Individual Options

Program Overview

Repeated hospitalization and institutionalization of individuals living with a serious mental illness is costly to society, but its greatest expense is to the individuals whose potential is lost to the revolving institutional door. Individual Options seeks to offer a different path to individuals who find themselves in this cycle – an opportunity to receive needed treatment and support services that will promote their stability in the community.

There are individuals who have not been successfully engaged in mental health services, and, therefore, have not had the opportunity to fully benefit from them. Individual Options will be a new pilot project in Baltimore City that will attempt to better engage these individuals by providing a comprehensive range of treatment and support services delivered by a mobile multidisciplinary team. The scope of this new program will be similar to an Assertive Community Treatment (ACT) team and the Capitation Project in that the provider will be responsible for providing and coordinating all of the consumer’s care. The biggest difference will be that Individual Options will provide increased intensive outreach and assertive engagement to try to enroll consumers who have been historically difficult to engage in community-based treatment. The program will also emphasize culturally competent, person-centered and strengths-based services.

Individuals with frequent psychiatric inpatient hospitalizations will be the target population for this program. They will be identified at the point of being admitted for an inpatient psychiatric hospitalization. Public mental health system data will be used to identify those individuals (referred to as “high-cost users”) with service utilization patterns characterized by heavy reliance on inpatient care. Assertive engagement will be used to both outreach to individuals before enrollment and to keep enrolled clients out of hospitals and jails and in the community. Services will be designed to meet the unique needs of each individual, and participants will be supported in working toward improved health and functioning. Staff will receive regular and comprehensive training and be supported through supervision in their efforts to address the intensive service needs of program participants. The program will be sufficiently and flexibly funded to meet participants’ needs and to ensure that services are delivered in alignment with the program’s values of being culturally competent, person-centered and strengths-based.

A significant aspect of this program will be to use person-centered outreach to engage clients to enroll in the program and to keep them as active program clients. The program will outreach in this manner to eligible clients until they either voluntarily enroll in the program or would no longer benefit from or qualify for program services. Client refusal to enroll does not result in a cessation of effort to engage the client. Outreach to the client will typically begin during an inpatient hospitalization. If a client refuses services, but is re-hospitalized following the initial contact, the program will be notified and outreach will be conducted to again introduce the benefits of the program to the client. The responsibility for engagement is placed on the program and the system, not the individual client. When the client is willing to consent to services offered by the program, he/she will be enrolled. Enrollment in the program is voluntary. Once enrolled, the client will receive services from the program until the client is successful in achieving his or her stated goals and can be successfully transitioned to a lower level of care.
The program will define success as:

1. Increased engagement by the client in their own recovery;
2. Increased tenure in the community;
3. Increased engagement in non-hospital-based treatment
4. Improved outcomes in illness management;
5. Reduced reliance on costly inpatient or other institutional services(i.e. correctional system); and
6. Increased efficiency in the use of public mental health system funds.

**Eligibility Criteria**

Eligible individuals will include Baltimore City residents, ages 18 or older, who meet **all** of the following four criteria:

1. Is eligible for the Public Mental Health System
2. Is currently in an inpatient hospital psychiatric unit
3. Is diagnosed with one of the following primary diagnoses:
   - Schizophrenia
   - Schizophreniform Disorder
   - Schizoaffective Disorder
   - Major Depressive Disorder, Recurrent, Severe
   - Bipolar Disorder
   - Delusional Disorder
   - Schizotypal Personality Disorder
   - Borderline Personality Disorder
4. Has not benefited from ongoing involvement in treatment, as evidenced by system failure to engage client in intensive treatment such as mobile, ACT or Capitation and one of the following:
   - 10 or more inpatient admissions for psychiatric reasons within the last 2 years
   - A combination of 10 or more inpatient admissions and/or arrests within the last 2 years
5. Other individuals with compelling indications of needing program services could be enrolled on an exception basis with approval from the core service agency

The referral source must document that the assessment of eligibility included family input, if available.
Program Design

Individual Options will provide a comprehensive range of services, including intensive outreach, with the goal of fully engaging individuals in their recovery process. The team will take full responsibility for all treatment services including addiction treatment, crisis care and hospital admission and discharge. Services will be flexible, client-centered, community-based and offered 24 hours per day, 7 days per week. Staff will work together as a team, meeting daily to review each client’s progress. A peer specialist will provide intentional peer support services and use tools like Wellness Recovery Action Plans to assist clients with engaging in their recovery process. Other services like therapy, medication management, case management, rehabilitation and supported employment will be offered by the same team of multidisciplinary staff and will be mobile. The team will consist of the following disciplines at a minimum: nursing, psychiatry, social work, peer support, supported employment, addictions, and case management.

The frequency of contact and attempted contact will be high and guided by formal guidelines that are linked to risk categories; i.e., those clients at highest risk will have a higher frequency of contact. Contact will occur in the community or in the office depending upon the client’s needs and preferences. Interventions will be trauma-informed, individualized to the client’s stage of engagement and aimed at reducing negative consequences such as repeated hospitalizations. In addition to engaging the client, the program will also attempt to intensively engage the family and provide support to them, whenever possible.

Case management and engagement will be critical to the success of the project. The use of assertive engagement mechanisms, like representative payeeship, outreach and collaboration with courts, will be expected. The program will be responsible for ensuring that housing and entitlements are secured. Adequate client support funding that the program can use flexibly to meet client needs will be available.

Services will be comprehensive and include the provision of preventative and routine somatic care. When specialty somatic services are needed, the program will be responsible for coordination with specialty somatic care providers.

The program will also ensure intensive oversight and management of program services, as follows:

- Obtains CSA approval for admission to the program
- Monitors to ensure continuity in the admission process
- Monitors the frequency of contact and outreach attempts
- Monitors discharges and slot utilization
- Conducts utilization review process using continued stay criteria
- Conducts quality improvement and outcome monitoring with staff participation
- Provides intensive staff training and supervision
- Utilizes consultation from an independent physician to ensure creative service planning
- Has a review process for critical incidents
- Monitors high-risk clients based on established criteria
- Utilizes a continuous quality improvement process
System Accountability

The Core Service Agency (CSA) will serve as the local oversight authority in collaboration with the program and the State to address system-level, program-level and client-level issues that arise. Through client-level oversight, the CSA will monitor the status of enrolled clients in various domains of interest. This will provide a level of accountability greater than ACT and Capitation, and will ensure that the program and the system are meeting the needs of the individuals served by the program.

The local oversight authority will ensure that:

1. **The right people are being served**
   a. Approve all enrollments and discharges
   b. Develop a process and provide an ongoing review of continued stay criteria

2. **Participants are getting the services they need**
   a. Conduct program audits including unannounced visits to look at client and personnel records to ensure that:
      - the target population is being served
      - service delivery conforms to the model
      - individual client outcomes are being achieved
      - the process for reviewing continued stay criteria is being followed
      - qualified and adequate staffing levels are maintained
   b. Conduct critical incident and mortality reviews
   c. Implement processes for utilization monitoring that includes at a minimum the following data points:
      - Length of time to engage with new referrals
      - Frequency of outreach attempts
      - Frequency of face-to-face contact
      - Frequency and type of services provided

3. **Program participants are achieving desired outcomes**
   a. Participants’ status in the following areas will be assessed on a regular basis:
      - Engagement in treatment
      - Compliance with medication
      - Hospitalization use
      - Emergency room use
      - Jail use
      - Substance use
      - Housing stability
      - Income
      - Insurance
      - Education
      - Employment
      - Volunteer activity
      - Quality of life
      - Somatic care use
• Progress in recovery
  b. For those individuals not demonstrating positive outcomes in the above areas, a comprehensive review will be conducted to determine what the program can do to better meet the individuals’ needs

4. Program services are of the highest caliber
   a. Oversee a psychiatric consultant to provide technical assistance and training to ensure creative service planning
   b. Ensure intensive and ongoing training for program staff
   c. Develop and implement a process to monitor participants identified as high-risk clients

5. The program continues to evolve in partnership with participants
   a. The program is implemented with fidelity to the model
   b. The program model is modified based on what is learned Identified challenges are addressed

In addition to ongoing oversight by the core service agency to assess outcomes, identify program modifications and problem-solve around system challenges, the program will be evaluated to ensure fiscal viability, system efficiency and ongoing funding at the system level. This evaluation will include interviews with participants to assess their experience in the program and interviews with clients who never consented to services to assess what the program could have done differently to meet their needs.
<table>
<thead>
<tr>
<th>Program Comparison and Contrast – Target Population</th>
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<tbody>
<tr>
<td><strong>Utilization History</strong></td>
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<tr>
<td><strong>Individual Options</strong></td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
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</tbody>
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| **ACT** | No defined utilization history | In at least one area:  
• At risk for higher level of care  
• Risk to self, others, property  
• Inability to engage in traditional outpatient treatment  
• Inability to form an ongoing therapeutic relationship | Priority Population |
# Program Comparison and Contrast – Program Design

<table>
<thead>
<tr>
<th></th>
<th>Mobile, Community-Based Services</th>
<th>Intensive, Assertive Engagement Mechanisms Used</th>
<th>24/7 Services</th>
<th>Frequency of Face-to-Face Contact</th>
<th>Frequency of Contact linked to Formal Guidelines</th>
<th>Full Responsibility for Crisis Services</th>
<th>Full Responsibility for Hospital Admission and Discharge</th>
<th>On-Site Drop in Capability</th>
<th>Program Incentive for Individual Client Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Options</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>3 - 4/week</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Capitation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Average 10/month</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>ACT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Average 4/month with range of 4 - 10</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th></th>
<th>EBP Fidelity - ACT</th>
<th>EBP Fidelity - IDDT</th>
<th>Supported Employment Services</th>
<th>Peer Support Services</th>
<th>Fully Integrated Substance Abuse Counselor</th>
<th>Intensely Coordinate or Provide Somatic Care</th>
<th>Client Support Funds to Flexibly Meet Client Needs Including Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Options</td>
<td>Subscribes to most elements</td>
<td>Subscribes to most elements of IDDT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes – provide care</td>
<td>Yes</td>
</tr>
<tr>
<td>Capitation</td>
<td>Subscribes to some elements</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes – coordinate care</td>
<td>Yes</td>
</tr>
<tr>
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<td>No</td>
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<td>No</td>
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</tbody>
</table>

* Extensive pre-enrollment engagement will be adequately funded.
# Program Comparison and Contrast - Accountability

<table>
<thead>
<tr>
<th></th>
<th>Monitors individual client outcomes</th>
<th>Frequency of Audits</th>
<th>Type of Audits</th>
<th>Responsibility for Audit</th>
<th>Utilization Reporting to the CSA</th>
<th>Individual Client Outcome Reporting to CSA</th>
<th>Individual Client Outcome Analysis and Aggregation by CSA</th>
</tr>
</thead>
</table>
| **Individual Options** | Yes                                 | Quarterly – frequency to be determined | • Validation of individual client outcomes  
• Validation of service delivery, i.e. is the program doing what it is intended to do?  
• Validation of staffing level  
• Fidelity reviews?? | CSA | Weekly | Quarterly | Quarterly |
| **Capitation**         | No, only in aggregate form           | 1 time per year    | Validation of service delivery and contract deliverables                      | CSA                      | Monthly                           | Monthly                                     | Annual                                           |
| **ACT**                | No, only in aggregate form           | 1 time per year    | Fidelity review and COMAR regulations                                          | MHA and OHCQ             | None                             | Monthly                                     | Quarterly                                         |