Managing Risk for Your CCBHC with MHRRG and Negley Associates

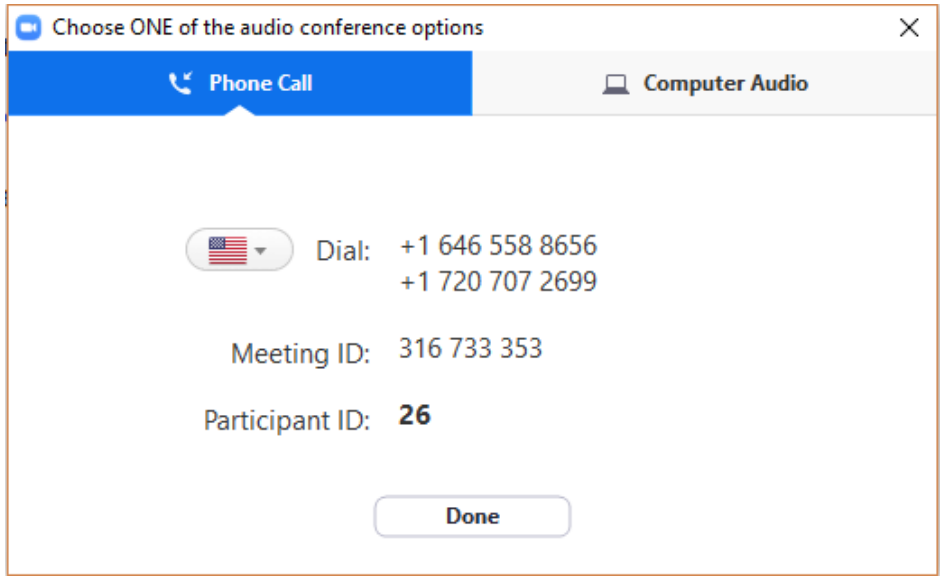
Tuesday, July 14th, 2021

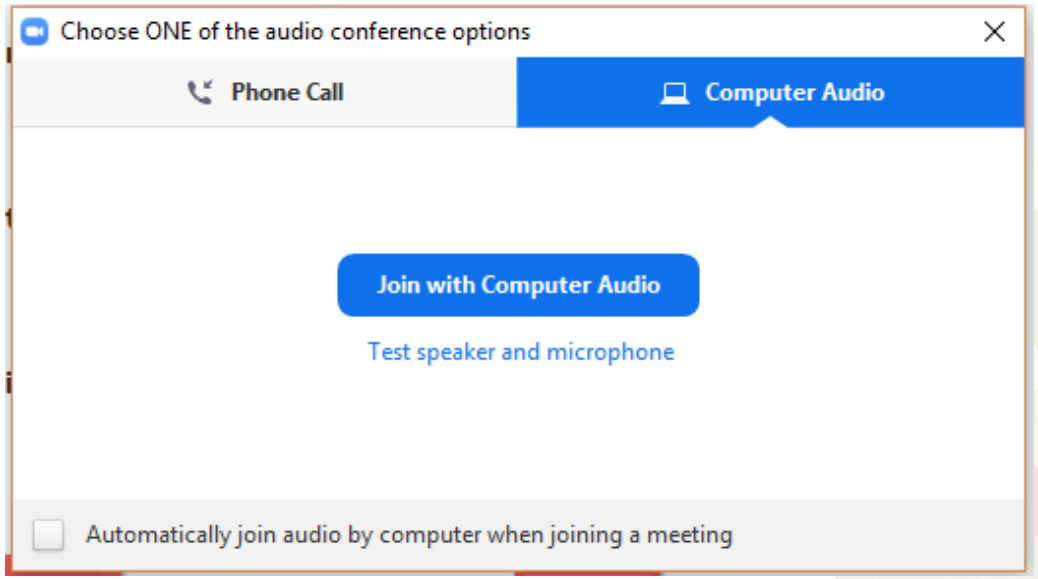
1:00-2:00pm E.T.

Zoom Logistics

Call in on your telephone, or use your computer audio option

If you are on the phone, remember to enter your Audio PIN





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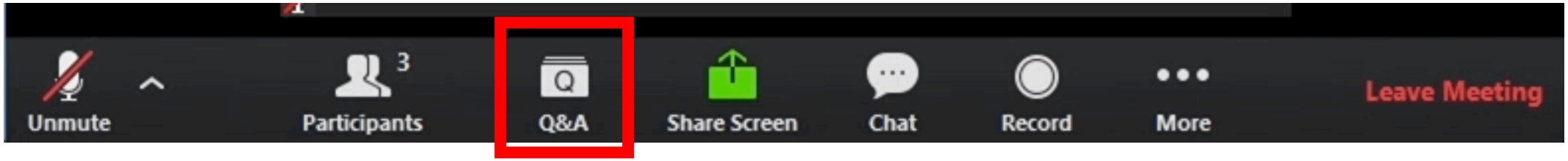
How to Ask a Question



Type in the chat box or use the Q&A function. Both are located at the bottom of your screen. You can choose who to send a chat or question to, and you can "up-vote" questions.

We'll answer as many questions as we can throughout today's session.

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Disclaimer

This session is not a CMS- or SAMHSA-funded or sponsored event. While this session is intended to provide context and information, the National Council team and presenters are unable to answer any inquiries on behalf of CMS or SAMHSA. Any questions related to the funding opportunity itself will need to be directed to your funding or project officer.

Today's Presenters

Samantha Holcombe, MPH
Senior Director, Practice Improvement
National Council for Mental Wellbeing

Ronald Zimmet, JD
General Counsel
Mental Health Risk Retention Group

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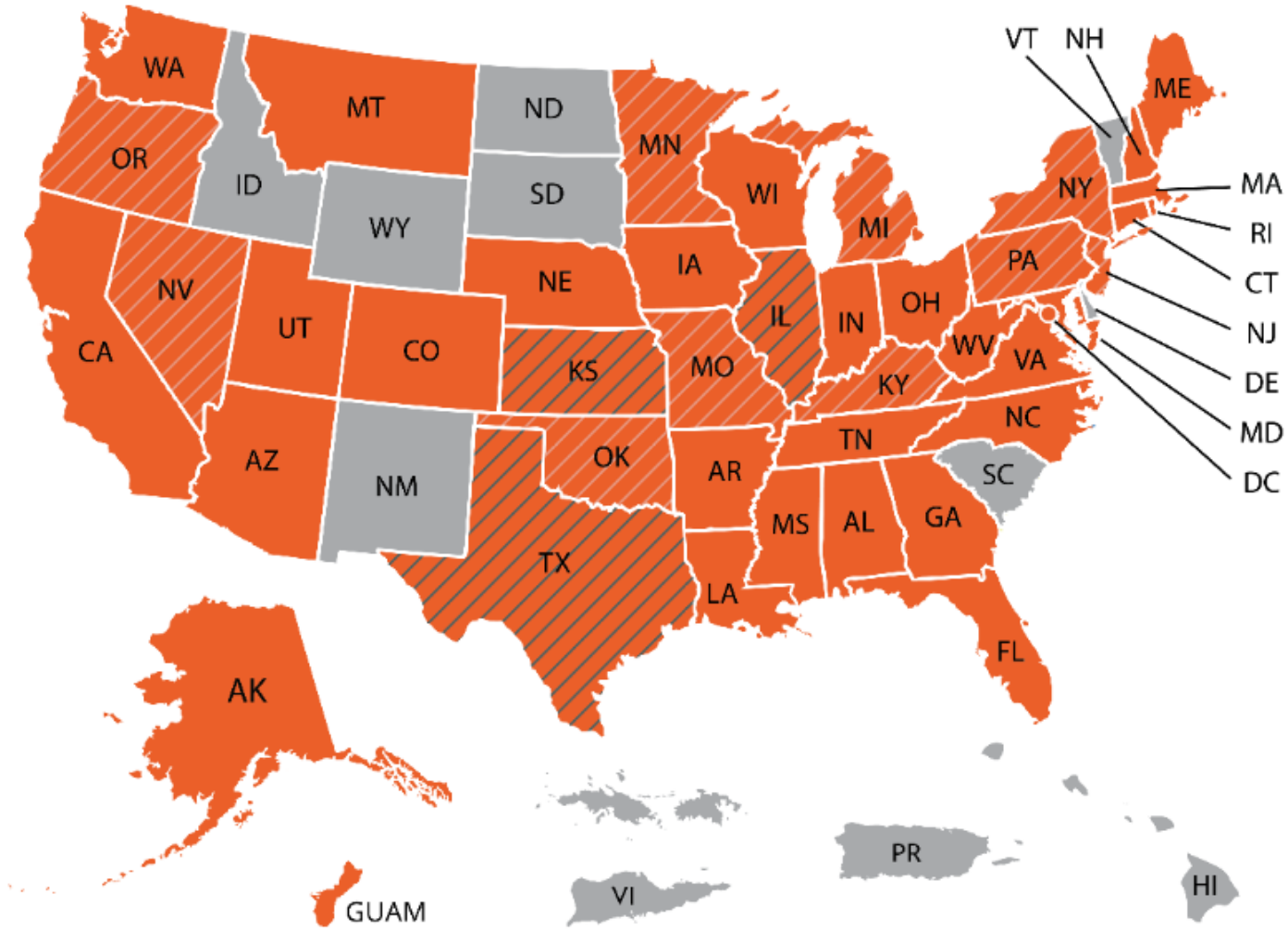
Status of Participation in the CCBHC Model

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Independent statewide implementation
- No CCBHCs

There are **431 CCBHCs** in the U.S., across 41 states, Guam and Washington, D.C.



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The Value of CCBHC

Standard definition	→	Raises the bar for service delivery
Evidence-based care	→	Guarantees the most effective clinical care for consumers and families
Quality reporting	→	Ensures continuous quality improvement
Prospective payment system	→	Covers anticipated CCBHC costs

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Session Agenda

- CCBHC risk management advantages
- Documenting care to increase quality care and reduce liability risk
- Why and when information from collateral sources is critical

Summary

- Applying often overlooked HIPAA exceptions

CCBHC Advantages – Quality Care

- Expanded care coordination
  - Organizing patient care activities & sharing information
  - Integrated care
- Reduced wait times
- Crisis support services
  - National Suicide Prevention Lifeline network

CCBHC Advantages – Quality Care

- Increased hiring – adequate staffing
- Increased access to MAT
- Commitment to family involvement

Detailed Documentation

- Important for:
  - Avoiding and winning lawsuits
- More important for:
  - Quality care
    - Adequate evidence-based information for decisions
    - Communication to other providers

Documenting Sufficient Detail

- Document in sufficient detail to:
  - Identify the presence of evidence-based risk factors
  - Determine level of risk
- Use evidence-based instruments to identify treatable risk factors
  - Ask enough questions
  - Ask the right questions

Documenting Assessments and Treatment

- Documentation can often be too general to know whether the matter is a risk factor

Document sufficient detail

- Suicide risk example
- Too general
  - “Long term risk factors…” Family relational problems…”

Why do people die by suicide?

- "Because they can, and because they want to – because they develop both the desire and capability to do so."

Joiner, Van Orden, Witte, & Rudd, *The Interpersonal Theory of Suicide*, American Psychological Association, 2009

Acquired Capability

- Lowered fear of death and increased tolerance of physical pain
  - Acquired Capability for Suicide Scale (ACSS)
    - Self-report measure
  - Painful and Provocative Events Scale
    - Self-report measure

Acquired Capability

- Those with past suicide attempts habituate to pain more than others

Risk = Acquired Capability +

- Acquired capability alone does not create risk
- Acquired capability by itself is not a risk factor
- Acquired capability + desire creates risk

Desire

- Sustained
  - Perceived burdensomeness +
  - Failed belongingness

Desire

- **Perceived burdensomeness**
  - “a mental state characterized by apperceptions that others would be better off if I were gone”
  - Which manifests when the need for social competence… is unmet
    - Family discord
    - Unemployment
    - Functional impairment

Desire

- **Thwarted belongingness**
  - Psychologically painful mental state that results when the fundamental need for connectedness… is unmet
    - Loneliness
    - Living alone
    - Low social support

Failed Belongingness

- Social isolation has the clearest support in the literature as a risk factor for suicidal behavior

Combining factors

"And so, I am prepared to defend the view that 100% of suicides are characterized by the combination of learned fearlessness, perceived burdensomeness, and profound alienation from others…"

Joiner, *Myths about Suicide*, Harvard University Press, 2010, p.193

SUICIDE RISK ASSESSMENT

DANGER SIGNS

Talking about Suicide Social withdrawal	Agitation Weight loss	Insomnia Marked Irritability	Nightmares Extreme emotional states (e.g. rage)

Assess Suicidal DESIRE and IDEATION	Assess RESOLVED PLANS and PREPARATIONS	Assess OTHER SIGNIFICANT FINDINGS
• Have you been having thoughts or images of suicide (thoughts of images of killing yourself)? Tell me about that. • Do you think about wanting to be dead? • **THWARTED BELONGINGNESS**: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you are feeling bad? (Are supporting relationships completely absent?) • **PERCEIVED BURDENSOMENESS**: Sometimes people think, "The people in my life would be better off if I were gone." Do you think that?	• **Duration** (look for pre-occupation): When you have these thoughts, how long do they last? • **Intensity**: How strong is your intent to kill yourself? 0 = not intense at all, 10 = very intense. • **Past suicidal behavior**: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., admitted to hospital?). Non-suicidal self-injury? Family history? • **Specified plan** (look for vividness, detail): Do you have a plan for how you would kill yourself? • **Means and opportunity**: Do you have the pills (or a gun, etc.)? Do you think you'll have an opportunity to do this? • Have you made preparations for a suicide attempt (e.g., buying pills) • Do you know when you expect to use your plan? • **Fearlessness**: **Thinking about suicide, do you feel afraid**? 0 = very afraid; 10 = not afraid at all	• **Precipitant Stressors**: Has anything especially stressful happened to you recently? (e.g., death of a loved one, divorce, major break-up, job loss)? • **Hopelessness**: Do you feel hopeless? • **Impulsivity**: When you are feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? (e.g., cutting your skin, drinking alcohol, running away, binge eating, promiscuous sex, physical aggression, or shoplifting)? • **Presence of psychopathology:** (rated by interviewer)

Depressive Symptom Index – Suicidality Subscale
Acquired Capability Scale (ACSS) **Interpersonal Needs Questionnaire (INQ)**

RISK CATEGORY

LOW	MODERATE	SEVERE	EXTREME

ACTIONS TAKEN:

- Continue to monitor regularly
- Given Emergency numbers
- Scheduled mid-week phone check-in
- Provided info about adjunctive treatment
- Coping Card/Safety Plan
- Consulted Supervisor
- Other

Form Provided by Dr. Thomas Joiner, Florida State University, Dept. of Psychology

Document Sufficient Detail

- **Too general:**
  - "Long term risk factors:… Family relational problems…"
- **Ask questions about and document specific information relating to risk factors**
  - Social isolation?
  - Lack of support?
  - Feelings of being a burden?
  - Acquired capability?

Document Sufficient Detail

- Violence risk example
  - “Patient hears voices.”

Mental Disorders and Violence

- Only some types of mental disorder are most reliably associated with violence
- Which disorders and why?
  - Despite strong associations, most people with the disorders are not violent

Mental Disorders and Violence

- Diagnoses with the strongest associations with violence:
  - Substance use disorders
  - Schizophrenia spectrum and other psychotic disorders
  - Personality disorders
  - Paraphilic disorders

Mental Disorders and Violence – Psychosis

- Psychosis
  - Acute & serious disturbance in thought, perception, affect and behavior
  - Delusions
    - Overvalued ideas that are clearly untrue
  - Hallucinations
    - Disturbance of thought content & perception

Evidence-based Risk Assessment Instrument

- HCR-20
  - Includes a list of 20 evidence-based risk factors and
  - Detailed indicators
    - Details to determine whether the diagnosis is a risk factor

Behaviors and Conditions That Increase Risk – Psychosis

- Psychosis
  - Feelings of being threatened and controlled
    - Self protection

Behaviors and Conditions That Increase Risk – Psychosis

- Psychosis
  - Disorganization of thought
    - Odd behavior, impaired communication, and inappropriate affect leads to:
      - Annoying others
      - Interpersonal conflict

Behaviors and Conditions That Increase Risk – Psychosis

- Psychosis
  - Interpersonal conflict from not observing social norms

Document Details

- History of problems with psychotic disorder
  - Included acute positive symptoms
    - Hallucinations
    - Delusions
  - Included agitation, irritability or hostility during psychotic episodes

Document Details

- History of problems with psychotic disorder
  - Included distress (fear, stress) associated with psychotic symptoms
  - Included symptoms with themes of violence or aggression

Level of Risk – Suicide Risk

- General example:
  - “He had a suicide attempt 6 months ago.”

Level of Risk: Acquired Capability

Get and describe the details

- How serious – risk rescue ratio
- How well planned and prepared
- Circumstances leading up to attempt - stressors
- Means
- How does patient feel about not succeeding
- Alcohol or drugs as a factor
- Why did attempt fail?

Level of Risk – Violence

General examples:

- "The patient was aggressive during his admission to the CSU."
- "He was picked up by the police due to a physical altercation with a person."

Level of Risk – Past Violent Incidents

- Violent incidents
  - **Precipitants**
  - Weapons
  - Threats
  - Injury
  - Instigator
  - Planned or reactive
  - Motivation

Collateral Sources

- Why critical?
- When?
- Frequent court rulings

Sources of Information

- Significant limitations with reliance on the patient's self-report
  - Patient's stigma against help seeking for suicidal thoughts
  - Past negative experiences with disclosure
  - Uncertainty or ambivalence about suicidal thoughts

Sources of Information

- Significant limitations with reliance on the patient's self-report
  - Lack of perceived need for services
  - Preference for self-management
  - Fear of hospitalization
  - Suicidal ambivalence, uncertainty and temporal instability

Sources of Information

- "A recent study found that 78% of patients who died by suicide explicitly deny suicidal thoughts in their last verbal communications before killing themselves."
  - Measuring the Suicidal Mind: Implicit Cognition Predicts Suicidal Behavior, *Psychological Science* 21 (4)
    - Citing Clinical Correlates of Inpatient Suicide. *Journal of Clinical Psychiatry, 64, 14-19*

Sources of Information

- "Study findings indicated that hospitalized patients who did not disclose suicidal intent following a self-inflicted gunshot wound often denied their injuries were due to suicide attempt..."

McClay, *Many Self-Inflicted Gunshot Wound Survivors Deny Suicide Attempt as Cause*, Psychiatr Serv, 2018

Sources of Information

- …[but] psychiatric examination revealed that 43% of these patients present under circumstances suspicious of suicide.”

McClay, *Many Self-Inflicted Gunshot Wound Survivors Deny Suicide Attempt as Cause*, Psychiatr Serv, 2018

Sources of Information

- Inaccurate or deceptive self reporting of suicide risk
  - Selective disclosure – withholding information from unknown individuals until they are trusted
    - Suicidal individuals are much more likely to report thoughts and behaviors to close family and friends over medical providers

Podlogar and Joiner, *Allowing for Nondisclosure in High Suicide Risk Groups,* Assessment 1-13, 2019

Collateral Sources

- Ask about danger signs/acute symptoms and risk factors

When is the information critical?

The Most Dangerous Times

- Violent episode in the week before hospitalization
  - 9 times more likely to be violent again within two weeks of discharge

Otto, *Assessing and Managing Violence Risk in Outpatient Settings*, 56 Journal of Clinical Psychology 1239-1262 (2000)

The Most Dangerous Times

- Meta-analysis study:
  - "The suicide rate was highest within 3 months after discharge [from a psychiatric hospitalization]."

Suicide Rates after Discharge from Psychiatric Facilities, JAMA Psychiatry, Volume 74, Number 7, 694-702 July 2017

The Most Dangerous Times

- "Discharged patients have suicide rates many times that in the general community. Efforts aimed at suicide prevention should start while patients are in the hospital, and the period shortly after discharge should be a time of increased clinical focus."

Suicide Rates after Discharge from Psychiatric Facilities, JAMA Psychiatry, Volume 74, Number 7, 694-702 July 2017

The Most Dangerous Times

- "This study demonstrates that there are 2 sharp peaks of risk for suicide around psychiatric hospitalization, one in the first week before admission and another in the first week after discharge…"

Quin & Nordentoft, Suicide Risk in Relation to Psychiatric Hospitalization, Arch Gen Psychiatry, 62: 427- 432, 2005

So….

- When do you need the information?
  - Intake evaluations, and
  - After some treatment or judicial event, especially
    - ER and psychiatric hospital discharges
    - CSU discharges
    - Arrest for a violent event and release

So….

- When do you need the information?
  - Ongoing treatment whenever risk needs to be reassessed
    - Schedule reassessments
    - Identify triggers
  - Any crisis
    - Because it’s not the admission or discharge that creates risk
    - It’s the mental status that creates the risk

HIPAA

- Applying 3 often overlooked (or misunderstood) exceptions

So….

- When do you need the information?
  - Intake evaluations

Hypothetical

- At an intake assessment a patient discloses that he was evaluated at the local general hospital ER and admitted to the hospital's psychiatric unit for suicidal ideations and an attempt.
- He was diagnosed with:
  - Major depressive disorder, severe, recurrent

Hypothetical

- He was discharged from the psychiatric unit 6 days ago. The patient now lives with his wife at home.
- The hospital ER records disclose that the attempt occurred 3 weeks after the patient stopped taking antidepressant medication because he was feeling better.

Hypothetical

- The patient tells you his wife is supportive and helps him take his medication.
- The patient says that the event leading up to his hospitalization was not a real attempt and denies any other attempts.

Hypothetical

- The ER nurses notes, but not the ER doctor's notes or discharge summary, document 3 prior attempts.
- He denies current suicidal ideation.

HIPAA

- The patient's wife calls for an appointment the day after he leaves the hospital.

HIPAA

- 45 CFR 164.506 (c) (2) “A covered entity may disclose protected health information for treatment activities of a healthcare provider.”

HIPAA

May the hospital send you the ER and psychiatric unit records without a release so you will have them for the intake assessment?

- ❑ No, because you do not have a signed release
- ❑ No, because the hospital cannot send you behavioral healthcare records without a written consent
- ❑ Yes, if you need them for the patient's treatment, but not psychotherapy notes

HIPAA

Correct answer:

- Yes, if you need them for the patient's treatment, but not psychotherapy notes

HIPAA

- 45 CFR 164.506 (c) (2) “A covered entity may disclose protected health information for treatment activities of a healthcare provider.”

HIPAA

- "Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections."

HIPAA Privacy Rule and Sharing Information Related to Mental Health, OCR Guidance 2017

HIPAA

- Psychotherapy notes:
  - "… Notes recorded by… a mental health professional documenting or analyzing the contents of a conversation during a private counseling session…that are separate from the rest of the patient's medical record…" 45 CFR 164.501 (emphasis added)

HIPAA

- Psychotherapy notes do not include:
  - Information about medication prescription and monitoring
  - Counseling session start and stop times
  - The modalities and frequencies of treatment furnished

HIPAA Privacy Rule and Sharing Information Related to Mental Health, OCR Guidance 2017

HIPAA

- Psychotherapy notes do not include:
  - Results of clinical tests
  - Summaries of diagnosis, functional status, treatment plan, prognosis and progress to date

HIPAA Privacy Rule and Sharing Information Related to Mental Health, OCR Guidance 2017

HIPAA

- An exception to the exception
  - "A notable exception [to the psychotherapy notes requirement for consent] exists for disclosures required by other law, such as for mandatory report of abuse, and mandatory 'duty to warn' situations regarding threats of serious and imminent harm made by the patient."

OCR, HIPAA Privacy Rule and Sharing Information Related to Mental Health, 2017

HIPAA

- “May” disclose but not “shall”
- Information sharing agreements

HIPAA

If your patient is so depressed that he cannot concentrate on your questions sufficiently to provide a complete or reliable answer, may you call the wife at her home without consent to ask about the circumstances of the recent "attempt" and the history of past attempts?

- ❑ Yes, but only if you have a signed consent form
- ❑ No, because making the call reveals PHI
- ❑ Yes, because a HIPAA exception applies
- ❑ Yes, but only if you give the patient the opportunity to object

HIPAA

Correct answer:

- Yes, because a HIPAA exception applies

HIPAA

- "When a patient… cannot agree or object [to disclosure] because of some incapacity or emergency a healthcare provider may share relevant information about the patient with family, friends or others involved in the patient's care…if the healthcare provider determines, based on professional judgment, that doing so is in the best interest of the patient." (emphasis added)

OCR, Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder-Including Opioid Abuse, 12.19.17

HIPAA

- (b) disclosures for involvement in the individual's care
- (3)… if the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity **or** an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement…

What if……

- **Patient diagnosed with schizophrenia attacked mother 6 months ago**
  - Agitation
  - Slurred speech
  - Intermittent medication compliance
  - Insomnia
  - Accused mother of controlling him & planning to kill him
- Now you see the same symptoms…

Duty to Warn/Protect?

- The patient has not communicated a specific threat

Call the Mother?

- For additional information
- Victim safety planning
- Frequent response:
  - If I have an ROI

Steps in the Process – Structured Risk Assessments

1. Gather needed information
2. Determine risk factors from a checklist
3. Consider relevance of risk factors for your patient
4. Consider likely scenarios
5. Management strategies – monitoring, treatment, and victim safety
6. Conclusions

HIPAA in the Way?

- "When a patient poses a serious and imminent **threat** to his own or someone else's health or safety, HIPAA permits a healthcare professional to share the necessary information about the patient with anyone who is in a position to prevent or lessen the threatened harm—including family, friends, and caregivers — without the patient's permission." (emphasis added)

OCR, Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder-Including Opioid Abuse, 12.19.17

Proposed Change

- From “serious and imminent threat” standard
- To a “serious and reasonably foreseeable threat” standard

HIPAA in the Way?

- What if an expert witness disagrees with your judgment about "serious and imminent"?

HIPAA in the Way?

- "HIPAA expressly defers to the professional judgment of health care professionals when they make determinations about the nature and severity of the threat to health or safety. See 45 CFR 164.512 (j) (4)." (emphasis added)

OCR, Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder-Including Opioid Abuse, 12.19.17

HIPAA in the Way?

- "Specifically, HIPAA presumes the healthcare professional is acting in good faith in making this determination, if the professional relies on his or her actual knowledge **or** on credible information from another person who has knowledge or authority." (emphasis added)

OCR, Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder-Including Opioid Abuse, 12.19.17

Questions and Comments

Ron Zimmet, JD: ronsr@zimmetlawyers.com

National Council CCBHC Team: CCBHC@TheNationalCouncil.org

Consulting Opportunities

- EHR and data collection workflows
- Understanding CCBHC criteria and readiness
- Building staff buy-in through organizational change management
- Evidence-based practices and staff development
- Same-Day Access and Just-in-Time Prescribing
- Data-driven decision making
- Prospective payment system

Email us to set up a free 45-minute consultation:

CCBHC@TheNationalCouncil.org

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