like CAMHD. Behavioral health services are being provided at the current Medicaid fee schedule to individuals receiving SMI services through the QUEST and CCS programs.

Long Term:
1- Develop models for how nursing facilities can become viable placements for SPMI individuals.
2- Explore the potential for an increase Med Quest rates.
3- Develop the capacity to have levels of service intensity with different rates.
4- Add accountability, performance metrics, and quality standards to provider AMHD contracts to achieve better outcomes.

The nursing facility issue receives a lot of attention in this report, but this report does not quantify the magnitude of this problem or its impact to HSH census. Adding a logic model of the various factors contributing to HSH's census with their relative magnitude will help frame where to direct resources for the greatest effect.

Reimbursement has been previously addressed. All individuals must meet SMI criteria so have some similar average need for services. In a capitated reimbursement structure, the responsible provider receives an average payment and is able to shift intensity of services to those most in need.

In addition, we called the Access line as a "secret shopper". We could not reach a live person and received a voice message to call 911 or leave message. I don't know how many individuals call 911 because they were unable to reach someone through the Access line, but increasing ability to respond to callers might assist diversion.

Received from **Herbert Gupton, Ph.D., Director of Human Services Department Honolulu Police Department (HPD)**

On behalf of HPD, I reviewed the SAT Report Draft dated August 24th, 2012. The report appears to reflect the discussion of the most recent SAT meeting and I have no comments to add or revisions to suggest.

I would like to reinforce that I believe the HPD Emergency Psychological Services and Jail Diversion Program (EPSJDP) is a pivotal program on Oahu for diverting SPMI individuals out of the criminal justice system and into the mental health system, thereby not only directing individuals to more appropriate, more cost-effective care, but having a direct impact on reducing referrals to the HSH. Currently, we can document that we diverted fewer than half (approximately 3,000 of the likely 7,000) individuals who came to HPD attention last year because they were not referred to the EPSJDP. This is largely a function of training and capacity, neither of which are we able to increase with current resources. I appreciate that this issue and need have been noted and hope that the current SAT initiative will help us to become more effective in better serving the needs of the community, reducing the demand on the criminal justice system, including the courts, and in reducing the demand on the HSH.

Please call on us if we can be of further assistance.

Aloha, Herb

Received from **Mark Mitchell, Ph.D., Mental Health Administrator**
Hawaii Department of Public Safety (PSD)

Also, I think we need to add a new bullet in either the short or long term section concerning HRS 334.121-134 concerning the Outpatient Involuntary Commitment that reads something like the following:

> "As the Governor's plan completed by the Interagency Council on Homeless has already committed the state to a revision of HRS 334.121-134, the Department of Health with work the Attorney General and other affected parties to revise this statute."

....I would, however, add an item to the legal section whereby there is a "clinical determination" of the detained made on the basis of acuity (irrespective of the charge or panel issues). This could be done by a court clinician, present courts and corrections staff, or other identified diversion staff. What... [is sought]... is for only those detainees that reach the acuity level of inpatient care sent to HSH and all the others sent to PSD (other than the CR's that are addressed elsewhere in the report). Also, I might suggest we somehow "companion" the CR section by not only changing HRS 707-411, but also migrating these clients into an Involuntary Outpatient Treatment order (HRS 334.121-134), as revised.

ATTACHMENT 1

EXECUTIVE CHAMBERS

HONOLULU

NEIL ABERCROMBIE
GOVERNOR

June 14, 2012

EXECUTIVE MEMORANDUM

TO: Bruce Anderson, Chief Executive Officer
Hawaii Health Systems Corporation

Neil Dietz, Chief Negotiator
Office of Collective Bargaining

Loretta J. Fuddy, A.C.S.W., M.P.H., Director
Department of Health

Beth Giesting, Health Transformation Coordinator
Office of the Governor

Keith M. Kaneshiro, Prosecutor
Office of the Prosecutor

Barbara Krieg, Director
Department of Human Resource Development

David Louie, Attorney General
Office of the Attorney General

Patricia McManaman, Director
Department of Human Services

Mark E. Recktenwald, Chief Justice
Hawaii State Supreme Court, Hawaii State Judiciary

Ted Sakai, Director
Department of Public Safety

Dean Seki, Comptroller
Department of Accounting and General Services

John Tonaki, Public Defender,
Office of the Public Defender

Kalbert K. Young, Director
Department of Budget and Finance

FROM: Neil Abercrombie. Governor
State of Hawaii

SUBJECT: Participation in Governor's Special Action Team on the Hawaii State Hospital Census

By this Executive Memorandum, I am directing the above identified Executive Branch agencies and inviting the partner agencies to participate in my Special Action Team to address the increasing census at the Hawaii State Hospital (HSH).

HSH is a key barometer of the pressure on the mental health system across the state. HSH and publicly financed adult inpatient psychiatric treatment in Hawaii are experiencing increasing stress. In the last 6 months, the monthly number of admissions to the HSH has increased by 50% with no corresponding increase in the rate of discharges. As a result, the census has been over licensed capacity for much of the time since May 31, 2012. I am concerned that this may lead to compromised patient care, an outcome we must avoid.

As part of my New Day Plan, revitalizing the mental health system is a key priority. I am convening this Special Action Team to conduct an analysis of the causes of this situation, consider options to address the causes, develop a priority list of recommendations for change, proposals for short and long term solutions, and provide a summary report to my office by August 24, 2012. Please identify one person with decision-making authority from your agency, and one alternate to serve as a designee when needed, who will join in this important activity as we develop solutions. The Special Action Team will be under the capable leadership of Kate Stanley, Governor's Senior Policy Advisor, whom I have asked to convene this group.

Thank you for your assistance as together we work to address this need and improve our services to our citizens most in need.

c: Bruce Coppa, Chief of Staff, Office of the Governor
Kate Stanley, Senior Policy Advisor, Office of the Governor
Lynn Fallin, Deputy Director, Department of Health, Behavioral Health Administration

ATTACHMENT 2

The Hawaii State Hospital (HSH) is the only inpatient institution of the Adult Mental Health Division (AMHD) in the Department of Health Behavioral Health Administration. The mission of AMHD is to provide effective safety net mental health services to ADULTS with severe and persistent mental illness. Services are provided by a recovery based system of community care that integrates evidenced based services, continuous monitoring, and Federal Medicaid revenue reimbursement. Over the last 4 years, the cuts to state and private services due to budget shortfalls have adversely affected the behavioral health system statewide. The cuts combined with access to fewer acute psychiatric beds available statewide, the impact of the closure of HMC to hospitals like Queens and the increased statewide focus on connecting the chronic homeless with behavioral health and other medical care have all contributed to the crisis at HSH.

HSH is a key barometer of the pressure on the mental health system. HSH and publicly financed adult inpatient psychiatric treatment in Hawaii are in crisis. There has been a dramatic increase in the rate of admissions with no corresponding increase in the rate of discharges. With constraints on the amount of resources available to discharge from the facility, we are faced with lack of capacity in the community for lower levels of care. HSH has exceeded its licensed capacity of 202 a number of times during the past five months. AMHD has purchased additional beds, to a total of 32, at Kahi Mohala (a private psychiatric hospital in Ewa Beach).

FY 2010 2011	221 admissions	229 discharges
FY 2009 2010	230 admissions	220 discharges
FY 2008 2009	192 admissions	187 discharges
FY 2007 2008	226 admissions	238 discharges

Calendar year 2012 to the end of May (five months) there have been 133 admissions, projecting an annual rate of $133 * \left(\frac{12}{5}\right) =$ 319 admissions. 319 admissions for a calendar year would represent a 50 % increase above the usual rate of admissions, which is unsustainable given the fixed number of beds available.

A break down on the sources of admissions by the court that referred, severity of charge, and commitment status, for the year to date, is available.

All admissions during this calendar year have been forensic admissions, individuals committed by State of Hawaii Courts. The projected increase in costs associated with the increased medical acuity, increased purchase of overflow beds at Kahi Mohala, increased staffing costs to cover the increased number of patients, and other vacancy related overtime costs are estimated to be **$ 5 million in the next fiscal year.**

It is important that decision makers understand this phenomenon of an increased rate of admissions and engage in problem solving and make added resources available to address the underlying causes.

Many of the individuals hospitalized at HSH either do not require inpatient psychiatric services, do not have a bona fide mental illness, or remain in HSH much longer than is clinically required to treat their conditions to stability. Individuals are committed to HSH with primary problems including dementia, substance abuse, and general medical conditions, primarily because courts either cannot require or cannot identify a more appropriate disposition. There are significant inequities in how individuals with psychiatric disorders committed to HSH are able to access long term care beds, medically necessary physical health interventions, and other needed supports, in comparison to individuals without psychiatric illness or those not committed to DOH.

These significant inequities (e.g. access to long term care, or access to programs or placement alternatives for individuals with developmental disabilities or traumatic brain injury) and the persistent over census situation heighten the risk of litigation (e.g., an Olmstead or United States Department of Justice suit under the Civil Rights for Institutionalized Persons Act (CRIPA)) and vulnerability to claims of regulatory or statutory noncompliance. Hospital operations are made much more difficult and are more risky at times of heightened census and with the current mix of patients.

How Other State Agencies Can Help:

Department of Human Services/Medicaid program: Begin covering medically necessary treatment for individuals who would otherwise qualify for Medicaid while at HSH (This would require a change to DHS's Administrative Rules), by expediting eligibility for individuals at time of discharge from HSH (approximately 20 individuals/month), by reinstituting a Memorandum of Agreement on eligibility, and addressing several key reimbursement rate issues (e.g., community based inpatient and long term care).

Department of Public Safety: Increase internal capability to identify and treat offenders with mental health issues at all Community Correctional Centers, including the successful petition to the courts for involuntary orders to treat (medicate), by addressing potential issues in fitness to proceed (the most common reason for commitment to HSH) while a pretrial detainee is in jail, and by PSD purchasing inpatient psychiatric beds as required for individuals in their custody who require this and update the Memorandum of Agreement between the Department of Health and the Department of Public Safety regarding transfer of prisoners from OCCC to Hawaii State Hospital.

Judiciary: implement consistent administrative standards for issuing orders, expediting scheduling returns to court for individuals who no longer require inpatient level of care, and by supporting a change in law and practice for Adult Client Services (Probation) to emphasize pre trial probation, with a jail term as a consequence of non compliance in alternative to Conditional Release.

Office of the Attorney General: Conduct an analysis and proposing legal alternatives to custody in a hospital setting for individuals who do not require that, Complete a legal analysis and provide support for intermediate sanctions (e.g. electronic monitoring upon release to mitigate public safety risk, as opposed to continued inpatient commitment), review and amend the surrogacy policy, and review and amend the statutes to clarify the eligibility for admission to Hawaii State Hospital.

Department of Human Resource Development/Office of Collective Bargaining,: Negotiate supplemental agreements to allow DOH to reduce overtime costs and streamline hiring practices, prioritize recruitment and hiring support for HSH direct Care positions.

Budget and Finance: Support increases to the budgetary appropriation for AMHD and DOH to allow the rebuilding of the mental health system to provide enough housing and service capacity to maintain community tenure for those who otherwise would be admitted to the HSH.

There has recently been external scrutiny of HSH operations in the areas of overtime and sick leave use, time accounting, overpayments, and pension spiking. The Legislative Auditor is expected to conduct an audit of HSH with a focus on these areas. Additionally, given the lack of an effective mechanism to control the rate of admissions, any limits on filling vacancies will result in an increased use of overtime and will make managing the above areas of HSH finances even more challenging.

Recommendation : The creation of a time limited 'blue ribbon panel' work group to develop options to address these issues described above and on the attached Table, and report back to Chief of Staff by August 24 as to those which are most feasible, with timelines, and that these be considered for inclusion in the Governor's FY 2013 Legislative Package.

Examples for Discussion

Pre / Avoid HSH	HSH (average patient year= $250K)	Post HSH
Expand community level Inpatient beds statewide • Queens Currently no Psych rate negotiated. • Hawaii Health Systems Corporation (HHSC) Hilo $894 Kona $892 Sam Mahelona $784, Maui $791, • Kahi Mohala $745	Lower Overtime Costs • Budget predicated on growth (i.e. 10% increase in patients annually i.e. staffing ratios so add positions and other operational costs including CIP for added beds). • POS beds added automatically in response to triggers (e.g. census exceeds 178)	Long Term Care: Avalon (50 mental health beds). Financing – 2 options • DHS funds supplemental MH services • DOH funds state share of supplemental services through Geriatric ACT[1] Prevail on HHSC long term care to accept more HSH patients at nursing home level of care. Don't know daily rate for AVALON bed so unsure of how to project the cost.
Explore other more appropriate levels of care in community • Crisis Stabilization (locked) • Long Team Care (establish diversion to LTC prior to admission, if indicated) Legislative: If Judges orders to custody, statutory change probably required if not hospital. Attorney General: Review surrogacy policy to place consumers in treatment home (homeless), amend statutes related to eligibility for HSH admission, hospitalization limit, define what "dangerous" means in statute.	Discharge Planning • MOA(s) with DHS on eligibility determination while at HSH(estimated 20 discharges/month) • Medicaid presumptive eligibility upon discharge • DHS to modify Administrative Rules regarding excluding medically necessary coverage while a patient at HSH • HSH modifies treatment planning process and engages community providers earlier.	Special Residential and Therapeutic Living Community based programs – purchase approximately 30 more beds. I am assuming 30 of each type of bed. TLP: 30x$175 per dayx365=$1,916,250 This is based on 100% occupancy of 30 beds at the current AMHD rate of $175. Specialized Residential: 30x$236.14x365=$2,585,733 This is based on 100% occupancy of 30 beds at the current AMHD rate of $236.14.
Increased capacity and Substance Abuse Treatment Options – very high frequency occurrence, too few beds. • Co-occurring Disorder Treatment – add slots for forensic involved. • Other Specialized Capacity	MOA between DOH and PSD/OCC regarding MH-9 transfers. • PSD purchases own inpatient capacity • Provides security support for transferees	Forensic ACT[1] – establish as a pilot for individuals on Conditional Release, with a history of non compliance The cost in FY07 for 588 consumers to receive ACT was $10,6million and in FY08 for 526 consumers to receive ACT was 10.5million. So based on this, it is about 18-20,000 per consumer per year to receive ACT services.
PSD and HSH Forensic Behavioral Health Facility – organize joint planning group to develop plan for specialized facility for dangerous individuals truly requiring inpatient treatment. PSD and DOH update the MOA regarding commitment of prisoners from OCCC to HSH.		Electronic monitoring post release for individuals with history of leaving placements.
Access ACA Incentive payment options to target needed services, reduction of census, or diverting admissions		

[1] ACT , which stands for Assertive Community Treatment, is an intensive community based model designed to avert hospitalization, through involvement of a team of Mental Health professionals, with frequent, up to daily, contact with consumer

ATTACHMENT 3

Governor's Special Action Team (SAT)

July 17, 2012

1

Why are we here?

- Hawaii State Hospital admission rates are exceeding available capacity in the system
- Department of Health responses have not materially resolved the situation
- This Special Action Team is convened to review the situation and make recommendations to the Governor's Office

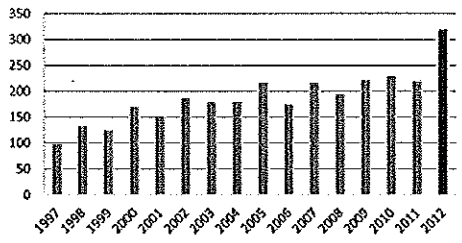
2

Adult Mental Health Division overview

- Community Mental Health Centers (CMHCs)=2036 consumers in case management
- Purchase of Service Providers = 4439 In case management
- Hawaii State Hospital (HSH) = licensed for 202 and budgeted for 168 - Average census exceeded licensed capacity for all of June 2012
- Conditional Release (CR) Consumers = 520
- All services combined = about 14,000 people per year

3

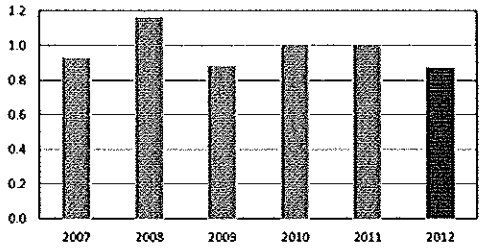
HSH Admissions by Calendar Year



Note: Number of 2012 is projected based on the data of 1/1/2012 - 6/30/2012.

4

Discharge/Admissions Ratio by Calendar Year: Ratio below 1 = census increase



Note: Number of 2012 is projected based on the data of 1/1/2012 - 6/30/2012.

5

HSH admissions: Compared to the same time period in 2011, an additional 58 admissions in the first six months of 2012

- **57% increase, compared to 102 admits first six months 2011**
- 18 added admissions were pending an evaluation of fitness (more than double) – Clark does not apply
- 36 added admissions were unfit, pending restoration of fitness (more than double, from 34 in 2011) – Clark applies

6

Where have the added admissions in 2012 come from ?

- Oahu admissions increased from 60 to 98
- Maui admissions increased from 11 to 19
  - 13 of the Maui admissions were pending evaluation of fitness (404), 40 % of the statewide total for this admissions category
- Hawaii Island admissions increased from 22 to 34

2011: 35 % of admissions were new to HSH

2012: 44 % of admissions were new to HSH

7

Calendar 2012: HSH/Kahi Mohala discharge destinations

- 28 went home on their own, to family or semi independent living (most frequent outcome)
- 23 went to Special Residential Programs
- 19 went to a supervised group home (24/7)
- 19 went to jail
- 7 went to a Therapeutic Living Program (TLP)
- 6 went to an Expanded Adult Residential Care Home (E-ARCH)

8

What do HSH patients need ? Most patients don't need inpatient, even upon admission

Level of Care needed upon Admission for 96 admissions Jan-April 2012			
LOCUS 3	Independent Living with high support	6	6%
LOCUS 4	Group Home, Case management, etc	32	33%
LOCUS 5	Special Residential, ICF, SNF	46	48%
LOCUS 6	Inpatient	12	13%
	Total	96	

9

What do HSH patients need? Survey of HSH MDs

Of 191 patients (July 7, 2012) : Only 48 need acute inpatient

- 12 need nursing home placement
- 17 are stable but kept at HSH due to a violent crime (usually murder)
- 17 need locked drug treatment rather than psychiatric treatment(12 are here with drugs as their only problem)
- 26 have violent histories that make placement very difficult
- All placements need support around increased tolerance:
  - –History of violence
  - –History of specific charges

10

More about HSH inpatients and financing

- Most patients (90+%) meet financial eligibility requirements for Medicaid upon admission
- Many (90+%) are either disabled or meet eligibility requirements for General Assistance upon discharge
- Physical Health Care poorly coordinated prior and post admission – meaningful fraction have significant physical health conditions, some very serious and very expensive.

HSH is funded with 100% General Appropriation, except for small Medicare "D" program.

11

Recent History 2009-2012

- Economic downturn affected all branches of state government and services
- Service capacity was affected:
  - – AMHD
  - – Community inpatient capacity decreased
  - – Increased use of police
  - – 30% increase in court ordered examinations
  - – Two hospitals closed

12

DOH response actions

- Twice weekly Division wide discharge and system capacity reviews
- Expanded contracted beds at Kahi 16 to 40
- Attempted to admit to Hawaii Health System Corporation and Castle Medical Center
- Filled virtually all available outpatient housing beds and services
- Meetings with courts and prosecutors

13

Outcomes of actions

- 100+% occupancy of HSH beds
- 95+% occupancy of contracted community group home beds
- 150% increase in contracted beds in community hospitals (40 now, was 16)
- >300% increase in admissions to HHSC hospitals in July thus far (5 compared to 1.5 average daily census)
- 8 more residential treatment beds pending licensing

14

Department of Justice (DOJ) -CRIPA

- A Civil Rights of Institutionalized Persons Act (CRIPA) lawsuit against the State of Hawaii and Hawaii State Hospital began in 1991, alleging unconstitutional conditions such as:
  - Inadequate food, shelter, clothing
  - Unsafe pharmacology
  - Inadequate medical care
  - Lack of active treatment leading to undue physical restraint
  - Unsafe housing
- The DOJ case expanded federal court jurisdiction into the community mental health system as the court deemed there was an insufficient array of treatment and discharge options to relieve crowding at HSH and allow for adequate care

15

DOJ - Olmstead

- DOJ has an interest in requiring states to provide increased supported housing in the community rather than institutional placements (Olmstead v. Zimring, ADA case from U.S. Supreme Court)
- Advocacy groups also active in this area

16

Clark Permanent Injunction

- U.S. District Court permanent injunction named for the lead plaintiff
- Sets very specific short timelines in which certain individuals remanded to the custody of DOH must be transferred over
- Constitutional issues
- Directors of DOH and PSD are subject to the injunction
- Reporting requirements to Hawaii Disability Rights Center (HDRC)

17

Summer 2012: DOH believes capacity is essentially being fully used

- The HSH rate of admissions and census remains higher than system can manage
- Consultation with Governor's Office resulted in the creation of this Special Action Team
- No 'silver bullet' solution is expected
- The input and assistance of other State agencies is appropriate and necessary

18

Future DOH Interventions Planned

HSH Diversion	HSH Internal	Post Discharge
↑ community services	↑ beds	↑ community services
↑ inpatient contracts	↑ discharges	↑ inpatient contracts
Outpatient fitness program		Outpatient fitness program
↕ state operated services	↕ state operated services	↕ state operated services
↕ budget	↕ budget	↕ budget
Change laws	Change laws	Change laws
New services	New services	New services

19

Next Steps - Special Action Team

- Subcommittees to meet twice
  - Personnel/Finance/Procurement
  - Legal/Legislative
  - Programs and Operations
- SAT meets twice more
- Report to Governor's Office by August 24

20

SAT and Subcommittee schedule

SAT Meeting	Tuesday, July 17 State Capitol, 5th Floor 1:30PM-3:30PM	Tuesday, August 7 State Capitol, 5th Floor 10:00AM-12:00PM	Tuesday, August 21 Kinau Hale, 1st Floor CR 2:00PM-4:00PM

Subcommittees: Between now and August 21st, please hold 2 meetings.
Meetings can be face to face, teleconference or by email.

Subcommittee 1 Human Resources/Procurement/Financing	Subcommittee 2 Clinical Operations/Program Capacity	Subcommittee 3 Legal/Judicial
Participants:	Participants:	Participants:
As a starting point, what are the relevant factors that influence and impact Admissions to HSH. >	As a starting point, here are relevant factors that influence and impact Admissions to HSH. >	As a starting point, here are relevant factors that influence and impact Admissions to HSH. >
Short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.	Short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.	Short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.

21

Subcommittee 1
Human Resources / Procurement / Financing

Participants:
- Accounting and General Services
- Budget and Finance
- Human Resources Development
- Office of Collective Bargaining
- HRO-DOH

As a starting point, what are the relevant factors that influence and impact the Admissions to HSH.
- ➢ Work force and HR issues
- ➢ Procurement of expanded community programs
- ➢ Building or buying more inpatient capacity

Short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.

22

Subcommittee 2
Clinical Operations/Program Capacity

Participants:
- Hawaii Health Systems Corporation
- DOH
- Department of Human Services
- Department of Public Safety
- Other

As a starting point, here are relevant factors that influence and impact the Admissions to HSH.
- ➢ Increased capacity
- ➢ Expedite benefits
- ➢ Enhance treatment in PSD

Short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.

23

Subcommittee 3
Legal/Judicial/Legislative

Participants:
- Judiciary
- Office of the Attorney General
- Office of the Prosecutor
- Office of the Public Defender
- DOH
- PSD

As a starting point, here are relevant factors that affect Admissions to HSH.
- ➢ Are there changes in Law which could be proposed ?
- ➢ Are there potential changes in systems of practice which would make a difference?
- ➢ Are there intermediate venues for care, treatment or custody which can be developed?

Short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.

24

THANK YOU!

- Discussion
- Questions
- Items left out
- Anything else?

25

ATTACHMENT 4

OVERVIEW / SCHEDULE OF COMMITTEES

SAT Meeting	July 17 State Capitol, 5th Floor 1:30 p.m.-3:30 p.m.	August 7 State Capitol, 5th Floor 10:00 a.m.-12:00 p.m.	August 21 Kinau Hale, 1st Floor CR 2:00 p.m.-4:00 p.m.

Sub-Committees: Because of the short timeline, we'll be looking at short and long-term strategies. The short term strategy needs to focus on Hawaii State Hospital's census. **Between now and August 21st, please hold 2 meetings.** The meetings can either be face to face, by phone or by email.

Sub-Committee 1 **Human Resources / Procurement / Financing**	Sub-Committee 2 **Clinical Operations / Program Capacity**	Sub-Committee 3 **Legal / Judicial**
Participants: • Accounting and General Services • Budget and Finance • Human Resources Development • Office of Collective Bargaining • DOH HRO/ASO	Participants: • Hawaii Health Systems Corporation • Health • Human Services • Public Safety •	Participants • Judiciary • Office of the Attorney General • Office of the Prosecutor • Office of the Public Defender
DOH/AMHD/HSH Facilitators: William Elliott Mark Fridovich	**DOH/AMHD/HSH Facilitators:** William Sheehan Dawn Mendiola, Steve Balcom	**DOH/AMHD/HSH Facilitators:** Andrea Armitage William Sheehan, James Westphal, Mark Fridovich
As a starting point, here are relevant factors that influences and impacts the Admissions to HSH. ➢ ➢ Determine short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.	As a starting point, here are relevant factors that influences and impacts the Admissions to HSH. ➢ ➢ Determine short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.	As a starting point, here are relevant factors that influences and impacts the Admissions to HSH. ➢ ➢ Determine short-term goals and long-term solutions. Provide doable and realistic solutions to include in the report to the Governor.
PROPOSED MEETING DATES		
1ST Meeting: Between July 30-August 3 2nd Meeting: Between August 13-16	1ST Meeting: Between July 30-August 3 2nd Meeting: Between August 13-16	1ST Meeting: Between July 23-27 2nd Meeting: Between August 8-10
STAFFING		
Amy Morton-Sogi Office of Program Improvement and Excellence	Mary Brogan, Performance Improvement Coord. Office of Program Improvement and Excellence	Dudley Akama, Deputy Attorney General

Suggestions for Discussion/Kick off Topics

Sub-Committee 1 **Human Resources / Procurement / Financing**

As a starting point, here are some possible issues/proposals for discussion

- Support budget increases for AMHD and HSH to allow rebuilding and revitalizing the publicly funded mental health system
- Assist HSH in overtime and sick leave use, time accounting, overpayments, and spiking
- Approve increases in HSH position counts, capital improvements, and operating funds to address planned deficit in budget
- Expedite all requests to fill positions from AMHD
- Assist in procuring or building additional beds at HSH
- Assist in procuring added community resources
- Authorize and help negotiate Supplemental agreements to allow HSH to reduce overtime and streamline hiring
- Prioritize recruitment and hiring for HSH direct care positions
- Integrated planning for a Joint PSD-DOH facility
- Help PSD to acquire separate inpatient capacity

Sub-Committee 2 **Clinical Operations / Program Capacity**

As a starting point, here are some possible issues/proposals for discussion.

- Expedited eligibility for HSH discharging consumers
- Presumptive eligibility for HSH discharging consumers
- Expedite long term care benefits eligibility
- Increase certain rates to attract more providers, especially in long term care
- Continue medicaid for medically necessary treatments while at HSH
- Increase number of beds for AMHD consumers, what new program types?
- Liberalize admission criteria for AMHD consumers to be accepted and paid for under current contracts
- Expand community inpatient psychiatric beds statewide
- Propose ideas as to how to better assist consumers maintaining their tenure in the community
- Increase internal clinical capacity to provide services to all detainees in all PSD facilities – statewide
- Expand capacity for PSD to obtain Orders to Treat, statewide

Sub-Committee 3 **Legal / Judicial**

As a starting point, here are some possible issues/proposals for discussion.

- Implement consistent administrative system for issuing orders statewide
- Ensure orders are written before court adjourns, and provide timely transport to a PSD facility, when ordered
- Ensure examiner reports come with defendant to HSH
- Expedite return to court dates for HSH
- Support Adult Client Services emphasizing pre-trial probation rather than hospitalization
- Support electronic monitoring for individuals with a history of eloping
- Implement quality improvement projects for forensic issues in courts
- Establish and enforce criteria for inpatient hospitalization to be met before prosecutors agree to HSH as placement
- Advocate for increased psychiatric services to be provided in public safety facilities
- Assist in advocating for increased access to psychiatric services with Public Safety facilities
- Advocate for community placement and services for those charged with non-violent crimes rather than inpatient hospital
- Advocate for those not charged with non-violent crimes to remain in custody rather than hospital
- Recommend other legal alternatives to custody to director of health
- Support surrogacy policy for HSH
- Analyze considerations for intermediate sanctions other than hospitalization
- Propose amendments to statute on eligibility for admission to HSH, definitions of dangerousness, and limits on length of stay
- Review the Clark Permanent Injunction for modification of requirements
- Propose legislation to define the term 'dangerous'
- Propose language to allow commitment to a non-hospital level of care for those ordered to DOH custody
- Propose legislation to allow individuals ordered to custody of DOH to be able to legally return to custody without court action once HSH staff assesses them to no longer require inpatient level of care.

ATTACHMENT 5

Governor's SAT
Subcommittee #3

Legal / Judicial

Place: Office of the Attorney General Ph: 586-1500
425 Queen Street, Second Floor
(Corner of Punchbowl and Queen Street)

MEMBERSHIP REPRESENTATIVE	TITLE / ORGANIZATION	SUPPORT	1st Mtg WILL ATTEND 7/26/12	2nd Mtg WILL ATTEND TBA
Armitage, Andrea Andrea.j.armitage@hawaii.gov	Deputy Attorney General Office of the Attorney General	Doreen T. Takata 587-3050 Doreen.t.takata@hawaii.gov	Yes	
Christopher, Michael drmechristopher@gmail.com mchristopher@honolulu.gov	Psychologist (MH1 Program) Honolulu Police Department	723-7743		
Fallin, Lynn 586-4416 lynn.fallin@.doh.hawaii.gov	Deputy Director Behavioral Health Administration	Valery Nomura-Ishida 586-4416 valery.nomura@doh.hawaii.gov	Yes	
Fridovich, Mark Mark.fridovich@doh.hawaii.gov	Administrator Hawaii State Hospital	Toki Thomas 236-8237 Toki.thomas@doh.hawaii.gov	Yes	
Goto, Lance Lance.m.goto@hawaii.gov	Deputy Attorney General Criminal Justice Division, AG	586-1160		
Iboshi, Charlene ciboshi@co.hawaii.hi.us	Prosecuting Attorney Office of the Prosecutor - Hawaii	Porsha Hara 808-961-0466 p.hara@co.hawaii.hi.us	No	
Iseri-Carvalho, Shaylene scarvalho@kauai.gov	Prosecuting Attorney (Appointed Position) Office of the Prosecutor – Kauai	Renee Layosa 808-241-1888 rlayosa@kauai.gov	Yes **By phone	
Kaneshiro, Keith Kkaneshiro5@honolulu.gov	State Prosecutor Office of the Prosecutor	Lynn Nishiki 768-6407 lnishiki@honolulu.gov	Yes	
Kim, John John.kim@co.maui.hi.us	Prosecuting Attorney (Appointed Position) Office of the Prosecutor - Maui	Karen Montalvo 808-270-7777 Karen.montalvo@co.maui.hi.us	Yes By phone	
Mitchell, Mark Mmitch0424@gmail.com Mark.r.mitchell@hawaii.gov	Mental Health Branch Administrator Department of Public Safety	Christine M. Pang 587-3379 Christine.m.pang@hawaii.gov	Yes	
Perkins, Judge Richard Richard.k.perkins@courts.hawaii.gov	Judge Circuit Court of the First Circuit	Kesha Wing Morton 539-4044 Kesha.m.wing@courts.hawaii.gov	Yes	
Phillips, Janet Janet.phillips@doh.hawaii.gov	Forensic Coordinator Hawaii State Hospital		Yes	
Rian, Heidi Heidi.m.rian@hawaii.gov	Deputy Attorney General Office of the Attorney General	Diane Shito 587-3050 Diane.a.shito@hawaii.gov	Yes	
Sheehan, William 586-4770 William.sheehan@doh.hawaii.gov	Chief Adult Mental Health Division	Valerie Low 586-4770 Valerie.low@doh.hawaii.gov	Yes	
Tonaki, John John.m.tonaki@hawaii.gov	State Public Defender Office of the Public Defender	Esther Fukushima 586-2200 Esther.m.fukushima@hawaii.gov	Yes *Designee	
Tyler, Carol Carol.tyler@doh.hawaii.gov	Courts Examiner Supervisor Courts & Corrections, AMHD, DOH	832-5620	Yes	
Westphal, James James.westphal@doh.hawaii.gov	Medical Director (Acting) Hawaii State Hospital	Charlene Yee 236-8238 Charlene.yee@doh.hawaii.gov	Yes	
Young, Chris Christopher.d.young@hawaii.gov	Deputy Attorney General Criminal Justice Division, AG	586-1160	No (on leave)	

* Bagasol, William Willima.c.bagasol@hawaii.gov, Deputy Public Defender attending for John Tonaki
**Jake Delaplane jdelaplane@kauai.gov, First Deputy Prosecutor will phone in to represent Shaylene Iseri-Carvalho

DEPARTMENT OF HEALTH (DOH) THE SPECIAL ACTION TEAM (SAT)

DRAFT SUMMARY
Subcommittee #3 Legal / Judicial

Date: July 26, 2012
Time: 2:00 p.m.
Location: Hale Auhau Second Floor Conference Room; 425 Queen Street
Facilitator/Participants Andy Armitage & Jim Westphal
Attendees: Judge Perkins; Mark Mitchell; Keith Kaneshiro; Jan Futa; Michael Christopher; John Kim (Maui, via phone); Jake Deleplane (Kauai, via phone); Willy Bagasol; Heidi Rian; Dudley Akama; Lynn Fallin; Carol Tyler (Oahu, via phone); Janet Phillips; Lance Goto; Mark Fridovich; and Bill Sheehan **Unable to attend:** Charlene Iboshi (Big Island) and Judge Simms (State Council on Mental Health)

Problem	DISCUSSION	Short Term Proposals	Long term Proposals	HSH Impact/ Fiscal estimate	Follow up (who/when)
Forensic Exams take too long.	Reasons: 1. Many defendants waiting for evaluations do not need hospital level of care.	1a. Order defendants to go to "other suitable facility[ies]" for evaluations rather than HSH pursuant to HRS §704-404(2). Need to define "other suitable facility." 1b. Implement a "courtroom clinic" model or expand AMHD's court-based clinician program to Honolulu Circuit Court (may be a long term proposal).		Increased HSH length of stay Fiscal impact: $1 million dollars per year in excess HSH inpatient days plus cost of 3 panel exams to the judiciary	
	2. It takes too long to obtain the records.	a. Revise standard orders to order public agencies to turn over their records to Adult Probation.			

Problem	DISCUSSION	Short Term Proposals	Long term Proposals	HSH Impact/ Fiscal estimate	Follow up (who/when)
		b. PSD to provide reports on defendants who they have seen for a while to Probation.			
	3. VA records often missing.	[Not discussed.]			
	4. Extensions requested due to examiner workload (usually State examiners).	Consider using private examiners for HRS §704-404(2) non felony evaluations rather than the State evaluators – issue will be who will pay, DOH or Judiciary.	a. Implement National Model for Competency Evaluations, which would eliminate 3-panel examinations (requires change to HRS §704-404). b. Separate evaluations for fitness from evaluations for penal responsibility. Only do the latter when the defendant wants to use the defense of NGRI (requires change to HRS§704-404(4)(d) and (e)). Do not require a formal diagnosis for fitness evaluations since may not be necessary for fitness determination (requires changes to HRS §704-404(4)(b)).		
	5. Defendants don't consent to release of records perhaps because examination reports are not confidential or sealed.	Require all competency evaluations to be confidential and sealed – may encourage defendants to consent to the examinations more often.			
	6. Diversion Project's Psychological Emergency Report Forms (PERF) rarely requested or reviewed.	Educate examiners as to the existence of the PERFs and how to obtain them.			

Problem	DISCUSSION	Short Term Proposals	Long term Proposals	HSH Impact/ Fiscal estimate	Follow up (who/when)
II. HPD's Diversion Program may be underfunded.	HPD could expand psychologists on call 24/7. The program could be implemented on Neighbor Islands; there are not enough trained on-call doctors or officers to have success on the outer islands.	Estimate optimal level of funding for Diversion program.		HSH impact; increased diversions could decrease admissions Fiscal impact: unknown	Michael Christopher to provide data
III. **a. Court orders are unclear.** **b. Court orders are not received by HSH in a timely fashion.**	Judge Perkins is working with Judge Koyanagi (Honolulu District Court) to draft standard orders. Andy Armitage volunteered to assist.	a. Create standard orders to be used Statewide. b. Have all orders on Mental Health cases be expedited so that no one leaves the courthouse without one.		b. increased HSH length of stay fiscal impact: $150, 000 for previous 6 months	Judge Perkins and Andy Armitage
IV. HSH is only possible placement for a Conditional Release violation	There is no place to send CR violators but to HSH, even if they do not need hospital LOC. HSH does not address the reasons for their violations of CR – stopped taking meds; dirty UAs; no shows to appointments. CR is an expensive status, especially for those acquitted of a non felony. Most states do not have CR for non felony offenses.	Fix Act 99 (2011) so that 1 year CR limitation for non felony offenses applies to all placements on CR and not just ones that are ordered directly after acquittal (change HRS §704-411(1)(b) to provide, "this chapter" rather than "this paragraph").	Modify Hawaii's Outpatient Involuntary Treatment Order statute. HRS §334-121 et seq. GPS monitoring of people on CR?	Reduce HSH admissions, fiscal impact:	Mark Fridovich to have statistics re. CR violators for next meeting. Andy Armitage will follow up with DOH on the Act 99 fix as part of 2013 Legislative Package.

Problem	DISCUSSION	Short Term Proposals	Long term Proposals	HSH Impact/ Fiscal estimate	Follow up (who/when)
V. Some patients at HSH are unfit and not restorable due to problems other than Mental Illness, such as developmental disabilities, dementia, or traumatic brain injury.	There appear to be no other public agencies responsible for their care.	Mention this issue to SAT Subcommittee #2.			
VI. Adjournment	Meeting adjourned at 4:15p.m.				

Governor's SAT
Subcommittee #3

Legal / Judicial

Place: Office of the Attorney General Ph: 586-1500
425 Queen Street, Second Floor
(Corner of Punchbowl and Queen Street)

MEMBERSHIP REPRESENTATIVE	TITLE / ORGANIZATION	SUPPORT	1st Mtg WILL ATTEND 7/26/12	2nd Mtg WILL ATTEND 8/9/12
Armitage, Andrea Andrea.j.armitage@hawaii.gov	Deputy Attorney General Office of the Attorney General	Doreen T. Takata 587-3050 Doreen.t.takata@hawaii.gov	Yes	Yes
Christopher, Michael drmechristopher@gmail.com mchristopher@honolulu.gov	Psychologist (MH1 Program) Honolulu Police Department	723-7743		? (No response)
Fallin, Lynn 586-4416 lynn.fallin@.doh.hawaii.gov	Deputy Director Behavioral Health Administration	Valery Nomura-Ishida 586-4416 valery.nomura@doh.hawaii.gov	Yes	? (previous appt.)
Fridovich, Mark Mark.fridovich@doh.hawaii.gov	Administrator Hawaii State Hospital	Toki Thomas 236-8237 Toki.thomas@doh.hawaii.gov	Yes	Yes
Goto, Lance Lance.m.goto@hawaii.gov	Deputy Attorney General Criminal Justice Division, AG	586-1160		? (No response)
Iboshi, Charlene ciboshi@co.hawaii.hi.us	Prosecuting Attorney Office of the Prosecutor - Hawaii	Porsha Hara 808-961-0466 p.hara@co.hawaii.hi.us	No	Yes By phone
Iseri-Carvalho, Shaylene scarvalho@kauai.gov	Prosecuting Attorney (Appointed Position) Office of the Prosecutor – Kauai	Renee Layosa 808-241-1888 rlayosa@kauai.gov	Yes **By phone	Yes
Futa, Jan (for Kaneshiro, Keith) jfuta@honolulu.gov	Deputy Prosecuting Attorney Office of the Prosecutor	768-6458	Yes	Yes
Polak Simone (for Kim, John) Simone.polak@co.maui.hi.us	Deputy Prosecuting Attorney Office of the Prosecutor – Maui	808-270-5715	Yes By phone	Yes By phone
Yee, Victor (for Mitchell, Mark) Victor.s.yee@hawaii.gov	OCCC MH Section Administrator Department of Public Safety	Sally 832-3762	Yes	Yes
Perkins, Judge Richard Richard.k.perkins@courts.hawaii.gov	Judge Circuit Court of the First Circuit	Kesha Wing Morton 539-4044 Kesha.m.wing@courts.hawaii.gov	Yes	Expected (not confirmed)
Phillips, Janet Janet.phillips@doh.hawaii.gov	Forensic Coordinator Hawaii State Hospital		Yes	Yes
Rian, Heidi Heidi.m.rian@hawaii.gov	Deputy Attorney General Office of the Attorney General	Diane Shito 587-3050 Diane.a.shito@hawaii.gov	Yes	Yes
Sheehan, William 586-4770 William.sheehan@doh.hawaii.gov	Chief Adult Mental Health Division	Valerie Low 586-4770 Valerie.low@doh.hawaii.gov	Yes	Yes
Tonaki, John John.m.tonaki@hawaii.gov	State Public Defender Office of the Public Defender	Esther Fukushima 586-2200 Esther.m.fukushima@hawaii.gov	Yes *Designee	Yes
Tyler, Carol Carol.tyler@doh.hawaii.gov	Courts Examiner Supervisor Courts & Corrections, AMHD, DOH	832-5620	Yes	Yes
Westphal, James James.westphal@doh.hawaii.gov	Medical Director (Acting) Hawaii State Hospital	Charlene Yee 236-8238 Charlene.yee@doh.hawaii.gov	Yes	Yes
Young, Chris Christopher.d.young@hawaii.gov	Deputy Attorney General Criminal Justice Division, AG	586-1160	No (on leave)	? (No response)
	Call-In Number Conf. call Access No.: 888 482-3560 7 Digit Access Code: 3608009			

DEPARTMENT OF HEALTH (DOH) THE SPECIAL ACTION TEAM (SAT)

DRAFT SUMMARY

(From the Second Meeting)

Subcommittee #3 Legal / Judicial

Date: August 9, 2012
Time: 3:00 p.m. - 5:00 p.m.
Location: Department of Health, Kinau Hale, 1st Floor Conference Room
Participants:

Judge Richard Perkins
Victor Yee, PSD
Jan Futa, Honolulu Deputy Prosecuting Attorney
Dr. Michael Christopher, HPD
Charlene Iboshi, Hawaii Island Prosecutor
Simone Polak, Maui Deputy Prosecuting Attorney (attending by phone)
Carol Tyler, DOH Acting Administrator of Courts & Corrections Branch
Heidi Rian, Supervising Deputy Attorney General
Jack Tonaki, Public Defender
Lynn Fallin, DOH Deputy Director of Behavioral Health
Shaylene Iseri-Carvalho, Kauai Prosecutor
Janet Phillips, DOH Forensic Coordinator for HSH
Lance Goto, Deputy Attorney General, Criminal Justice Division
Judge Sandra Simms, Retired, State Council on Mental Health

Facilitators: Andrea Armitage, Deputy Attorney General; William Sheehan, DOH AMHD Chief and Acting Medical Director; Mark Fridovich, DOH HSH Administrator; James Westphal, DOH Acting Medical Director of HSH

1. Introductions

2. Review concerns from Kate Stanley:
   a) Short Term = by 6/30/13; Long Term > 6/30/13
   b) No long wish list; be realistic and cost effective
   c) Look to interagency solutions
   d) Coordinate decision making with other subcommittees – send subcommittee meeting summaries to all members of each subcommittee

3. Summaries of what Subcommittees #2 and #1 are doing; by Bill Sheehan and Mark Fridovich, respectively.

Problem	Discussion	Short Term Proposals	Long Term Proposals
I. Forensic Exams take too long. Fiscal Impact: $1 million dollars per year in excess HSH inpatient days plus cost of 3 panel exams to the Judiciary.	**1. Many defendants waiting for evaluations do not need hospital level of care.**		**1a. Implement a "courtroom clinic" model or expand AMHD's court-based clinician program to Honolulu Circuit Court and to Neighbor Island Courts (forensic coordinator?) to give Court an assessment of defendants' level of care needs (not fitness).** **1b. Order defendants to go to "other suitable facility[ies]" for evaluations rather than HSH pursuant to HRS §704-404(2). Need to define "other suitable facility." Can this include unlocked facilities?**
	2. It takes too long to obtain the records.	**2a. Revise standard orders to order public agencies to turn over their records to Adult Services Branch. Judiciary is already working on this.** **2b. PSD to provide reports on defendants who they have seen for a while to Adult Services Branch. Explore ways of using secure technology to share information.**	
	3. Extensions requested due to high examiner workload (usually State examiners).	**3a. Consider using private examiners for HRS §704-404(2) non felony evaluations rather than the State**	**3b. Separate evaluations for fitness from evaluations for penal responsibility. Only do the latter when**

Problem	Discussion	Short Term Proposals	Long Term Proposals
		evaluators – issues: Who will pay, Judiciary or DOH? And Will this violate civil service laws/Konno? No consensus on this issue. Do not require a formal diagnosis for fitness evaluations since may not be necessary for fitness determination (requires changes to HRS §704-404(4)(b)). No consensus.	the defendant wants to use the defense of NGRI (requires change to HRS §704-404(4)(d) and (e)). No consensus (?). Perhaps change HRS §704-404(4) "shall" to "may." ("The report of the examination shall include the following:") 3c. Implement National Model for Competency Evaluations, which would eliminate 3-panel exams (requires change to HRS §704-404). Find out more about this and explore.
	4. Defendants don't consent to release of records perhaps because examination reports are not confidential or sealed.	Require all fitness and penal responsibility evaluations to be confidential and sealed – may encourage defendants to consent more often. Done per new HCRR Rule 9	
	5. Diversion Project's Psychological Emergency Report Forms (PERF) are rarely requested or reviewed by examiners.	Educate examiners as to the existence of the PERFs and how to obtain them. Revised Court order that orders public agencies with relevant information to share with Adult Services Branch should solve confidentiality issue.	

Problem	Discussion	Short Term Proposals	Long Term Proposals
II. a. Court orders are unclear. **b. Court orders are not received by HSH in a timely fashion.** Fiscal Impact: $150.000 for previous 6 mos.	**Judge Perkins and Judge Koyanagi are working together with assistance from Andy Armitage to draft standard, statewide, expedited orders.**	**a. Create standard orders to be used Statewide.** **b. Have all orders on chapter 404 cases be expedited so that no one leaves the courthouse without one.** **Yes, with Neighbor Island input.**	
III. HSH is only possible placement for a Conditional Release violation.	**CR is an expensive status, especially for those acquitted of a non felony. Most states do not have CR for non felony offenses.**	**Fix Act 99 (2011) so that 2 year CR limitation for non felony offenses applied to all placements on CR, not just ones that are ordered directly after acquittal (change HRS §704-411(1)(b) to provide, pursuant to "this chapter" rather than "this paragraph." Also make it clear what happens to the 1 year timeline when person put on 72 hour hold or CR revoked. Can we make 1 year limitation for non felonies retroactive? Yes.** **All agree to make this a priority.**	

4. Adjourned at 5:15 p.m.

Governor's SAT
Subcommittee #2 Clinical Operations / Program Capacity

MEMBERSHIP REPRESENTATIVE	TITLE / ORGANIZATION	SUPPORT	ATTEND 7/30/12	ATTEND 8/13/12
Balcom, Steven 453-6922 Steven.Balcom@doh.hawaii.gov	Crisis/Specialized Residential Services Coordinator/ AMHD		Yes	Yes
Brogan, Mary 586-4125 Mary.Brogan@doh.hawaii.gov	Performance Improvement Coordinator OPIE		Yes	Yes
Christopher, Michael 723-7743 drmechristopher@gmail.com mchristopher@honolulu.gov			Yes	Yes
Durant, Michael 949-7553 gmdurant@earthlink.net	Chair State Council on Mental Health	**Designee:** Chad Koyanagi, M.D. koyanagic@dop.hawaii.edu	Yes	Yes
Fallin, Lynn 586-4416 lynn.fallin@.doh.hawaii.gov	Deputy Director Behavioral Health Administration	Valery Nomura-Ishida 586-4416 valery.nomura@doh.hawaii.gov	Yes	Yes
Ferreira, Paul (808) 961-2244 pferreira@hawaiicounty.gov	Deputy Police Chief Hawaii Police Department		XX	
Fink, Kenneth S. 692-8056 kfink@medicaid.dhs.state.hi.us	Med-QUEST Division, Administrator Department of Human Services	Jeri-Ann Kido 692-8056 jkido@medicaid.dhs.state.hi.us	Yes	
Greene, George 521-8961 Ggreene@hah.org	President and CEO Healthcare Association of Hawaii	Leslie Ho 521-8961 lho@hah.org	Yes	Yes
Lee, Vince 733-7911 vlee@hhsc.org	Chief Executive Officer, Oahu Region Hawaii Health Systems Corporation	Susan Villiatora 733-7911 svilliatora@hhsc.org	Yes	By Phone
Licina Leonard 677-2503 licinal@kahi.org	CEO Kahi Mohala Hospital		Yes	Yes
McManaman, Patricia 586-4997 PMcManaman@dhs.hawaii.gov	Director Department of Human Services	Kamaile Brown 586-4996 KBrown2@dhs.hawaii.gov		
Mendiola, Dawn 586-4689 Dawn.mendiola@doh.hawaii.gov	RMD Coordinator/Interim OT Lead Adult Mental Health Division	Crystal Cortez-Dall 586-4684 Crystal.Cortez-Dall@doh.hawaii.gov	Yes	Yes
Mitchell, Mark R. 256-1508 Mark.r.mitchell@hawaii.gov	Mental Health Branch Administrator Department of Public Safety	Christine M. Pang 587-3379 Christine.m.pang@hawaii.gov	Yes	
Perry, Darryl D. (808) 241-1600 dperry@kauai.gov	Chief of Police Kauai Police Department		XX	
Pettit, Emily 236-8238 emily.pettit@doh.hawaii.gov	Associate Administrator Hawaii State Hospital	Hara, Stacie 236-8238 Stacie.hara@doh.hawaii.gov	Yes	Yes
Pressler, Virginia 535-7403 ginnyp@kapiolani.org	Executive Vice President, Chief Strategic Officer Hawaii Pacific Health	Zelda 535-7403 Secretary	Yes	Yes
Schultz, Karen 691-4605 kschultz@queens.org	Vice President, Patient Care The Queen's Medical Center	Char Ouchi 691-4605 couchi@queens.org	Yes	Yes
Sheehan, William 586-4770 William.sheehan@doh.hawaii.gov	Chief Adult Mental Health Division	Valerie Low 586-4770 Valerie.low@doh.hawaii.gov	Yes	Yes
Westphal, Laura westphlr@ah.org	Interim Vice President Castle Medical Center	Alicia Hatori 263-5142 hatoriak@ah.org	* Designee	Yes
Wong, Rachel 521-8961 rwong@hah.org	Vice President and COO Healthcare Association of Hawaii	Leslie Ho 521-8961 lho@hah.org	Alternate G. Greene	Alternate G. Greene
Yabuta, Gary (808) 244-6300 Gary.Yabuta@mpd.net	Chief of Police Maui Police Department		XX	
Yee, Victor 832-3762 Victor.S.Yee@hawaii.gov	MH Administrator OCCC	Sally Vergara 832-3762		

DEPARTMENT OF HEALTH (DOH) THE SPECIAL ACTION TEAM (SAT)

DRAFT SUMMARY

Subcommittee #2 Clinical Operations and Program Capacity

Date: July 30, 2012
Time: 8:00 a.m. - 10:00 a.m.
Location: Department of Health, Kinau Hale, 1st Floor Conference Room

Facilitator/Participants: William Sheehan, Mark Fridovich, Michael Christopher, Lynn Fallin, Kenneth Fink, George Greene, Chad Koyanagi, Brooke Schneider, Vince Lee, Leonard Licina, Mark Mitchell, Emily Pettit, Virginia Pressler, Lorraine Fleming, Damien Uzueta, Mary Brogan

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
Introductory discussion	• Accelerated rate of admissions unsustainable given the current capacity at Hawaii State Hospital. • December 2011- present - Internal AMHD group has been responding but the rate has not changed. • Admission rate increased significantly in May 2012. • Many admissions don't meet criteria for inpatient level of care, or if they do, they require shorter length of stays than currently. • Issues are more than only a function of admissions; discharges did not keep pace. What are discharge alternatives? What are diversion alternatives?			

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	• SAT was created to develop proposals; this session is to brainstorm: What more can we do? What should we stop doing? This is planned to make a "short list" by the end of the second meeting.			
I. Increasing number of calls to the police; lack of resources to respond or triage	• Based on national studies, calls to Honolulu Police Department (HPD) psychologist team coverage are expected to increase and plateau at 6000/year; HPD believes 2000-3000 could be diverted if there was and alternative to Emergency Dept (ED). • Currently, on Oahu all MH-1s go to Queens (80%), Castle (20%) or Tripler (5%) • 5% are Crisis Mobile Outreach (CMO) responses, 90% are calls because an arrest would be appropriate. These numbers are increasing. • Currently the police are only able to send people to a secure inpatient facility; the law says that police are required to MH-1 to entities designated by the DOH. HPD could triage and individualize, but they are not staffed for this. • Per Queens, the large majority of MH-1s do not require admission, but rather crisis stabilization and linkage with services. • Need to relieve burden on EDs and connect people with stabilization and services they need. • Need more preventative and outpatient	Police need more alternative places to send people rather than arrest or MH1. Alternatives to ED/increased support to prevent police involvement: Use Community Mental Health Centers (CMHC) as part of crisis response; assure care coordination; expand hours. This is a state-run existing asset. Need way to stratify risk. Crisis Stabilization Center with basic medical, Mental Health (MH) services and case management. More CMHC involvement before decompensation, extend clinical hours and other "prevention" services. Relook at bringing up evidence-based Assertive Community Treatment (ACT) and crisis services that have fidelity and accountability. Develop services that support	More HPD capacity and model to individually triage. Increase detox capacity	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	services. • Using EDs is not an optimal use of resources. • Kahi Mohala has some additional bed capacity; currently staffing up. • Historically, CMHCs provided crisis services. • Does Hawaii have enough crisis/CMHC capacity? What are the resources in CMHCs? What is the role of the CMHCs and their capability? • Lack of after-hours capacity for emergency placement except crisis shelters. • AMHD had Assertive Community Treatment (ACT) at one time, it was discontinued in 2008; ACT did not reach fidelity standards and was billed as case management.	police departments in each county, through county/state partnerships. Statewide implementation of the Honolulu Police Department diversion program. Expand both pre- and post- booking jail diversion programs.		
II. Lack of cross-system identification and solutions for group that need a different kind of response and services (Community Capacity)	• Of all the high utilizers of the HPD MH1 response system, there are approximately 15% (about 40 people) that may refuse treatment, don't get better, don't do well in congregate care, and the current system does not work well for them. • Department of Public Safety (PSD) also identifies a group of people who move in and out of that system- these may be the same people who show up in other systems. • Queens/Kekela also knows 2/3 of patients from previous frequent visits; they have ongoing issues with insurance, housing, case management, psychiatry. • Some need more structure and some need 24	Develop placements for people who do not do well in typical group home settings, but don't need to be hospitalized Develop team of case managers and psychiatrists to help this group. Identify this group and anyone following them and coordinating their care Re-establish ACT teams. Expand case management service		

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	hour care, and should not be moved to a different level of care because placement is needed by others. • This group may destabilize the other residents when in group homes. • Staff in group homes often doesn't know the person's needs or how to respond when there is a problem so they call the police. • Case management is not always connected to them or responsive to their needs on a 24/7 basis. • Reduced case management is impacting risk factors for MH-1and EDs. • Inadequate capacity for addressing co-occurring substance abuse and mental health for people who come through EDs. • More outpatient care is needed	authorization amounts. "Red flag" recidivists/high utilizers and make special arrangements for the highest risk pool. Target services for the small group of high utilizers.		
III. Reduce readmissions to the Hawaii State Hospital	• In a typical month, two-thirds or 67% are readmissions (ever previously been admitted),Conditional Release (CR) status is a trigger; the number of readmissions within 30 days of prior discharge is very low (0-2) • Potentially could reduce readmits through a model such as INTERACT which is part of Affordable Care Act (ACA) and focuses on better coordination, education and reimbursement issues.			

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
IV. Services that could strengthen the system are not part of the array.	• Fuller crisis array and Assertive Community Treatment	Fuller crisis array and Assertive Community Treatment More effective transitions from one level of care to another.		
IV. Barriers to addressing Service "Gaps"	• All rates are the same within a level of care. • Med Quest Division (MQD) rates have not changed • For geriatric population, nursing homes may not take them, they may need 1:1 support, or use of pharmacological intervention for behavioral control may impact accreditation. • MQD is exploring their authority to provide concurrent psychiatric services when people are in nursing homes; need to conduct analysis to see if this will cover the actual cost: does the facility need a certain number of beds for cost-effectiveness, what is the actual demand? • Hawaii Pacific Health (HPH) has data: the numbers of people who are waiting in HPH facilities for placement who need both nursing and mental health service. • There are models for geriatric-psych outreach teams to provide consultation, support, and management. • Need for better coordination and continuity of care for follow-up post-crisis, acute or inpatient stay. • Need a better way to address the needs of	Capacity to have levels of service intensity with different rates What do Nursing Homes need to be viable placements for people with mental health issues? Develop polices that increase coordination and continuity of care across the system, with a focus on HSH to CMHCs. Look at different models or contracting for services. Add accountability and quality. Increase rates paid to vendors, both for AMHD contracted services and Med Quest rates to providers Create a 'geriatric psychiatric' long term care rate Hire more psychiatrists for provision of services. Expand AMHD policies on eligibility Contract for group homes that	Enhance coordination and service delivery through electronic medical records (make records available to crisis responders) and telemedicine.	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	families that need help. • There may be opportunities through federal dollars and the Center for Medicaid and Medicare Services (CMS) Innovation initiative with wrap-around case management, especially for people with co-occurring medical issues. • AMHD services may be able to be provided and reimbursed by MQD for those in long term care facilities. • PSD reports large numbers of individuals who need special types of placements, for example: supported outreach; individual living (rather than group) living arrangements; geriatric psychiatry outreach teams • Group homes need better staffing, programming, and tolerance, especially for those who are 'hard to place' and those for whom group homes call the police as a default intervention	tolerate deviant behavior, and do not default to 'call the police' when deviant behaviors occur. Create more programs for family support and services. Use Advanced Practice Registered Nurses for field triage.		
V. Neighbor Islands have less capacity to address issues.	• Lack of psychiatry on the Neighbor Islands • Neighbor Islands have a disproportionately high share of State Hospital admissions compared to population. • No mental health crisis intervention training for police in Neighbor Islands. • No capacity in other counties' police departments for data collection and analysis (specific to population with Severe and Persistent Mental Illness (SPMI)).	Train police and other responders on Neighbor Islands.	Create infrastructure in Neighbor Islands to stabilize and address needs there.	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
VI. Service capacity-skills and programming	• Group Homes staff needs skills to understand and provide services to "high-end" residents. • Case Management capacity may not be 24/7 or intensive enough to address prevention. • Adequacy of crisis response. • AMHD is open to other models. • Not all at the state hospital are automatically AMHD eligible (as they may not have mental illness) although those on CRs are: others may not qualify.	Identify models that work and have cost-benefit for the population Other funding sources for those that don't qualify for AMHD		
VII. Need better understanding and use of data; data integration system wide for planning and coordination and tracking of outcomes of policies and programs.	• What is the number of beds that are needed in order to have an adequate community-based system? Are we 1000 beds short and should we have 60 crisis/diversion beds given our population? • Why is the rate of SPMI going up? • HPD tracks all encounters, doing data sharing following the Sequential Intercept Model; would like to integrate hospital data and post MH1/criminal justice. No capacity for analysis. • UH Psychiatry Residents may be a resource for data analysis. • HPH can commit to data sharing • Should we be integrating our data across systems to better understand the population and address issues in a systematic way? This would allow for more precise targeting of population and needs, and advocacy-legislature needs this data.	Get involved with Hawaii Health Information Clearinghouse (HHIC) to obtain better data on utilization.	Intergovernmental (state/city) partnership for data sharing	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
VII. Need to better understand barriers/problems that may be a result of State system structure	• How much of an issue is the state structure of AMHD/Med-QUEST/ADAD creating a problem for people who may not "fit into the right system"? • Is there a lack of integration? • Lack of uniform rates is a problem.	More stringent enforcement of AMHD contract provisions. Consider using a purchase of service provider for eligibility determinations so as to increase objectivity of policies. Consider special rates for specific programs.	Consider a reorganization of state processes for service provision to better integrate the state system of services.	
VIII. Needs of people in the State Hospital who don't need to be there	Individuals who are not mentally ill but are in the legal system also need placements that are not currently available There is a cohort of individuals who do not fit into the current services available for placements and novel or additional service types are needed	Create additional capacity of current service arrays. Create new types of services to fill in service gaps identified by needs assessments.		
IX. Clarification of planning focus	• Whole system solutions vs. immediate needs to divert and discharge individuals from the State Hospital? • How far "up-stream" and what level of safety-net, and will it result in fewer patients?	Make short term proposals in report to Governor from the Special Action Team	Make longer term proposals in report to Governor from the Special Action Team	
X. Adjournment	Meeting adjourned at 10:00 a.m.			

DEPARTMENT OF HEALTH (DOH) THE SPECIAL ACTION TEAM (SAT)

DRAFT SUMMARY

(From the Second Meeting)

Subcommittee #2 Clinical Operations and Program Capacity

Date: August 13, 2012
Time: 8:00 a.m. - 10:00 am
Location: Department of Health, Kinau Hale, 1st Floor Conference Room
Facilitators/Participants: William Sheehan, Mark Fridovich, Lynn Fallin, George Greene, Michael Christopher, Chad Koyanagi, Brooke Schneider, Vince Lee, Leonard Lucina, Mark Mitchell, Emily Pettit, Virginia Pressler, Karen Schultz, Damien Uzueta, Steven Balcolm, Kenneth Fink, Dawn Mendiola, Leighton Kanaele, Darryl Perry, Daniel Fork, Gina Kaulukukui, Laura Westphal, Victor Yee, Mary Brogan

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
Introductions and brief discussion	• Since the last meeting, the larger SAT met and reviewed each sub-committee's work to date. • The task now is to prioritize several short-term proposals (can be implemented this fiscal year), and several long-term proposals (beyond this fiscal year) that are realistic. • Proposals to be selected by consensus of the group. • DOH made contact with the Neighbor Island police departments to invite them to participate and assure their perspectives are represented.			

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
I. Increase diversion capability	• MH1s become more complicated when the sheriffs are involved; they don't have on-call staff for MH1s and must rely on the police. This is not high volume relative to other MH1s. • A key question is where would people be diverted to. • Building a crisis stabilization capacity would likely be a longer-term solution and a multi-fiscal year project; it also come up in other sub-committees • The proposal to bring up ACT may not be able to happen in ten months or less. Does ACT have the forensic interface? Is it the right model for high utilizers who traditionally don't want services? • Need an intensive model that includes case management that is funded in a way that it is not limited and is flexible. People need continuous engagement and support, and stability of placement. • Crisis services can be "revitalized" using existing crisis capacity. • Forensic coordination positions in AMHD were not abolished, they just are not filled. • Kauai PD had an effective post-arrest diversion, but no longer has this capacity. Maui PD uses the AMHD forensic coordinator who provides services pre and post arrest.	1- Expand crisis services 2- Expand locally-relevant legal system diversion through state-county partnerships on the neighbor islands 3- Expand pre-arrest and post-booking jail diversion programs statewide.	1- Alternative places to jail/hospital EDs 2- Crisis Stabilization Center with basic medical, Mental Health (MH) services and case management. 3- ACT or model of intensive case management that is accountable	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
II. Service expansion and closing service gaps	• People who have frequent recidivism and have difficulty with treatment compliance or need structure need an intensive type of case management and service delivery.There may be 40-100 people statewide in this group. • ACT is potentially helpful with this group • There may be a way to use existing contracts to provide a different type of case management, maybe through a case rate model. • Queens is looking at providing expanded clinic hours and a model where individuals will be followed by Queens over the long-term providing "persistent" case management and continuity of treatment. • Case management would need to be provided with no authorization limits and low case ratios. • Need to look at "shelter-plus" care and housing first model. Housing is key- and needs to be provided to create long-termed stability for people. Often fiscal feasibility concerns, especially on neighbor islands, stand in the way of serving people who are mentally ill in the community. • Rather than discharge people from a placement when their needs change, change their service level or type of funding so their housing is not	1- Expand case management service authorization amounts through existing contracts 2- "Red flag" recidivists and high utilizers and make special arrangements for the highest risk pool, with targeted services for the small group of high utilizers- 3- Provide a different model of intensive case management and connection to stability (housing)	1- Develop placements for people who do not do well in typical group home settings, but don't need to be hospitalized with an emphasis on stability; Expand housing services and develop partnerships with Hawaii Public Housing Corporation, Homeless programs, Dept. of Vocational Rehabilitation, and other groups; include Neighbor Islands	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	destabilized.			
III. Issues around Service Gaps	• The biggest need is housing consistency, and consistent providers. • A pressing need is for people who are in hospitals and no longer have acute needs, but have continuing mental illnesses including challenging behaviors. There is often a gap between when Medicare no longer covers the cost, and when people can become eligible for Medicaid. Have sought establishing presumptive eligibility in the past- most people will qualify. Nursing facilities want to be guaranteed payment, and will not take people awaiting eligibility determination.. Without supports, nursing homes will call police, and then people become entangled in the legal system. Nursing facilities also don't have psychiatry capacity or other expertise • This also applies to people "stuck" at Hawaii State Hospital; especially problematic for those who lack guardianship. • Consider MQD rate to address these issues, or LTC rate plus behavioral supports • MQD needs accurate data, and has explored ability to have AMHD services provided in nursing facilities. Questions remain on whether facilities have this	1-Explore having DHS eligibility workers in the hospitals to expedite Medicaid eligibility 2- Add AMHD services to long-term care facilities-explore LTC facilities becoming AMHD providers. 3- Increase rates paid to vendors by AMHD contracts for priority services	1- Develop models for how nursing facilities can become viable placements for SPMI individuals. 2- Increase Med Quest rates. 3- Capacity to have levels of service intensity with different rates 4- Add accountability, performance metrics and quality standards to provider contracts to shape better outcomes.	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	expertise, and how could they bring up a business model. • If rates were increased, would need to determine where the largest impact would be. Would need to establish metrics to evaluate effectiveness.			
IV. Improve use of data; data integration system wide for planning and coordination and tracking of outcomes.	• HHIC has data, however there is a cost tied to creating new data sources and reports • Need to define what information is needed. • Should data collection start with individuals and be used for program planning • Police data is not considered a medical record and is not tied to HIPAA.	1- Start data collection discussion including data sharing around individuals to track outcomes	1- Intergovernmental (state/city) partnership for data sharing	
III. Adjournment	Meeting scheduled to adjourn at 10:00 a.m.			

By: Mary Brogan/Bill Sheehan

Governor's SAT
Subcommittee #1

HUMAN RESOURCES / PROCUREMENT / FINANCING

Place: Department of Human Resources Development
235 S. Beretania Street
Director's Conference Room, 14th Floor

SIGN IN	MEMBERSHIP REPRESENTATIVE	TITLE / ORGANIZATION	1st Mtg WILL ATTEND 8/1/12	2nd Mtg WILL ATTEND TBA
Sharon Abe	Abe, Sharon	Chief Administrative Services Office, DOH	Yes	
	Chu, Edward	Financial Officer Hawaii Health Systems Corporation	By phone	
Neil	Dietz, Neil	Chief Negotiator Office of Collection Bargaining	Yes	
Bill Elliott	Elliott, William	Associate Administrator, Administrative & Support Services, Hawaii State Hospital, DOH	Yes	
Lynn Fallin	Fallin, Lynn	Deputy Director Behavioral Health Administration, DOH	Yes	
Anthony Fraiola	Fraiola, Anthony	Chief, Business Office Hawaii State Hospital, DOH	Yes	
Mark Fridovich	Fridovich, Mark	Administrator Hawaii State Hospital, DOH	Yes	
	Fuddy, Loretta	Director Department of Health	Yes	
Brian	Higgins, Brian	Chief Financial Officer Office Program Improvement and Excellence, DOH	Yes	
Rita Hoopii-Hall	Hoopii-Hall, Rita	Human Resources Officer Human Resources Office, DOH	Yes	
Barbara Krieg	Krieg, Barbara	Director Department of Human Resources and Development	Yes	
	McManaman, Patricia	Director Department of Human Services		
Amy	Morton-Sogi, Amy	Contracts Coordinator Office Program Improvement and Excellence, DOH	Yes	
E. Ann Nishimoto	Nishimoto, Ann	Budget Officer Administrative Services Office, DOH	Yes	
Dean	Seki, Dean	Comptroller Department of Accounting and General Services	Yes	
Keith	Yamamoto, Keith	Deputy Director Department of Health, DOH	Yes	
Kalbert	Young, Kalbert	Director Department of Budget and Finance		

Sheela
Tamara Ishii

DEPARTMENT OF HEALTH (DOH) THE SPECIAL ACTION TEAM (SAT)

DRAFT SUMMARY

Subcommittee #1 Human Resources / Procurement / Financing

Date: August 1, 2012
Time: 2:00 p.m.
Location: Department of Human Resources Development, Director's Conference Room, 14th Floor
Facilitator/Participants: See Sign-In Sheet

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
I. Human Resources: High levels of sick leave and overtime are utilized by HSH staff	• What is driving the high rate of sick leave? ○ Older work force ○ Stressful work environment ○ Workers trade shifts for overtime pay ○ Workers "earn it and burn it" • Under the collective bargaining agreement, HSH can't request a physician's note to justify sick leave time unless the employee is out for 5+ days • HSH pays out approximately $120,000 per month in direct care overtime, $60,000 of which seems to be directly related to overcensus • Need to look at what factors drive overtime		Negotiate with the union on the following: • Reassess when physician's note is required for sick leave • Require compensatory time off be used within a specific time frame	Report from HSH to SAT on: • Causes of overtime payments • Who's getting overtime? (Staff working over 40 hours per week vs. staff working "call in" shifts)

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
II. Human Resources: Difficulty filling vacant positions	• HSH is authorized to fill all vacant positions, but has had difficulty filling them because: (1) the hiring process is inefficient, and (2) DHRD is short-staffed • Currently, DOH HR employees are working with DHRD in screening applications related to HSH to speed up the filling of positions	• Continue agreement between DOH and DHRD to allow DOH employees to assist DHRD in screening applications • Create an on-call pool of exempt, pre-qualified workers that may be utilized as needed		
III. Revenue Enhancement: Can HSH generate revenue to offset the cost of providing expanded services?	• Is it feasible for HSH to bill for services? • The following are needed for HSH to bill: ○ Changes in the Hawaii Administrative Rules to: (1) permit a realistic reimbursement rate, and (2) permit unbundling of professional services from the day rate ○ Medicare/Medicaid certification ○ Internal billing mechanisms •Under the current Administrative Rules, HSH can only bill $133 per day • HSH has a small Medicare Part D program that helps to offset pharmacy costs	• Change the Hawaii Administrative Rules to: (1) permit a higher reimbursement rate, and (2) permit unbundling of professional services from the day rate • Gain Medicare/Medicaid certification • Create internal billing mechanisms		
IV. Community Capacity, Pre-Admission: Lack of alternatives to HSH admission	• A significant number of HSH patients do not require acute inpatient care, but judges lack alternatives to HSH admission • Many patients need services, such as substance abuse treatment and long term care, but do not need the acute level of care offered at HSH • Need capacity to divert patients that are not acutely mentally ill away from HSH to appropriate community-based alternatives		• Build a Crisis Stabilization Center: a free-standing entity that would offer the level of care between a hospital and outpatient facility	

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
V. Community Capacity,Post-Admission: Lack of outpatient options at discharge	•Should maximize discharge from HSH, but this is difficult because: ○ Judiciary controls when patients are discharged, not HSH ○ Lack of appropriate placements in the community • Need more residential capacity (i.e., specialized residential; therapeutic living) and clinically appropriate discharge options • Can current contracts be expanded to change the number of beds available or convert existing beds? Or is new procurement needed to expand services? • How do we get providers to accept discharged patients? ○ Change reimbursement structure	• Modify existing contracts to expand community capacity • Procure additional specialized residential services • Utilize bed hold contracts (This would help alleviate peak issue, but DOH would be paying for empty beds when not filled)	• Procure additional services to meet the needs of the discharged patient population	
VI. HSH Capacity: Should HSH build more beds to manage peak utilization?	•Should HSH allocate resources to build more acute level beds? ○ Yes: ▪ Natural population growth will require additional beds at HSH ▪ Lack of acute inpatient beds available in the community ▪ More expensive to purchase beds at outside facilities ▪ HSH does not control when patients are admitted/discharged, so patient census is unpredictable ○ No: ▪ Significant number of current HSH patients do not need acute inpatient care ▪ Should decrease demand for HSH services by providing appropriate level of care to patients and creating alternatives			

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	▪ Vacant, sub-acute beds exist in the community; there are creative ways to use these existing beds for patients that don't need acute inpatient care ▪ Concern was expressed regarding the cost of operating the facility vs. the initial cost of building additional beds			
VII. Procurement: Role of emergency procurement in addressing peak census issue	• New services are needed quickly, but procurement process is slow and cumbersome • Very difficult to get approval for emergency procurement • Need solid justification for emergency procurement; the emergency must be unanticipated			
VIII. Adjournment	Meeting adjourned at 3:45 pm			

Governor's SAT
Subcommittee #1

HUMAN RESOURCES / PROCUREMENT / FINANCING

Place: Department of Human Resources Development
235 S. Beretania Street
Director's Conference Room, 14th Floor

SIGN IN	MEMBERSHIP REPRESENTATIVE	TITLE / ORGANIZATION	2nd Mtg WILL ATTEND 8/16/12
	Abe, Sharon	Chief Administrative Services Office, DOH	No (budget mtg)
	Chu, Edward	Financial Officer Hawaii Health Systems Corporation	No
	Dietz, Neil	Chief Negotiator Office of Collection Bargaining	No (off island)
	Elliott, William	Associate Administrator, Administrative & Support Services, Hawaii State Hospital, DOH	Yes
	Fallin, Lynn	Deputy Director Behavioral Health Administration, DOH	Yes
	Fink, Kenneth (for Patricia McManaman)	MedQuest Administrator Department of Human Services	Yes By phone
	Fraiola, Anthony	Chief, Business Office Hawaii State Hospital, DOH	Yes
	Fridovich, Mark	Administrator Hawaii State Hospital, DOH	Yes
	Fuddy, Loretta	Director Department of Health	
	Fujioka, Aaron (for Dean Seki)	Administrator, State Procurement Office Department of Accounting and General Services	Yes
	Higgins, Brian	Chief Financial Officer Office Program Improvement and Excellence, DOH	Yes
	Hoopii-Hall, Rita	Human Resources Officer Human Resources Office, DOH	Yes
	Krieg, Barbara	Director Department of Human Resources and Development	Yes
	Morton-Sogi, Amy	Contracts Coordinator Office Program Improvement and Excellence, DOH	Yes
	Nishimoto, Ann	Budget Officer Administrative Services Office, DOH	No (budget mtg)
	Salaveria, Luis (for Kalbert Young)	Deputy Director Department of Budget and Finance	Yes (will be late)
	Sheehan, William	Chief Adult Mental Health Division	Yes
	Yamamoto, Keith	Deputy Director Department of Health, DOH	Yes

DEPARTMENT OF HEALTH (DOH) THE SPECIAL ACTION TEAM (SAT)

DRAFT SUMMARY
(From the Second Meeting)
Subcommittee #1 Human Resources / Procurement / Financing

Date: August 16, 2012
Time: 2:00 p.m.
Location: Department of Human Resources Development, Director's Conference Room, 14th Floor
Facilitator/Participants: See Sign-In Sheet

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
I. Recap: Issues that Arose in Subcommittees 2 and 3	• Major topics/issues discussed in other subcommittees: ° Subcommittee 2: • Diversion • Service expansion • Closing service gaps • Data sharing across agencies ° Subcommittee 3: • Judicial practice • Court-clinic model • Changes to statute • All Subcommittees: Need alternative to inpatient care			

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
II. Human Resources: Follow up on discussion of overtime usage at HSH	• As follow-up to first subcommittee meeting, HSH provided the following information regarding overtime and staff working hours: ° Direct care staff: 70 of 346 employees (20%) worked a 40 hour work week ° Non-direct care staff: 138 of 280 employees (49%) worked a 40 hour work week ° Overtime holiday cost: $60,000 per holiday ° HSH still researching overtime usage in the following categories: (1) employees who worked on their day off; (2) employees who had less than 12 hours of rest; (3) employees who worked long stretches; and (4) employees who changed work day ° Graphs were provided to subcommittee showing rate of overtime hours per month • Inefficient utilization of current staff; most employees are not working a 40 hour work week • How can current overtime structure be changed? ° Need union buy-in; must give something in return for changes to overtime structure ° Short-term negotiation not possible because overtime is covered by collective bargaining agreement		• Negotiate with the union to modify overtime structure (Note: A task force has already been convened to look at factors driving overtime) • Devote resources to an employee wellness program	HSH to continue researching overtime usage

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
III. Human Resources: How can DOH quickly fill vacant HSH, AMHD, and CMHC positions?	• There are a number of vacant exempt positions at HSH, AMHD, and the CMHCs ° Lack of staff in AMHD and CMHC positions compromises the availability of community support; this support is needed to keep patients out of HSH • DOH is currently requesting authorization to fill exempt vacancies • Although DHRD does not handle the hiring of exempt workers, DHRD can provide department HR staff with training, support, and guidance • Filling vacancies in agencies outside DOH (ex: DHRD, DHS, PSD) could also help census issue	• Identify vacant positions that (1) may impact the census (either directly or indirectly) and (2) provide diversion services ° Focus on gaining approval to fill these positions that will have the most impact • Continue agreement between DOH and DHRD to allow DOH employees to assist DHRD in screening HSH applications (See Meeting 1 notes for further discussion on this proposal)		
IV. Financing: Which proposals from Meeting 1 will have a budgetary impact?	• Are there purchase of service changes that will impact operations and have budgetary significance? ° Modifying existing contracts (ex: adding residential capacity) ° Building crisis stabilization center • Building center will require: ° New statute ° New licensure level ° Procurement ° Infrastructure: UM, contract monitoring, and billing will be done within AMHD			

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
V. Procurement: Temporary Exemptions and Treatment Method of Procurement	• How can HSH provide services that are needed right away, but do not qualify for emergency procurement? ° Temporary Exemption • Exemption generally granted if (1) situation beyond agency's control and (2) exemption is limited • SPO questions/concerns: ° Will agency procure long term? ° How did this situation come about? ° What process must the agency go through to get temporary exemption? (Want to ensure no preferential treatment given) ° Treatment Method of Procurement • Method of procurement appropriate when services are needed irregularly on a short-term, limited basis • Includes list of providers with set unit rates, but list is limited in scope • Need subject matter expertise from DOH to expand list • Method is generally not used and has been phased out • Not an appropriate method to utilize when census fluctuates; however, during peak times HSH may need ancillary services that could be procured through this method ° Contingency Contracts • Can be utilized as needed so emergency procurement is not necessary	• Identify specific services that could utilize the treatment method of procurement		

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
VI. Revenue: Initiatives for Revenue Enhancement at HSH	• In what order should HSH pursue the proposals for revenue enhancement discussed at Meeting 1? 1. Modify the Hawaii Administrative Rules to: ° Increase the billable rate (the average rate at HSH is $750 per day, but under the HAR, HSH can only bill $133 per day) ° Unbundle services 2. Apply to CMS for Medicare/Medicaid certification ° Will DHS cover medically necessary care for people in state custody? 3. Create internal billing structure			
VII. HSH Capacity: Is State capacity on par with U.S. average?	• Hawaii has fewer acute care and long-term care beds than US average ° Statistics from Foley, Daniel J, M.S. et al., *Highlights of Organized Mental Health Services in 2002 and Major National and State Trends*, p. 208: • State and county mental hospitals per 100,000 population (U.S. average): 18.3 ° Statistics from State of Hawaii Health Services and Facilities Plan, p. 39: • Rate of beds per 1,000 for 2006: Hawaii: 2.3; U.S.: 2.7 • Rate of Nursing Facility Beds per 1,000 65+, 2005: Hawaii: 23; U.S.: 47 • Nursing facility occupancy rate (%), 2005: Hawaii: 94; U.S.: 85 • There are approximately 225 beds between HSH and Kahi Mohala overflow	• Continue researching capacity needs in the State		

Issue/Problem/Factor: Outcome expected, How will success be measured?	DISCUSSION	Short Term Proposals	Long term Proposals	Follow up (who/when)
	unit and approximately 230 patients (in population of 1 million) • Because Hawaii lacks adequate number of beds: ° HSH does not have capacity to take additional patients ° Patients cannot be discharged; there are few long-term beds available			
VIII. Community Capacity: Community Facilities Not Fully Utilizing Inpatient Beds	• Actual usage of inpatient beds is lower than OHCA licensed capacity in all community facilities • Need to identify reasons why community facilities are not providing licensed number of beds. Potential explanations: ° No medical necessity ° Inadequate reimbursement ° Inadequate staffing		• Investigate why community capacity is not being fully utilized; work with community to provide solutions for increasing capacity	
VI. Adjournment	Meeting adjourned at 3:45 p.m.			