



*Delaware Health
And Social Services*

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

TO: ALL OFFERORS

FROM CEASAR McCLAIN
CONTRACTS MANAGER

SUBJECT: REQUEST FOR PROPOSAL – ADDENDUM #3
NO. HSS-11-097-CRISP

Community Reintegration Support Project
The Purpose of this addendum is to provide:

Section 1 – Questions and Answers

Section 2 – Copy of DHSS Policy Memorandum #46

Section 3 – RFP Addendum

Section 4 – Baltimore Materials

Please accept our apologies for the delay in posting the questions and answers for this RFP.

HSS-11-097

Addendum #3

Section 1 – QUESTIONS AND ANSWERS

REQUEST FOR PROPOSAL No. HSS-11-097
Community Reintegration Support Project (CRISP)
Questions & Answers
January 12 2012

1. **Q.** Some of the pot of money available is used for ER services or inpatient days. Is there a limitation on the days?

A. Please understand this model. There is no restriction, one way or another on how the provider uses their total funding under this contract. Some clients may require more hospital days than others. It is up to the provider to work to prevent the need for ER services or inpatient days. Who with or how the provider does this is the provider's responsibility.

The provider will be at risk for these ER or inpatient episodes unless data can be provided that demonstrates that this particular client is not able to avoid these episodes due to clinical or safety issues that no-one would reasonably be expected to manage. That data is up to the provider to provide. If that data is provided then the provider will be able to negotiate a stop-loss amendment to the contract for that specific client.

2. **Q.** Are we authorizing the inpatient care like a managed care company?

A. No, the contractor's responsibility is to manage the care prior to the need for commitment even if necessary at door of ER. Once a client is hospitalized it is on the provider to get them out timely. The only similarity to managed care is that the "funder", in this case, is the provider and will be negatively affected if clients get expensive deep end care unnecessarily.

3. **Q.** What happens when an ER visit is for a medical reason?

A. Regarding your fiscal responsibility, nothing. However, the interface between medical and mental health needs are difficult, at times, to determine so it will behoove the provider to be very knowledgeable about the client's health status and medical needs.

4. **Q.** Is medical care covered under the case rate, such as ER visits due to physical disorders and short-term hospitalization because of physical illness or conditions?

A. No, these are not covered case rate services and the Provider is not required to pay for them. However, the Provider is allowed to pay for them out of the case rate if the team decides it is appropriate or worthwhile to avoid further deterioration of health status.

5. **Q.** Is there going to be an arbiter of decisions about whether an ER visit is for medical or psychiatric reasons?
- A.** Yes. We will put in place a process to review situations such as described. In general it is expected that the provider will have staff available to be onsite in these situations and that ER data will be available to the provider as to documented reasons for these visits. There will be a procedure in the contract which describes how disagreements like these are appealed if the DSAMH CRISP provider asks for this appeal.
6. **Q.** What if somebody is admitted for a medical reason such as low sugar diabetes, they act out, the hospital decides to put them on a one to one, and the visit becomes coded as a psychiatric visit?
- A.** In most situations, this is not the responsibility of the provider. What the provider will do is be responsible for the actions of the clinical team prior to admission, during the inpatient hospitalization, and for timely discharge planning. However, if this admission is determined, due to lack of data or clear data, to be a psychiatric visit, the contractor is responsible. **Q.** Will the hospitals need a prior authorization for admissions from the provider?
- B.** YES – if voluntary. No if involuntary. However for the latter the provider can intervene the next day. If the inpatient provider refuses to work with the CRISP provider than that can be reported next day and DSAMH will intervene at that point.
7. **Q.** What happens if the client feels they need an admission and the provider refuses to authorize? Is there an appeal process for the client?
- A.** Yes for all issues there is always an appeal process for the client. This does not remove responsibility from the provider to provide an adequate and acceptable alternative for the client. This kind of situation may occur more in the next year and until the provider has had time to build a relationship with the client and that will be taken into consideration. However, based on history, this situation will not be usual.
8. **Q.** How will involuntary treatment be paid for?
- A.** Involuntary or voluntary inpatient hospitalizations will be paid for out of the provider's case rate funding up to a negotiated cap. In general the provider will be routinely required to provide up to the 30 day benefit that the current MCOs provide per year at current rates. That is around a total of \$18,000 for the inpatient benefit per client per year. The provider will be expected to prevent the need for hospitalization before this becomes an issue. If a client's care is not managed well the provider may be at risk for more days in addition to the 30. We do not anticipate this occurring often.

9. Q. Do involuntary commitments impact this?

A. Yes, see #8.

10. Q. Are statistics from the Baltimore initiative for hospitalization rates available?

A. See #15. Specific questions can be requested through DSAMH. We will be providing all information to all bidders that any bidder has been privy too from the Baltimore project.

11. Q. Will participants contribute to room and board payment?

A. Yes if they have money or benefits. If not the provider is responsible to get the client eligible for benefits or to pay for these services out of the case rate.

12. Q. Who pays for hospitalization from time of referral until the person comes out of the hospital?

A. For psychiatric hospitalization, the provider is responsible for payment up to a negotiated cap that in most cases will depend on the individual client's issues. The provider will not be held responsible for unremitting symptoms that can not be resolved past the 30 day cap. For individuals who remain at DPC, this will be negotiated, per client, at the point of start up. For one, the provider will not pay for hospitalization days for clients currently in DPC for at least 30 days. After that they will need to present each client's discharge plan and negotiate when they will take responsibility. In general we expect that the current DPC clients will become the full responsibility of the provider within 9 months of the award. Given suggested practice that allows for six new clients a month this will allow for the discharge of at least 54 clients during this time frame. Some of the additional clients will be harder to discharge due to legal or political issues and their discharges will need to be discussed with DSAMH and at times the courts or other agencies.

13. Q. What happens if the client chooses not to leave the hospital?

A. The provider is expected to spend significant time developing a significant and mutually valued relationship with that client and to move slowly but clearly toward discharge by using Peer supports, outings, passes, overnight stays and attempting to meet the concerns of the client. We do not believe that this will be a significant issue based on our and other state's work. If this does become an issue for a single client the provider may appeal to DSAMH and DSAMH has the discretion to remove a name and assign another client to the provider. The burden of proof is on the provider/contractor to prove they did everything possible to engage the individuals and have them move out of the hospital. This work will require documentation and specific descriptions that are data based.

14. Q What are the current inpatient hospital rates? What are the caps for any inpatient hospital stays that will be deducted from the provider case rates?

A. DSAMH does not understand the question on what are current hospital rates? For whom? The current DSAMH inpatient rate is \$625/day. There are no caps at this time other than 30 days annually at which point the provider can request an appeal.

15. Q. What is the estimated hospitalization cost per year to the provider?

A. There is no estimated number of hospital days. The goal of the program is to prevent or limit this expensive deep end care when possible. Data from the Baltimore Project demonstrates that this program was very successful and saw a great reduction in inpatient stays for those individuals in that program. If a client presents who appears to need more than usual hospitalization days then the provider can appeal to DSAMH to remove them from the CRISP pool. However, the provider will have to also demonstrate extraordinary and creative approaches that they used to maintain the person in the community and or to get them discharged. Very few people require long hospitalization. Most of these long term hospitalizations have been due to a lack of new funding in our community system and the resultant lack of available services and supports required. This contract should minimize these issues.

16. Q How does the Provider get reimbursed for engagement while participants are still in hospital? Is there a set rate? Time limit?

A. Once the provider starts to work with a client at DPC they will receive the case rate funds. However, past the 30 days grace period the provider will also be responsible for the daily hospital rate. That is the reason that DSAMH has suggested a limit, if required, of 6 clients per month to be admitted to the provider's service.

17. Q Will the rate decrease or increase in years 2, 3, etc?

A. We anticipate the rate remaining the same with the caveat that all clients in this project will be expected to become either Medicaid and/or Medicare benefit eligible within the first 12 months of admission to this program and that these benefits will be deducted from the funds that DSAMH is providing by year two. There will be incentives built in to get clients eligible and disincentives for failure to do this.

18. Q If a participant is in the hospital for medical reasons, does this affect the provider's reimbursement?

A. No

19. Q. Do we need as part of the proposal, written referral and payment agreements with hospitals and ERs since we do not provide these services?

A. DSAMH would recommend that the provider expect to do this kind of relationship building but not prior to getting the contract. This would just be good practice and fiscally smart. Please also understand that if the DE commitment law is changed in a manner that gives the provider authority to authorize hospital stays, then yes.

20. Q. What is the average per Diem for inpatient care?

A. For psychiatric, \$625/day

21. Q. Average cost for an ER visit?

A. This varies depending on what occurs in the ED and the payer. It is our estimate that it is generally around \$2000 to \$3000 per stay without input from community providers.

22. Q. Average cost for transportation?

A. DSAMH currently reimburses for transport of involuntary patients at the rate of \$0.31 per mile and \$100 if transport crosses county lines. DSAMH does not currently pay for transport of voluntary patients as most of the time this voluntary transport is done by self, family and/or friends.

23. Q. Is there a penalty for a hospitalization if the client is insured?

A. Yes, the hospitalization reimbursement paid by insurance will be deducted from the case rate.

24. Q. If a participant is in the hospital past the cap limit does the Provider get any reimbursement for that "slot"?

A. We are not sure of the meaning of this question. The CRISP provider is expected to serve all clients in their caseload and pay for same. There is no reimbursement for failure of the provider to limit high end expensive services except as discussed above. The provider will be responsible for each client's inpatient hospitalization days but will have an appeal process for issues out of their control.

25. Q. What is happening to RCMs?

A. The DSAMH funded Recovery Care Managers will be phased out and carefully handed off for these clients only. The CRISP provider is expected to provide all services including TCM, ICM, ACT, Mobile Crisis, Detox, SA treatment, as needed upon discharge.

26. Q How will the current RCM's work fit into the plan?

A. DSAMH will work with the CRISP provider to negotiate who will remain on these case loads, in the interim, and the amount of time allowed. The DSAMH RCMs will then be phased out and handed over to the winning bidder. Again the new CRISP provider is being reimbursed to provide all services and supports needed for these clients. They will not be able to draw on other funding or services from DSAMH.

27. Q. Is there an expectation on the part of the hospital staff that they will be picked up as employees by this project?

A. No

28. Q. Is the intent not to close the hospital but to discharge people from the hospital?

A. The intent is to gradually change the scope of DPC to be more focused on acute care. We anticipate that DPC will settle with a census of around 100+maximum including the Forensic Unit that is currently at 42. The rest of the clients that DPC will serve in the future will be acute care beds (36), a very small geri psych unit at 10-15 beds and a unit that serves people that are court ordered to stay at DPC due to NGRI issues or Sex Offender issues which could potentially be another 15 beds or so. Given the changes in the DSAMH community system it is hard to predict the exact number of beds for DPC in the future. This could be 100-125.

29. Q. The Division has spent a lot of time in development of the peers. Is the expectation that the provider get a whole new cadre of peers, or do they work with the Division's peers?

A. The expectation is that the provider incorporate new peers into its program but make use of the existing DSAMH Peers, in the interim, and as negotiated.

30. Q. What sorts of trainings were helpful in the last initiative?

A. We assume you mean the Baltimore Project? Training by existing providers of this sort of capitated program. In addition training that includes the SAMHSA Consensus Statement on Recovery and the research and literature on what helps people with serious mental conditions recover. That is up to the provider/bidder to research.

31. Q. Is other money removed off the top in addition to the five percent incentive?

A. Yes, Please refer to the RFP.

32. Q. Is the business proposal included with the technical proposal or bound separately?

A. It can be bound together but must be clearly identified and separated in that proposal.

33. Q. Are there any minimum page requirements?

A. No, as stated in the RFP – “DSAMH discourages overly lengthy and costly proposals. It is the desire that proposals be prepared in a straightforward and concise manner. Unnecessarily elaborate brochures or other promotional materials beyond those sufficient to present a complete and effective proposal are not desired.

34. Q. Is there any required font size?

A. No

35. Q. Is there any required margin size?

A. No

36. Q. Besides QI are there any other required sections?

A. Submissions need to adhere to the technical proposal requirements beginning on page 19. Business proposal requirements begin on page 27.

37. Q. Do you require the ten printed and bound copies to be in any specific format?

A. Requirements are outlined in the RFP

38. Q. Where can we get PM 46?

A. Copy will be attached to Q&A addendum

39. Q. The housing units states that no more than twenty percent of a buildings population having mental health or substance abuse use disorder diagnoses. Does this mean an individual cannot rent a single family home with a roommate that has a diagnosis or a home by themselves?

A. No it does not mean that. Individual clients can do whatever they want to. They cannot be coerced to agree and they must be offered all choices that you and I have. The Olmstead or USDOJ "rules" are best practices; however, a client can always decide where he/she wants to live. If they decide to live in a place that may contradict with the Olmstead or USDOJ Rules, then DSAMH will expect to see documentation that describes how this decision came about, what options were discussed, and if any coercion was in place, etc.

40. Q. How are housing costs handled? CA fund?

A. Housing costs are included as part of the case rate. There will be no additional client assistance funding for the CRISP Program.

41. Q. Is rental assistance in the case rate or not?

A. Yes, it is part of the rate.

42. Q. If rent is in the case rate, should it be shown in the line item budget or in the client assistance budget?

A. There is no client assistance funding for this program. All housing costs for the target population are included in the case rate which is significantly higher than that was used in Maryland.

43. Q. General: Does Delaware provide any special housing vouchers or bridge funding for those who qualify for DOJ Settlement services?

A. Yes, but not for this program as housing is part of the rate.

44. Q. Will there be Section 8 vouchers available outside the case rate?

A. Not from DSAMH. Any outside funding sources utilized for housing will be deducted from the case rate.

45. Q. General: How will Delaware separate Housing First enrollees from ACT recipients for the purpose of outcomes measurement and incentive payments?

A. We will not separate. We do not understand the purpose of the question. Again, the case rate will be expected to cover all needs of the target population.

46. Q. General: Are congregate living arrangements (group homes, boarding houses) allowed if the consumer requests such a living arrangement?

A. This outcome will be heavily discouraged and would be limited to individuals who really desire this outcome and who are able to testify, by themselves, to the USDOJ Court Monitor why they want this outcome. The goal is for individuals to live in as independent a setting as possible. Any choice of congregate living will be investigated by the Court Monitor. We strongly discourage this path without very clear clinical reasons.

47. Q. Will congregate living be allowed? Was it allowed in the Baltimore model?

A. No See #47

48. Q. May we contact the Baltimore program? Who would we contact?

A. The Baltimore programs are not really set up to handle questions in this context. You are free to contact whomever you like, but we suggest that questions be channeled through DSAMH. DSAMH will be sending out basic information on the Baltimore Project but frankly most of this information is included in this document.

49. Q. The RFP specifies that integrated housing which meets the criteria laid out in the agreement between DHSS and the U.S. Department of Justice will be a covered service under CRISP. The scope of housing that will be provided does not make provisions for individuals who may need in-home supports. At the same time, many of the individuals who have been recently discharged from DPC under the earlier RCM initiative have preferred and/or required in-home staffing support which costs much more on an annual basis than the proposed case rate would support. In similar capitated programs in other states, few of the participants live independently with no staff support, largely because they require personal care and daily living supports as a reasonable accommodation to make a good transition from institutional living to community living.

A. Our data disagrees with yours. The Baltimore project is an example of how this worked with a case rate of \$30,000 or less per person. The approved bidder will need to figure this out. Most clients discharged from DPC may need intensive supports for a few months but can then be stepped down. The successful provider will need to be alert and able to step down clients from 24/7 care when able to do this. There are many creative ways to provide the needed supports to people in this program that are not cost prohibitive. This may mean stepping out of old models of care.

50. Q. If, on assessment, individuals assigned to CRISP desire or requires in-home support in order to live effectively in the settings defined in the RFP; will there be any additional funding or acceptable modifications to the requirements to provide them with reasonable accommodations?

A. No. These supports are expected to be covered by the case rate except with rare exceptions that can be appealed to DSAMH with data that supports this request.

51. Q The required use of the DSAMH pharmacy is for uninsured CRISP participants only, correct?

A. Clients with Medicaid/Medicare benefits will have their choice of pharmacy services. Clients who are uninsured will be directed to the state pharmacy until they become eligible for benefits or for as long as they need. Co-payments cannot be paid by DSAMH going forward and co-pays will also be collected in the state pharmacy.

52. Q The RFP states that 'All psychotropic medications will be provided by the DSAMH pharmacy. The costs associated with these will be paid for by DSAMH and are not included in the Case Rate. However, the provider is expected, and will be monitored by DSAMH, to take full advantage of available mechanisms for defraying these costs (e.g. Prescription Assistance Plans, appropriate use and management of Medicare Part D plans, collection of prescription co-pays, sample medications, use of generics when clinically appropriate, etc.) as well as all DSAMH pharmacy reporting requirements. The DSAMH pharmacy **will not** provide non-psychiatric "somatic" medications.'

A. Yes, the DSAMH pharmacy will not cover somatic medications. The provider may choose to. See Q #52 A. for our response to the rest. We apologize that the original wording was directed to clients without benefits (clients currently at DPC as eligible for this program) as our wording did not take into consideration that most of these clients will be eligible for benefits down the road.

53. Q. What packaging options does the DSAMH pharmacy provide as a reasonable accommodation to individuals who have not independently taken medication while hospitalized and who may need environmental modifications and other assistance to ensure safe medication practices?

A. DSAMH will put in place whatever packaging is required for the specific client needs. DSAMH will have several packaging methods to offer. However, DSAMH will not pay extra to private pharmacies for packaging above the Medicaid or state rates for these services.

54. Q. Can the DSAMH pharmacy accept electronic prescriptions which will be required under Meaningful Use?

A. Yes

55. Q Some of the individuals we currently serve are restricted to a single pharmacy because of past abuse of prescription medications. The restriction is imposed by DMAP. If the DSAMH pharmacy will not be able to provide medications other than psychotropic, and an individual with a pharmacy restriction requires both psychiatric and 'somatic' medications, how will this be accommodated?

A. DSAMH will work this out with DMAP.

56. Q. Using a single pharmacy for all medications is a time-saver and can be a money-saver, freeing up expensive nursing and physician time for patient care rather than recordkeeping. Can consideration be given to removing the requirement to use the DSAMH pharmacy for participants who have insurance if that is their preference and there is no cost to DSAMH?

A. See #52

57. Q. The CRISP RFP promotes person-centered care and client choice. In this spirit, participants who are Medicaid / Medicare beneficiaries (or are insured by third party) should be allowed to choose their own pharmacy. In addition, how does DSAMH reconcile this requirement with Section 1902(a) (23) of Title XIX of the Social Security Act which requires that Medicaid / Medicare beneficiaries may obtain medical services...? "From any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services?"

A. See question #52

58. Regarding the pace at which individuals will be admitted to the program, the RFP states 'this will be done on a staggered basis that can be negotiated but with no less than 10 people every 30 days.' However, in other parts of the RFP, specifically on page 7, it states 'Crisp will include an ACT level of service that meets Dartmouth fidelity criteria' and on page 21, 'applicant must document they are prepared to meet full Dartmouth ACT fidelity.'

The Dartmouth ACT Fidelity Scale, section O 'Organizational Boundaries,' gives the highest rating to programs wherein the 'highest monthly intake rate is no greater than 6 clients per month'. Programs which admit 10-12 clients per month are rated at the middle of the fidelity scale. It will be up to the provider to decide how many clients they can admit given the risk and financial issues of a client remaining in hospital vs being discharged. DSAMH will work with the provider to support their data based decisions.

Q. How can these items be reconciled? Is DSAMH willing to reduce the intake rate to no more than 6 clients per month in order to enable the provider to achieve maximum DACTS fidelity?

A. Yes, but DSAMH will consider the rate of discharge as part of its annual evaluation of the program's effectiveness and accomplishments.

59. Regarding the selection of the target population, the RFP states that 'DSAMH expects that the contractor will accept for services all individuals assigned to them by the...EEU.' We agree with this philosophy, but think that there will be some people whose clinical needs might be better met by referral to other services than CRISP.

Q. Will there be an opportunity to negotiate where individuals are referred if, in the opinion of the clinicians working on the case, there is a better alternative which might lead to better outcomes?

A. Yes, there will be an appeal process that will be included in contract.

60. Q. The RFP states that the applicant organization 'cannot act as their client's representative payee. This service will be provided by a third party provider under contract with DSAMH...' Is there such a third party provider in place to accommodate this requirement?

A. It is DSAMH's intent to contract for this entity to manage this service, as an independent advocate, in the next year.

61. Q. Who does DSAMH envision as serving as Rep Payee?

A. An agency that is not a provider of clinical services and has no assailable conflicts of interest in managing individual's funds. TBD

62. Q. Will the DSAMH be the Rep Payee for these clients?

A. No.

63. Q. Ensuring that pharmacy co-pays, rents and other obligations are met will be critical to helping individuals who are leaving DPC to maintain community tenure. Many of them have no recent experience managing their funds. Will DSAMH have a third party contract for this service in place before the CRISP program is awarded and begins to take individuals out of DPC?

A. That is our intent.

64. Q. Is the provider at full financial risk, i.e. if the provider exceeds the total case rate dollars and the Adversity Fund allocated under the project, does the provider dig into their own reserves to pay for the project?

A. Yes.

65. Q. It appears that this is a full risk contract. Does the Delaware Department of Insurance regulate or approve such contracts?

A. This is not a full-risk contract. The contractor is not paying for health, dental etc. and there will also be a stop-loss. Also, the client and or provider can access additional non-DSAMH funds for uncovered services.

66. Q. In the first year of this Risk Contract, will the provider be made whole?

A. No. We work as partners and that is our commitment, but based on case rates used in similar programs, the CRISP case rate is extremely generous and considered sufficient.

67. Q. Does DSAMH or DHSS require the provider to have a certain amount of financial reserves on hand?

A. This will be addressed during contract negotiations as there will be restrictions on how the funds through this program will be managed.

68. Q. How will court ordered treatment be paid for?

A. If it is a covered service, the costs come out of the case rate. If the client does not have benefits it will be covered by the case rate.

69. Q. Are there any state owned buildings available for the project for office space?

A. We have some space in Sussex County, other than that we have very limited space and the provider should not depend on DSAMH to provide this

70. Q. The RFP does not indicate in which geographic areas individuals who are being discharged from DPC may wish to live. What is the expectation of DSAMH in regards to the geographic coverage of the CRISP program?

A. Statewide, most individuals have expressed a desire to live in New Castle or have not specified, but some will want to live in the other two counties, as such the expectation to serve clients under this RFP will be statewide.

71. Q. Will the provider be responsible for providing services statewide?

A. Yes

72. Q. Is there an expectation of multi-sites state-wide?

A. That is up to the provider. The people who are eligible for CRISP services will be the driver of where they get their services.

73. Q. Are the 75 individuals spread across the state?

A. Yes

74. Q. Will CRISP end when 75 discharges are completed?

A. No. We anticipate the initial contract to be one year with the possibility of renewal for up to four (4) years contingent upon funding and satisfactory performance. Depending on success of this program it may well expand in future years.

75. Q. General: How will transition from CRISP be made if a person is too medically fragile to be safely treated in the community? Will the CRISP team continue to serve the mental health needs of the consumer in a rehabilitative center or nursing home?

A. There are no persons on the list for discharge at DPC who are too fragile to be safely treated in the community. If this issue arises the provider will have full and ready access to DSAMH staff to discuss that issue. The CRISP contractor is not responsible for care in nursing homes or rehabilitative centers.

76. Q. General: How physically healthy are the individuals referred to CRISP? Are any individuals at high risk of serious medical care that would require nursing home level of care currently?

A. Individuals requiring nursing home level of care will not be assigned to CRISP unless that provider is willing to take that level of service on.

77. Q. Is there a penalty if CAPES or DPC are used?

A. Yes. For costs incurred. . See above.

78. Q. Will there be a start-up budget?

A. NO – please refer to the funding and payment methodology section of the RFP.

79. **Q.** The RFP does not specify the amount of funding that is available for this program. Multiplying 75 participants by the suggested \$45,000 case rate, it is inferred that somewhere between \$2,868,750 and \$3,375,000 will be available. Is this an accurate assumption?

A. Funding will be based on the number of clients assigned to the program. The contract amount will be pro-rated accordingly. These rough estimates apply basically, if you are also considering the three special funds (5% each) set aside from this case rate (See RFP).

80. **Q.** General: What is the anticipated payment range for community reintegration services (transition planning activities) while the consumer remains in the DPC?

A. Please refer to funding and payment methodology in the RFP.

81. **Q.** (Page 25, N. Implementation Plan): What are the ramp-up expectations? To be faithful to the DACT model a full staff should be in place before the first consumer is enrolled in services. Are there start-up costs to pay for the highly specialized staffing requirements of an ACT team?

A. As stated in the RFP, DSAMH will pay two quarterly payments based upon the number of clients expected to be enrolled during the first six months of the Project, one at the beginning of quarter one and the second at the beginning of quarter two. These payments will be computed by first subtracting the off – the –top payments for Central Accounts and then dividing the rate by four.

Separate and/or additional funding is not available for start-up. These payments are assumed to be sufficient to implement start up.

82. **Q.** For any Medicaid covered service, should the provider bill Medicaid and then expect the reimbursement from DSAMH to be decreased by that same amount?

A. Yes, if the payment is for a CRISP covered service.

83. **Q.** If an individual wants outpatient services in addition to CRISP/ACT supports are they eligible (Medicare) and will it affect funding of CRISP/ACT?

A. The CRISP Proposal expects the provider to meet all of the needs of the client including the above.

84. Regarding the budget CD that was distributed at the pre-bid meeting, there is a section of the budget labeled 'IT costs.' In most DSAMH budgets, these costs are included in other operating and/or indirect costs. Sometimes the hardware costs, such as new computers, are covered in start-up costs.

Q In HSS-11-097, are we to assume that costs that are delineated as IT costs should NOT be included anywhere else in the budget? AND, is the per-person rate inclusive of the IT costs, or are the IT costs separate from the rate?

A. There are no start up funds. All IT costs are to be reported on the "IT Costs" of budget worksheet. As stated on page 14 of the RFP, providers must adhere to DTI policies and standards. All costs are considered as included in the rate.

85. Also regarding the budget, the RFP states that medical and dental care and medications are not included in the case rate and that they may be included in 'client costs'. The RFP also states that housing is included in the case rate. Yet, the budget breakdown includes 'client costs' in which rental and utility assistance are separated from other costs along with the cost of medical and dental care and medications.

A. Housing, rental and utility costs are included in the case rate.

Q. How should a responder show which of the client costs are in the case rate and which are not?

A. As stated in the RFP, the budget information requested is not for use in the contract – it is to ensure that the provider has considered all potential costs of providing these services. It should be clear in the RFP what is included in the case rate and what is not. Anything to be paid on behalf of a specific client (utilities, food, rent, etc) is to be captured in the client costs worksheet instead of the operating budget worksheet.

86. Q. General: Can persons enrolled in CRISP become concurrently enrolled in an evidence based IPS Supported Employment program?

A. Yes, but as a covered service, the program is responsible for the cost. For example, the program may decide to buy this service for an individual, or to develop an innovative service for any and all CRISP clients. **All of these services are included in the case rate.**

87. Q. (Page 13, A. Outcome Criteria a) Positive Outcomes): Regarding improvement in clients' scores on psychological and functional assessments, which instruments does the Department intend to use?

A. This will be determined through discussions with the provider and the entity conducting the evaluation.

88. Q. (Page 13, A. Outcome Criteria b) Negative Outcomes): Regarding negative outcomes, the Department will look at number of days spent in prison by client and in aggregate. Are prison days combined with jail days or are they separated? Do you look at days spent in jail as a negative outcome?

A. Jail (or detainee status in a prison in Delaware) is considered a negative outcome most of the time. If the provider can show that they did all work necessary to try and avoid this outcome than this will be carefully reviewed as no provider can both support recovery principles and control another individual's behavior. As an example, if a client has a known SA problem or anger issue the provider will be expected to prevent negative consequences by using EBPs or other interventions. If, in spite of this work the individual offends and gets arrested than this outcome will be assessed as to the provider's attempts. If someone is convicted and goes to "prison" they will not be discharged from the Crisp program immediately and the provider will need to bring this individual client's issue to the attention of DSAMH to determine their role, DSAMHs role and what if anything can be done to mitigate this outcome.

Delaware does not have distinct jail and prison facilities. Any incarcerated person, whether for someone who is sentenced, someone who is simply being detained, etc., is housed in Delaware's prisons.

89. Q. (Page 13, A. Outcome Criteria b) Negative Outcomes): Is there any financial penalty associated with negative outcomes?

A. It has an impact on how much of the 5% incentive fund can be "earned" back and how much savings (if any) is retained. All outcomes will have an impact on the CRISP provider's total budget, positive or negative.

90. Q. (Page 13, A. Outcome Criteria c) Reporting): Regarding utilization reporting, what are the specific measurements/instruments used to document an "increase in independent living skills"?

A. **First year**, you will give examples of independent living and the evaluator will quantify. In our experience these will modify and become more obvious overtime. Not everything can/should be exactly quantified. Obvious indicators are things like learning to use bus systems on their own, going to social events or church on their own, going to exercise on their own, making change to purchase food or other needs, competencies on 'who to dress', hygiene skills, social skills, volunteering etc.

91. Q. What type of data tracking system will providers be required to use?

A. DSAMH will work with the provider to develop this depending on the providers own system of date collection.

92. Q. (Page 59, 13. Corporation Data): Can documents be California vs. Delaware with intentions to obtain Delaware documents once/if funded?

A. Yes

93. Q. You ask for examples of how we might provide each of the following covered services using hypothetical client situations. Could you give us clarification on exactly what you mean when you ask for hypothetical client situations?

In the technical proposal instructions, we provided three (3) hypothetical client profiles and we are requiring that "mock" recovery plans be prepared and submitted for each of them.

HSS-11-097

Addendum #3

Section 2 – DHSS POLICY MEMORANDUM #46

ATTACHMENT 1



DELAWARE HEALTH AND SOCIAL SERVICES

DHSS Policy Memorandum 46 August 2009

Subject: Injury to Clients

I. PURPOSE

- a. To protect the right of residents/clients of Delaware Health and Social Services (DHSS) facilities to be free from abuse, neglect, mistreatment, financial exploitation or significant injury.
- b. To require that each Division that has, or contracts for the operation of, residential facilities establish standardized written procedures for the reporting, investigation and follow up of all incidents involving suspected resident/client abuse, neglect, mistreatment, financial exploitation, or significant injury.
- c. To require that all DHSS residential facilities comply with The Patient Abuse Law (Title 16, Chapter 11, section 1131, et seq.) and Title 29, Chapter 79, sections 7970 and 7971 (Attachments I and II); and that all Medicaid and/or Medicare certified long term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with the federal regulations (42 CFR) and State Operations Manual for such facilities. In addition, all residential facilities and Medicaid and/or Medicare certified long term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with Title 11, Chapter 94, Victims Bill of Rights, Subchapter I and Subchapter II. Compliance with Title 11, Chapter 5, Subchapter V Offenses Relating to Children and Incompetants, Subpart A Child Welfare; Sexual Offenses is required by all facilities that provide residential and/or inpatient services to children.
- d. To require that all DHSS residential facilities comply with all applicable state and federal statutes, rules and regulations pertaining to suspected abuse, neglect, mistreatment, financial exploitation, or significant injury. Applicable statutes include Title 11, Chapter 5, Subchapter II Offenses Against the Person, Subpart A Assaults and Related Offenses.

II. SCOPE

- a. This policy applies to anyone receiving services in any residential facility operated by or for any DHSS Division, excluding any facilities/programs in which the only DHSS contract is with the DHSS Division of Social Services Medicaid Program.
- b. This policy is not intended to replace additional obligations under federal and/or state laws, rules and regulations.

III. DEFINITIONS

a. Abuse shall mean:

1. Physical abuse the unnecessary infliction of pain or injury to a resident or client. This includes, but is not limited to, hitting, kicking, pinching, slapping, pulling hair or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.
2. Emotional abuse - This includes, but is not limited to, ridiculing or demeaning a resident or client, cursing or making derogatory remarks towards a resident or client, or threatening to inflict physical or emotional harm to a resident or client.

b. Neglect shall mean:

1. Lack of attention to the physical needs of the resident or client including, but not limited to, toileting, bathing, meals, and safety.
2. Failure to report client or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.
3. Failure to carry out a prescribed treatment plan for a resident or client.
4. A knowing failure to provide adequate staffing (where required) which results in a medical emergency to any patient or resident where there has been documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the department, all so as to evidence a willful pattern of such neglect. (Reference 16 DE Code, §1161-1169)

c. Mistreatment shall mean the inappropriate use of medications, isolation, or physical or chemical restraints on or of a resident or client.

d. Financial exploitation shall mean the illegal or improper use or abuse of a client's or resident's resources or financial rights by another person, whether for profit or other advantage.

e. Significant Injury is one which is life threatening or causes severe disfigurement or significant impairment of bodily organ(s) or functions which cannot be justified on the basis of medical diagnosis or through internal investigation.

- f. Assault (including sexual assault) as defined in Del.Code Title 11 § 611, § 612 and § 613.
- g. Attempted Suicide shall mean an intentional attempt at the taking of one's own life.
- h. SANE – Sexual Assault Nurse Examiner.
- i. Residential Facility shall include any facility operated by or for DHSS which provides supervised residential services, including Long Term Care licensed facilities, group homes, foster homes, and community living arrangements.
- j. Long Term Care Facility is any facility operated by or for DHSS which provides long term care residential services and the Delaware Psychiatric Center.
- k. High managerial agent is an officer of a facility or any other agent in a position of comparable authority with respect to the formulation of the policy of the facility or the supervision in a managerial capacity of subordinate employees.

IV. RESPONSIBILITIES

- a. The Director, or his/her designee of each Division within the scope of this policy, is hereby designated as an official DHSS designee under the State Mandatory Patient Abuse Reporting Law.
- b. Each Division will develop written procedures consistent with the standards contained in this policy and which will be activated immediately upon discovery of any suspected abuse, neglect, mistreatment, financial exploitation or significant injury of or to a client of a residential or long-term care facility. These procedures must clearly outline the reporting chain from the witness to the Division Director, and other appropriate parties, to require the expedient relay of information within the required time frames.
- c. These standardized procedures shall also apply when the preliminary inquiry suggests that the assault, significant injury, suspected abuse, neglect, suicide attempt, mistreatment or financial exploitation may have been caused by a staff member of the residential facility, whether on or off the grounds of the residential facility. Suspicion of facility/program negligence (including inadequate supervision resulting in client-client altercations) and incidents involving abuse by persons who are not staff members of the residential facility shall also be reported.
- d. The standardized procedures shall be approved by the appropriate Division Director prior to implementation. The Division Director or designee shall forward a copy of the approved procedures to the Chief Policy Advisor, Office of the Secretary, and other appropriate agencies.
- e. Each Division will require that the standards established in this policy are incorporated in all residential operational procedures and all residential contracts. Each Division shall require that all residents and providers of these programs be informed of their specific rights and responsibilities as defined in the Division's written procedures.

- f. Each Division shall require that all levels of management understand their responsibilities and obligations for taking and documenting appropriate corrective action.
- g. Each Division shall require appropriate training of all staff and contract providers in the PM 46 policy and procedures. Such training shall also include the laws prohibiting intimidation of witnesses and victims (11 Del. C., sections 3532 through 3534) and tampering with a witness or physical evidence (11 Del. C., sections 1261 through 1263 and section 1269).
- h. Each Division shall develop quality assurance/improvement mechanisms to monitor and oversee the implementation of the PM 46 policy and procedures.
- i. Each Division must ensure that all employees of, or contractors for, residential facilities shall fully cooperate with PM 46 investigations.

V. STANDARDS/PROCEDURES

Standard and consistent implementation of this Department policy is required. Each Division's written procedures shall include the following:

- a. Employee(s) of the residential facility, or anyone who provides services to residents/clients of the facility, who have reasonable cause to believe that a resident/client has been assaulted, abused, mistreated, neglected, subjected to financial exploitation, or has received a significant injury, or attempted suicide shall:
 - 1. Take actions to assure that the residents/client(s) will receive all necessary medical attention immediately, including calling '911' for transportation to the hospital, especially in the cases of assault, sexual assault, and serious physical injury. In the cases of sexual assault, a SANE examination should be completed at the hospital.
 - 2. Take action to report all crimes to the police through the '911' call system. All victims of crimes must be offered the ability to access victim advocate services, either through the police agency or other agencies. Victim advocates can be contacted by calling 1-800-VICTIM1 (1-800-842-8461). The Delaware Helpline can provide advocate information and Contactlifeline can provide confidential accompaniment to the hospital in cases of sexual assault.
 - 3. Take actions to protect the residents/client(s) from further harm.
 - 4. Report immediately to the Division of Long Term Care Residents Protection (if the incident occurred in a long term care facility or if the client was a resident of a long term care facility); and to the Department of Services for Children, Youth and Their Families/Division of Family Services (if the client is a minor, as required under 16 Del. C., section 903). It is essential that the reporting person ensure that the report be made to the appropriate division designee immediately.
 - 5. Report immediately to the facility/program director and the Division's designated recipient(s) of PM 46 reports.

6. Follow up the verbal report with a written initial incident report to the persons/ agencies named in (a) 3 and (a) 4 (above) within 48 hours.
- b. In addition to the above named persons, any other person may make a report to a staff person of the facility or to the Division director or his/her designee. Such a report shall trigger activities under V(a), items 1 through 5.
- c. Each written initial report of assault, suspected abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury (completed by the reporting employee) must include:
 1. The name and gender of the resident or client.
 2. The age of the resident or client, if known.
 3. Name and address of the reporter and where the reporter can be contacted.
 4. Any information relative to the nature and extent of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury.
 5. The circumstances under which the reporter became aware of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury.
 6. The action taken, if any, to treat or otherwise assist the resident or client.
 7. Any other information that the reporter believes to be relevant in establishing the cause of such assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury.
 8. A statement relative to the reporter's opinion of the perceived cause of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury (whether a staff member or facility program negligence).
- d. The Division's designated recipient of PM 46 reports shall report all allegations of assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, and significant injury, to the Office of the Secretary; the Office of the Attorney General/Medicaid Fraud Control Unit (for Medicaid and/or Medicare certified long term care facilities); the appropriate state licensing agency for the program, if applicable; and the Division Director or designee, within 24 hours of receiving notification of such. In instances where a suspected crime has been committed, the police must be notified immediately and they will take the lead in the investigation of the suspected crime.
- e. In instances where there is immediate danger to the health or safety of a resident/client from abuse, mistreatment or neglect; any sexual assault or alleged sexual assault; any physical abuse that leads to injury; any allegations of verbal abuse; any allegations of vandalism; any allegations of financial exploitation; any suicide; any assault or alleged assault, any suspected criminal action; or if a resident/client has died because of suspected assault, abuse, mistreatment, neglect, suicide, or significant injury, the Division Director or his/her designee shall immediately notify the appropriate police agency. The Division of Long Term Care

Residents Protection, and the Office of the Secretary, shall be notified if the police were contacted. Further, the Division Director or his/her designee shall notify the Office of the Attorney General/Medicaid Fraud Control Unit, the Office of the Secretary, the Chief Medical Examiner, if a resident/client has died because of suspected assault, abuse, mistreatment, neglect, suicide, significant injury, or as a result of any cause identified by 29 Del. C., section 4706 and Title 11, Chapters 5 and 94. In accordance with Title 16 § 5162, the Division Director or his/her designee shall notify the Community Legal Aid Society, Inc within seventy-two hours of the date of any patient or resident death.

- f. The Division Director or his/her designee shall review the initial incident report and initiate an investigation into the allegations contained in the report. The investigation, with a written report, shall be made within 24 hours, if the Division has reasonable cause to believe that the resident's/client's health or safety is in immediate danger from further assault, abuse, neglect, attempts of suicide, or mistreatment. Otherwise, the investigation and written Investigative Report, up to and including the Division Director's or designee's signed review of the report, shall be made to the Division of Long Term Care Residents Protection (DLTCRP) within 10 days. This timeframe may be extended by DLTCRP if extenuating facts warrant a longer time to complete the investigation. If the facility is a Medicaid-Medicare certified long-term care facility, or an ICF/MR facility, the report of suspected assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury shall be sent to the appropriate authorities, as required in the respective regulations under 42 CFR, within 5 working days of the incident.
- g. The investigative process shall be confidential and not subject to disclosure both pursuant to 24 Del. C., section 1768 and because it is privileged under the governmental privilege for investigative files. Each Investigative Report shall be labeled as confidential and privileged, pursuant to 24 Del. C., section 1768. Each investigation shall include the following:
 1. A visit to the facility or other site of incident.
 2. A private interview with the resident or client allegedly abused, neglected, mistreated, whose finances were exploited or whose injury was significant.
 3. Interviews with witnesses and other appropriate individuals.
 4. A determination of the nature, extent and cause of injuries, or in the case of exploited finances, the nature and value of the property.
 5. The identity of the person or persons responsible.
 6. All other pertinent facts.
 7. An evaluation of the potential risk of any physical or emotional injury to any other resident or client of that facility, if appropriate.

- h. A written report (Investigative Report) containing the information identified in V (g) shall be completed within the time frames identified in V (f) and shall include a summary of the facts resulting from the investigation. (Attachment 3)
- i. The Investigative Report shall be sent to the facility director and to the Division Director or designee. The Facility Director and the Division Director or designee shall review the report. If the incident is serious, the
Division Director must review the incident with the Department Secretary prior to the completion of the report. The Facility Director and the Division Director or designee shall indicate in writing their concurrence or non concurrence with the report. If the facts show that there is a reasonable cause to believe that a resident/client has died as a result of the abuse, neglect, mistreatment, or significant injury, the Division Director or designee shall immediately report the matter to the Office of the Attorney General/Medicaid Fraud Control Unit, the Division of Long Term Care Residents Protection, and the Office of the Secretary.
- j. All Investigative Reports shall be forwarded by the reporting division, forthwith, to the Division of Long Term Care Residents Protection. The Division of Long Term Care Residents Protection shall complete the investigation by making a determination of findings and documenting their conclusions.
- k. If a determination is made at the Division level (upon consultation with the Division of Management Services, Human Resources office) that discipline is appropriate, the Investigative Report shall be forwarded to the Human Resources office. Human Resources shall determine the appropriate level of discipline, forward their recommendations to the Office of the Secretary and to the originating division for implementation, and proceed as appropriate.
- l. The Office of the Secretary shall be informed by the Division of Long Term Care Residents Protection, in writing, of the results of the investigation, including the findings and recommendations, within 5 days following the completion of the investigation.
- m. The Division Director or designee shall notify the appropriate licensing or registration board, if the incident involved a licensed or registered professional, and the appropriate state or federal agency, including the appropriate state licensing agency of the program, if applicable, upon a finding of: 1) assault, abuse, mistreatment, neglect, financial exploitation, attempted suicide, or significant injury; 2) failure to report such instances by a licensed or registered professional; or 3) failure by a member of a board of directors or high managerial agent to promptly take corrective action.
- n. The Division Director or designee shall notify the employee, resident/client, the guardian of the resident/client, if applicable, and the incident reporter of the results of the facility-based case resolution, unless otherwise prohibited by law. They shall also advise the parties of the fact that there is a further level of review that will occur through the Division of Long Term Care Residents Protection and/or the Office of the Attorney General/Medicaid Fraud Control Unit.

- o. The Division of Long Term Care Residents Protection shall, at the conclusion of their review of the case, notify the DHSS employee (or the agency director for contract providers), the resident/client, or the guardian of the resident/client, if applicable, and the originating Division Director or designee, of the substantiated or unsubstantiated status of the case, unless otherwise prohibited by law. The Division of Long Term Care Residents Protection shall also notify the Office of the Attorney General/Medicaid Fraud Control Unit of all substantiated cases.

VI. IMPLEMENTATION

- a. This policy shall be effective immediately (upon the completion of mandatory departmental training).
- b. In carrying out this policy, all parties must protect the confidentiality of records and persons involved in the case, and may not disclose any Investigative Report except in accordance with this policy.

VII. EXHIBITS

- a. Attachment 1 - Delaware Code, Title 16, Chapter 11, Sections 1131-1140.
- b. Attachment 2 - Delaware Code, Title 29, Chapter 79, Sections 7970-7971.
- c. Attachment t 3 - Investigative Report form
- d. Attachment 4 – Delaware Code, Title 11, Chapters 5 and 94.

Rita M. Landgraf August 2009

Rita M. Landgraf, Secretary

HSS-11-097

Addendum #3

Section 3 – RFP ADDENDUM

Page 8, Crisp Elements are hereby modified to read:

CRISP Elements:

- Involved Senior Leaders from Executive Director down
- Individual client's strength-based evaluation
- Outcome-oriented and value driven services planning and delivery
- A system of incentives and safeguards linked to performance
- Centrally managed accounts
- A unified information system that meets State of Delaware requirements
- Intensive training for provider staff and involved stakeholders
- ACT service model

Page 10, Covered Service/Included in Case Rate and Medicaid are hereby modified to read:

Covered Service/Included in Case Rate:

- Mental health outpatient treatment
- Emergency room visit
- Hospital admission and stay
- Substance use disorder treatment
- Crisis beds
- 24 hour Mobile crisis response
- Transportation
- Supported employment
- Personal services such as sitters, aids or visiting nurses
- Personal needs such as clothing, supplies, food, job training, educational services, etc.
- Basic medical and dental well check ups
- Safe, affordable, and integrated housing:

a) Integrated housing, in all forms, must meet the following criteria (from the Bazelon Center for Mental Health Law):

- Housing units are scattered-site or scattered in a single building with no more than 20% of the total building population having mental health or substance use (co-occurring conditions) as best as can be determined.

- A wide array of flexible, individualized services and supports is available to ensure successful tenancy and support participants' recovery and engagement in community life.
- Services are delinked from housing. Participants are not required to use services or supports to receive or keep their housing.
- Participants have direct input in choosing their housing unit, any roommates (if they choose not to live alone) and which services and supports (if any) they want to use.
- Participants have the same rights and responsibilities as all other tenants. They should have their own personally signed lease agreement. They should be given any accommodations necessary to help ensure successful tenancy.

Page 11, Uncovered Services/Not included in Case Rate are modified to read:

For those services that are listed as "uncovered" or "outside of case rate", the provider is allowed to work with the client to obtain these services through a separate reimbursement mechanism or out of client funds. If other funds are used, there will be no deduction adjustment from the case rate. **Additionally, the Provider is allowed to pay for any services, including the uncovered services, approved by the provider's treatment team for the purpose of facilitating recovery in the community.**

a) Linkage to somatic care: annual physical and specialized follow-up, including, but not limited to:

- Physical rehabilitation
- Long term care in a general hospital for serious medical needs such as surgery for cancer or organ transplant or for other life-threatening, physical problems

Page 13, Negative Outcomes is hereby modified to read:

a) Negative Outcomes

- Numbers of clients voluntarily or involuntarily dis-enrolled in year (NOTE: all dis-enrollments will require DSAMH approval)
- Numbers of Emergency Department visits, by client and in aggregate
- Number of inpatient beds days/admissions, by client and in aggregate.
- Numbers of nights spent in homeless shelters by client and in aggregate
- Number of individuals in the population who become homeless, number of days per client and in aggregate
- Number of days spent in prison by client and in aggregate.
- Use of emergency respite bed days in community

TECHNICAL PROPOSAL SUBMISSION

Page 22, Scope of Services is hereby modified to read:

1. **Program Abstract:** Applicant must provide a description of its clinical management philosophy with respect to new, innovative and creative approaches and include an understanding of how this works with a focus on recovery, outcomes, and flexibility.

Applicant must describe how it will incorporate the SAMHSA Consensus Statement on Mental Health Recovery into its program design.

http://www.samhsa.gov/samhsa_news/volumexiv_2/article4.htm

2. **Program Design:**

- a) Applicant must provide examples of how they might provide each of the following covered services using hypothetical client situations:

- Mental health outpatient treatment;
- Emergency room visit
- Hospital admission and stay
- Substance use disorder treatment
- Crisis beds
- 24 hour Mobile crisis response
- Transportation
- Supported employment
- Personal services such as sitters, aids or visiting nurses
- Personal needs such as clothing, supplies, food, job training, educational services, etc.
- Basic medical and dental well check ups
- Safe, affordable, and integrated housing (see Scope of Services section III.1.a for housing definition).

Applicant must include a statement of understanding that these services will be included in the case rate negotiated with DSAMH.

- b) Applicant must describe how it will provide linkage to somatic care: annual physical and specialized follow-up, including, but not limited to:
 - Physical rehabilitation

- Long term care in a general hospital for serious medical needs such as surgery for cancer or organ transplant or for other life-threatening, physical problems.

HSS-11-097

Addendum #3

Section 4 – BALTIMORE MATERIALS

The Creative Alternatives training manual can provide the applicant an overview of the values and approaches to treatment that was adopted by this program in its work in Baltimore. While many of the elements of this manual will reflect how the program may operate in Delaware, it is not meant as a template for the Delaware program, nor a blueprint to base an applicant's respond to the RFP. The final Delaware program will not be a duplicate of the programs in Baltimore and will develop significant and specific differences that are not anticipated in this training manual.

Overview

Creative Alternatives is a comprehensive mental health program serving the most seriously ill and difficult to treat persons with severe and persistent mental illnesses. Using a capitated funding model, Creative Alternatives provides flexible, individualized, intensive services to persons who voluntarily enroll in the program. Our mission is to support, teach, and empower adults to successfully live, work, learn, and socialize in their community.

Part of Johns Hopkins Bayview Medical Center's Community Psychiatry Program, Creative Alternatives was elected as one of two Baltimore Capitation Demonstration Project sites for a five year pilot project administered by Baltimore Mental Health Systems (BMHS). BMHS is the mental health authority for the City of Baltimore. BMHS, the State Department Mental Hygiene, and Medicaid blend single stream funding which allows Creative Alternatives to flexibly and efficiently use resources unfettered by artificial barriers encountered by traditional mental health programs. A contract specifying the broad parameters of the project was signed by BMHS and Bayview in late 1993.

Creative Alternatives hired staff and began operating in the winter of 1994. As specified in the contract, the program will eventually serve 188 people. The first 60 were persons who had been in State psychiatric hospitals for at least six months. The average length of their last hospitalization prior to discharge was seven years. One person had been hospitalized for 47 consecutive years. The remainder of the enrollees will be a mix of individuals who have been in long term state psychiatric hospitals and Medicaid high users.

For each person who enrolls in the project, a lump sum of money is received to arrange for whatever services are needed. Creative Alternatives is then responsible for providing or purchasing all mental health services including psychiatric inpatient hospitalization, emergency room visits, traditional outpatient treatment, and rehabilitation services. In addition, Creative Alternatives addresses the individual's need for housing, employment, somatic care, substance abuse treatment, dental and eye care, community living skill training, crisis intervention, community integration activities, entitlements, and transportation.

The philosophy of Creative Alternatives is to work with each person as a unique individual and, as the work itself is also unique, the program adopted terms suitable to the setting. Creative Alternatives refers to clients as members of the program, differentiating itself from traditional patient care. The program is based on values of individualization of services, member choice, freedom, high risk/high support, and overall quality. Staff are empowered to use resources that enhance the individual member's quality of life.

At the end of the year, Creative Alternatives undergoes an independent evaluation of the program's performance on pre-established outcome criteria. Outcome performance

indicators include quality of life, improved functioning, employment, and how well the program has met the individual needs of each member. The contract rewards performance through an incentive plan that pays staff bonuses and allows the program to keep unspent funds for future service initiatives. To date, the independent evaluations of the project have been positive.

Each member of Creative Alternatives is assigned to a team consisting of a Team Leader, Psychiatrist, RN, Personal Service Coordinators, and Community Support Assistants. The teams and specifically the Personal Service Coordinators are responsible for working with each member to successfully achieve their individual goals. In addition to team members, Creative Alternatives has specially trained staff in the areas of psychotherapy employment, entitlements/money management, housing, and substance abuse to provide intensive and focused assistance in these areas. Support is available for day-to-day activities like grocery shopping, banking and medical appointments, while intensive support is provided if the member is having a crisis.

Ultimately, Creative Alternatives' philosophy of flexibility and high risk/high support is what makes it an innovative and effective program.

THE MISSION

TO support, teach and empower adults with serious and persistent mental illness to successfully, live, work and socialize in their communities.

TO work with the community to promote opportunities and acceptance through advocacy and education.

STATEMENT OF VALUES

WE do whatever it takes to provide services and support that are continuous, flexible and determined by the members' wants and goals (high risk/high support.)

WE encourage our members to assume personal responsibility for their lives through making their own choices.

WE strive to establish adult to adult relationships based upon respect and equality.

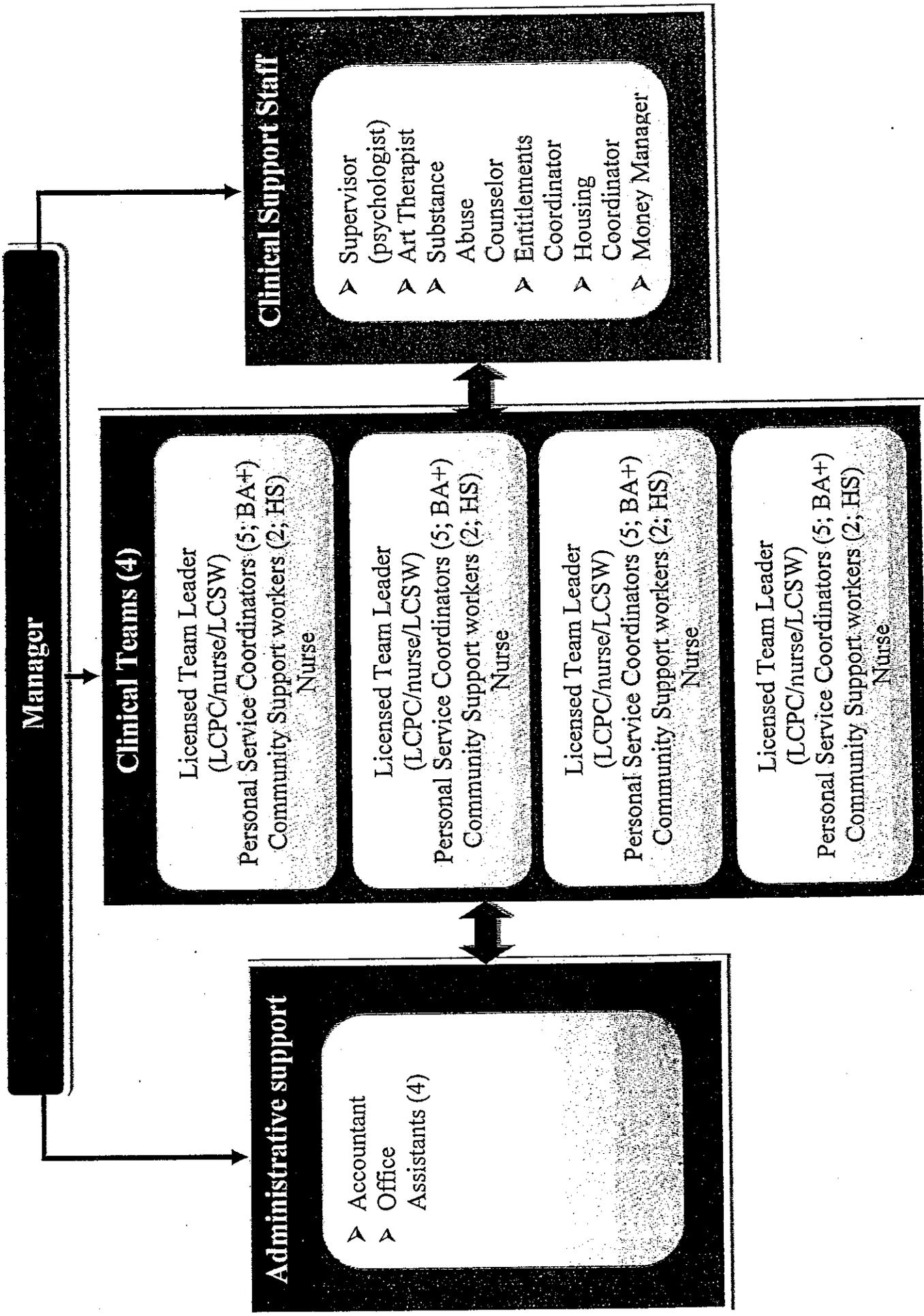
WE recognize and support the unique strengths and capabilities of each individual.

WE believe natural consequences are teachable moments for growth and learning.

WE support our members participating in their own communities, and learning in natural settings.

WE strive to teach and demonstrate these values to other persons and organizations.

Creative Alternatives



MODELS OF CARE

	<i>Traditional</i>	<i>Capitated</i>
Funding	Fee for Service	Capitated Funding
Funding Contingency	Continued symptoms requiring intervention	No contingency except members' interest in continuing to receive services
Service Delivery System	Outpatient Services CMHC Psychiatric Rehabilitation Day Treatment Case Management Residential Rehabilitation	Treatment Team
Focus of Treatment	Symptom reduction	Individual Strengths
Crisis Availability	Emergency rooms or specialized crisis team	Team available 24-hours a day
Staff Roles	Specialist Therapist Rehabilitation Therapist Case Manager Residential Counselor	Generalist
Site of Delivery Service	Office/Center-based	Community-based
Point of Responsibility	Multiple points depending upon needs	Single point of responsibility
Service Accountability	Diffused	Simplified
Organizational Structure	Complex	Simplified

	<i>Traditional</i>	<i>Capitated</i>
Systemic Values	Coordination of care and communication	Quick response by Team
Standards of Practice	Focus on credentials Regulatory oversight Prescribed approaches	Performance contracts Outcome evaluations Creative approaches
Caseload Size	High	Low
Continuity of Care	Achieved by offering a continuum of services flowing from inpatient to outpatient	Achieved by same staff following member through various treatment providers
Housing	Viewed as part of treatment continuum with usual long stays in group homes or residential rehabilitation settings	Emphasis on consumer choice and flexible time limited supports

9/06

Terminology

Member - Traditionally called a patient or client, a person who voluntarily enrolls in our program.

- ❖ **Personal Service Coordinator (PSC)** – Traditional programs call this position a case manager. Our members are not cases to manage. We establish and maintain adult to adult relationships to meet the needs of each member.
- ❖ **Community Support Assistant (CSA)** – Assist the PSCs and the members in everything from bus training and social visits to medical appointments.
- ❖ **Team Leader**– Supervises, supports, manages, teaches, coordinates, and advocates for the team that they lead.
- ❖ **Team** – Consists of a Team leader, Psychiatrist, RN, PSCs and CSAs.
- ❖ **Member Choice** – One member wants to move into her own apartment, another wants to stop taking her medications, and a third prefers to skip his 12-step meeting. These are choices that our members are making every day. We educate them on the pros and cons of each decision in order to empower them to make their own choices. Even if we do not agree with the choices they make, we support the member through the consequences.
- ❖ **High Risk/High Support** – A member wants a job, another is in crisis. These situations can create a higher amount of vulnerability for our members. Together the staff and member identify the amount of support they need to help them gain confidence and take control in their lives when these circumstances arise.
- ❖ **Whatever It Takes** – Stay overnight in her home until the mania dissipates, monitor their medications every single day of the week, bring his sister from Delaware to visit him for the first time in years, follow the bus in your car to see that she gets off at the right stop, have his 70th birthday party at your home, have breakfast with him every Sunday morning, take him to his Thursday evening 12-step meeting, pick him up from the homeless shelter.
- ❖ **Natural Consequence** – A member makes the choice to spend his rent money on drugs. It is February and his choice has landed him on the streets or in a shelter. Our program allows him to make that very choice and then live with the fallout.
- ❖ **Capitated Funding** – Rather than sending off a bill every time we provide a service, or having to think if a service is billable or not, Creative Alternatives' staff is allowed to concentrate on what the member needs. We can help them buy furniture to move into their own apartment, pay for medications that their insurance will not cover, or buy memberships to karate schools. Each member is

unique, with individualized wants and needs, and this flexibility allows us to use our financial resources to help achieve their goals.

- ❖ **Teachable Moment** – A member has problems at their assisted living home and decides that they don't want to return. He and his PSC discuss the situation and attempt to problem solve, but he refuses to return. His choice becomes homelessness or a shelter until a new assisted living home can be found. We encourage our members to look at how their behaviors have an impact on their own and others' lives, and then support them in making changes in these behaviors to feel happier and more stable.

- ❖ **Quality of Life** – Upon seeing her sister, one family member stated, "I've never seen her look so good." For many members, their life choices prior to enrollment were limited. It is our goal to enhance or improve the options that members have regarding lifestyle, health, mental health, and their over well-being.

Housing

Creative Alternatives provides assistance and support in finding housing for all members. Members choose if they want to live in either Baltimore City or Baltimore County, and then they are shown at least three housing choices in those areas. There are primarily two options for housing – dependent and independent housing.

Dependent homes are defined as living with family or in an assisted living home. Assisted living homes are private homes that provide room and board for a monthly fee. The typical Care Provider monitors medications, cooks, cleans, does laundry, and gives up to 24 hours of supervision in the home. These services are individualized to each member's needs. For example, some members complete household chores and get to and from work or a day program, while others need help with basic personal hygiene.

Creative Alternatives, the member, and the Care Provider all must agree upon services provided, the rent amount, and then sign a Care Provider Agreement form before the move takes place. Each home is registered through the State and should have a current license posted in order for members to live there. These homes must also have a fire and safety inspection done by the fire department. Creative Alternatives requires an annual inspection to be completed by the Housing Coordinator. Monthly housing inspections and regular communication between staff and Care Providers is expected as long as a member is in their home. In addition to home visits and telephone interaction, a Care Provider Education/Support Group is facilitated by Creative Alternatives staff.

Members may choose to live with their family or friends. In this situation, finances are decided between the member and the family member or friend, and staff support is on an as-needed basis depending on each situation.

Independent housing usually involves living in a rooming house or an apartment. Members who live independently sign their own lease with the rental agent. The member is expected to pay for as much of this as possible. The program may subsidize the members to cover the expenses. Donated items are often available to the members on a first come, first serve basis. In-home support is tailored to each member's needs, so staff may be in the home daily, weekly, or more if necessary. Regardless of housing type, and psychiatric level, when members move into a new home, staff are expected to be in the home at least once a week for the following month, and then finally one visit per month. These members may need extra support with medication monitoring, meal planning and cooking, or training with household chores. Creative Alternatives provides that support, and whatever else they need in order for them to successfully live independently in the community.

Occasionally, members are evicted or kicked out of their housing. When this occurs, we offer support while the member experiences the natural consequences of their action. For

example, one member spent his rent money on drugs and consequently had no place to live. Staff helped the member find a homeless shelter and provided transportation there for several weeks until he had enough money for rent again. Another member was evicted from her home due to behavioral issues. Staff went with her to find a new home, but she heard several rejections from prospective housing due to these previous behaviors. The natural consequence for this member's behavior was the reality that a homeless shelter would possibly soon be home. In both cases, staff supported the member through the crisis, and resolved the housing issue according to each member's personal situation. Staff will also assist members in finding soup kitchens or restaurant vouchers, if necessary.

Housing has been a difficult task for the program. Many members have moved multiple times due to safety concerns, behavioral issues, and personal choice. Some members have moved between assisted living homes and independent living based on their changing wants and needs. Creative Alternatives strives to do "Whatever It Takes" to help the members be as independent as possible in their home.

Case Study

Laura is a 56 year old woman diagnosed with schizophrenia. She is constantly delusional, speaking to her "children," calling herself a doctor, lawyer, judge, pharmacist, and adamantly denying the use of her real name. Initially, staff moved her from the State Hospital into an assisted living home, but she was very independent and determined to do what she wanted to do (i.e., smoking at all hours, refusing medications, and having poor relationships with anyone who lived with her.) The Care Provider felt unable to deal with her behaviors and outbursts. Laura requested her own apartment and staff decided to try it. At first, she wasn't cleaning and her cooking skills were limited. She was not taking her medication consistently; she stole her neighbor's mail, and had a long distance phone bill for hundreds of dollars. With staff's support, Laura hired another member to help her clean. She has improved her grocery shopping and cooking skills, and stopped making long distance calls. Staff calls her daily and she now monitors her own medication. Laura has been living on her own for ten years now.



4940 Eastern Avenue
Baltimore, MD 21224-2780
(410) 550-0100
TTY (410) 550-0316

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

Member: _____

Provider: _____

Address: _____

Phone No: _____

License/Registration No: _____

Date of License/Registration: _____

Expiration Date of License: _____

PROVIDER AGREEMENT

The Provider assures that licensure or registration with the State Department of Health and Mental Hygiene is current and valid. The Provider agrees to adhere to all relevant City, County, and/or State regulations. The Provider is responsible for immediately notifying the member and Creative Alternatives of any changes, which could affect the approval status of the facility. The Provider understands that Creative Alternatives shall not subsidize an unregistered unlicensed facility or one that is operating out of compliance with regulations.

The Provider shall assume all liability for the care provided to the member in the residence. The Provider agrees to hold harmless, save and indemnify Creative Alternatives against all claims for damages, costs, judgments, expenses and reasonable attorney fees incurred by Creative Alternatives as a result of actions of the Provider.

The Provider agrees to deliver services specified in the Personal Service Plan. Creative Alternatives expects the Provider to deliver the following services to the member:

Specify if Necessary

Meals _____

Personal Care _____

Laundry / Houskeeping _____

Access to Health Care and Social Services _____

Medication Management _____

Other _____

Any changes in the member's mental or physical health shall be reported to staff at Creative Alternatives a timely manner. The Provider agrees to consult with the program psychiatrist or nurse prior to administering any psychiatric PRN medication. The Provider agrees to consult Creative Alternatives prior referring member for any mental health services (except in emergency situations).

The Provider agrees to treat the member with respect and dignity.

Entitlements & Financial Services

The goal of the Financial Services Program at Creative Alternatives is to teach members how to manage their personal resources to meet their daily needs. There are four main sections to this program: **Entitlements, Member Budgets, Representative Payee, and Money Management.**

Entitlements

Prior to the member's enrollment to the program, the Entitlements Coordinator meets with each individual and the assigned Personal Service Coordinator to assess which entitlements they are currently receiving or may be entitled to receive. Due to the severity of their mental disability, most of the members enrolled are unemployed. The emphasis on the member finding employment is started during this meeting. This emphasis is consistent with our program philosophy of recovery and integration into all aspects of community life. In addition, many potential members have had extended stays (more than one year) in a State Facility requiring the opening of new cases with the Social Security Administration and Department of Social Services. If the Entitlements Coordinator assesses that the member is eligible for benefits, they then will support the member by guiding them through the bureaucratic maze of the application process. The potential member, the Personal Service Coordinator and the Entitlements Coordinator discuss the cost for the member to live in the community and start the development of the Member Monthly Budget Worksheet. (See attached)

The State of Maryland requires all Medicaid recipients to join a Managed Care Organization (MCO). This dramatic change in the delivery of primary medical treatment has left many persons unsure and unaware of what their choices are. The Entitlements Coordinator assists members in choosing the MCO that best suits their needs. The Entitlements Coordinator is responsible for assisting members who qualify for Medicare to enroll in each aspect of this healthcare program, Part A, B, C, and D which is the pharmacy assistance portion.

Member Budgets

Creative Alternatives uses its capitated funding to financially subsidize some members. Each member needing financial assistance meets with the Entitlements Coordinator to establish a personal budget (see attached). This budget lists a member's monthly/ estimated expenses. If expenses exceed income; the member is encouraged to seek out employment and enter the Money Management Program. This program helps members identify ways to improve personal money management skills.

Representative Payee Program

Members who are unable to manage their own finances due to the severity of their illness may identify Creative Alternatives as their Representative Payee. They must meet criteria established by Social Security Administration to enter this program. Creative Alternatives receives the member's monthly Social Security or Supplemental Security Income check and then uses these funds to pay for expenses listed on their Budget form. In addition to fixed financial obligations (e.g., rent, food, utilities, clothing, and medical and dental needs), members receive a consistent dollar amount to meet their personal needs. They are free to spend this money as they choose. The member is not expected to have a representative payee for the entire time they are enrolled in our program. Members are encouraged to join the Money Management Program and become their own payee. The Entitlements Coordinator and Money Manager work extensively with the members in teaching them the skills needed to be financially responsible and utilize their financial resources for their intended purpose. **The Entitlements Coordinator is expected by the program administration to support four or more members in becoming their own payee, each year.**

Money Management Program

The Money Management Program develops personal responsibility by teaching members the skills necessary to manage their own finances. The Money Management Program is individualized for each member contingent on their level of knowledge. For some members we utilize a sequential and progressive step-by-step approach. Establishing a monthly budget, opening a bank account, having money deposited in to the account and paying the monthly expenses may be part of the process. For others, it may entail paying their monthly bills at check cashing place or getting a money order to pay their bills, "Whatever It Takes." As they become successful in this process, members assume responsibility for all of their bills. After they have demonstrated their ability to pay bills, Creative Alternatives submits a request to Social Security to transfer the monthly check back to the member. Using a sequential and progressive step-by-step approach, members work with their PSC's and the Entitlements Coordinator to pay their own bills. Each member starts by opening his/her own bank account. Money is then transferred into their account to pay one of their bills. Members are taught how to make deposits and withdrawals, write checks, balance checkbooks, and, most importantly, plan for expenses. As they become successful in this process, members assume responsibility for all of their bills. After they have demonstrated their ability to pay bills, Creative Alternatives submits a request to Social Security to transfer the monthly check back to the member.

PERSONAL ONGOING MONTHLY BUDGET WORKSHEET

Member Name _____ Date comp'd 1/16/2006
 REP. PAYEE/AMT. CA \$603.00 PSC _____
 A: IPT/RECOV RENT _____ RENT AMOUNT \$159.00
 Check Distribution:

Wkly Disbursements:		Check Distribution:	
Allowance		Month	
WEEK 1		1st	\$200.00
WEEK 2		15th	\$200.00
WEEK 3			
WEEK 4			
WEEK 5			
Total Wkly Disb.		Tot. Mthly Disb	\$400.00

INCOME SOURCE	AMOUNT	EXPENSES	AMOUNT	MEMBER INPUT	MEMBER \$ @ CA
SS		RENT/B & C	\$159.00	\$159.00	\$0.00
SSI	\$603.00	BGE	\$0.00	\$0.00	\$0.00
FAMILY		TELEPHONE	\$60.00	\$60.00	\$0.00
VETERANS		LOANS	\$0.00	\$0.00	\$0.00
RET. ANNUITY		FOOD	\$200.00	\$200.00	\$0.00
FOOD STAMPS	\$ 18.00	TRANSPORTATION	\$0.00	\$0.00	\$0.00
WAGES		CLOTHING	\$0.00	\$0.00	\$0.00
OTHER		MISC/PERSONAL CARE	\$200.00	\$178.00	\$22.00
OTHER		SOCIAL ACTIVITIES	\$0.00	\$0.00	\$0.00
		TUITION/EDUCATION	\$0.00	\$0.00	\$0.00
		HOUSEHOLD SUPP/LAUNDRY	\$0.00	\$0.00	\$0.00
		SAVINGS AT CA	\$24.00	\$24.00	\$0.00
		OTHER	\$0.00	\$0.00	\$0.00
		OTHER	\$0.00	\$0.00	\$0.00
		OTHER	\$0.00	\$0.00	\$0.00
TOTAL INCOME	\$621.00	TOTAL EXPENSE	\$643.00	\$621.00	\$22.00

SECURITY DEPOSIT BELONGS TO CA

MEMBER CHART ENTIT.COORD. FINANCIAL

PERSONAL ONGOING MONTHLY BUDGET WORKSHEET

EFFECTIVE _____

Date comp'd _____

Member Name _____

PSC _____

REP.PAYEE/AMT. _____

RENT AMOUNT _____

MEMBER TO STAFF/MEMBER: _____

Check Distribution:

Wkly Disbursements:		Month	
Allowance		1st	
WEEK 1		15th	
WEEK 2			
WEEK 3			
WEEK 4			
WEEK 5			
Total Wkly Disb.		Tot. Mthly Disb	

INCOME SOURCE	AMOUNT	EXPENSES	AMOUNT	MEMBER INPUT	CA SUBSIDY
SS	\$0.00	RENT/B & C	\$0.00	\$0.00	\$0.00
SSI	\$0.00	BGE	\$0.00	\$0.00	\$0.00
FAMILY	\$0.00	TELEPHONE	\$0.00	\$0.00	\$0.00
VETERANS	\$0.00	LOAN	\$0.00	\$0.00	\$0.00
RET.ANNUITY	\$0.00	FOOD	\$0.00	\$0.00	\$0.00
FOOD STAMPS	\$0.00	TRANSPORTATION	\$0.00	\$0.00	\$0.00
WAGES	\$0.00	CLOTHING	\$0.00	\$0.00	\$0.00
OTHER	\$0.00	MISC/PERSONAL CARE	\$0.00	\$0.00	\$0.00
OTHER	\$0.00	SOCIAL ACTIVITIES	\$0.00	\$0.00	\$0.00
		TUITION/EDUCATION	\$0.00	\$0.00	\$0.00
		HOUSEHOLD SUPP/LAUNDRY	\$0.00	\$0.00	\$0.00
		SAVINGS AT CA	\$0.00	\$0.00	\$0.00
		OTHER	\$0.00	\$0.00	\$0.00
		OTHER	\$0.00	\$0.00	\$0.00
		OTHER	\$0.00	\$0.00	\$0.00
TOTAL INCOME	\$0.00	TOTAL EXPENSE	\$0.00	\$0.00	\$0.00

MEMBER

CHART

ENTIT.COORD.

FINANCIAL

Families

Creative Alternatives encourages members to maintain healthy relationships with their families if they express this desire. Staff also try to have ongoing contact with families both before and during member enrollment, unless the member has specifically requested that they not be contacted.

When Creative Alternatives first began enrolling people out of State hospitals, several families were very concerned about what would happen with their family member. Many felt that they should not be discharged from the hospital and moved back into the community. They also shared concerns about the future of the program and what would happen to the members if the grant was not renewed. Staff worked hard to develop trusting and supportive relationships with these families.

Some members live with their families, so we have frequent contact. For those who do not live with their families, we often initiate contact and coordinate visits, providing transportation when necessary. Many members initiate their own family visits. Sometimes relationships between members and their families are not always positive. Staff then acts as an advocate for the member, and may encourage them to have less contact with the family. We have also helped members find family that they have not seen in years.

Many of our members have some sort of contact with their families, so it is very important that we try to cultivate natural support systems. Creative Alternatives organizes a yearly family picnic and during our annual evaluation families respond very favorably about the care their family members receive here.

Community Integration

The goal of the Creative Alternatives Community Integration Program is to help members develop and maintain recreational interests, achieve a satisfactory social life, and integrate into their surroundings community, some of the means by which this is accomplished are as follows:

- Weekly community meetings called C.A. Club, where members and staff can meet to share information and discuss their interests, recreation plans, and ideas.
- Monthly calendars of staff and member planned activities and community activities.
- Individualized goal setting and planning, where each member meets with their Personal Service Coordinator to initiate a step-by-step plan developing and maintaining a specific community integration goal (e.g., Kung Fu or piano lessons).
- Spontaneous plans, where either staff or a member suggests an activity, and then it happens.
- Normalized socializing, where activities occur at any time – including nights, weekends, and holidays.
- Community board that includes community integration information such as educational opportunities, upcoming activities and events.
- Outreach, where members who are unable to socialize comfortably in the community are contacted where they live.
- Anything else that helps to get our members out in their community and experiencing their lives to the fullest.

In the past members at Creative Alternatives have wanted to get their driver's license. With high support, steps have been taken to accomplish this goal. Another member is learning how to take the bus to a local drop-in center so that she can play the piano whenever she wants, instead of waiting for staff to take her when it is convenient to them. A group of members have been encouraged to save their money for a two-night stay in Ocean City, MD. Members have had successful nights out with DJ's, Karaoke and to the Moose Lodge to dance, sing, and socialize together. These social activities happen consistently, and every day a new idea sparks the interest of another member hoping to connect with his/her community.

A Case History of Eric

Eric was introduced to the martial arts at the age of 13. After numerous hospitalizations, including 10 years in a state hospital, Eric, at age 38, wanted to begin Kung Fu lessons in the community. It started with a phone call to a Kung Fu center not far from his home, followed by a private introductory lesson, and then an assessment of his skills. Eric then had to decide if he really wanted to make the commitment of taking two lessons per week, learning two bus routes to get there, working out a loan agreement to pay for the lessons, and practicing his moves diligently at home. He decided that the lessons were worth it. Finally the Kung Fu Center, the team at CA, and, most importantly, Eric agreed to begin the process of starting his long awaited lessons.

Eric took out a loan for half of the amount for three months of lessons. The team at Creative Alternatives agreed to pay the rest. For the first two weeks, the Community Integration Coordinator took him to his bi-weekly lessons, reminding him that he would soon be learning the bus routes so that he could get to the center on his own. Eric worked very hard in his classes. The teachers and students were helpful when he had a hard time with a move, or if he began feeling delusional or paranoid. In the third week, Eric, with the assistance of CA staff, began taking the bus to the center. By the following week, he went to his lesson independently.

These are examples of what people who have historically been categorized as incapable, withdrawn, and crazy can do if given the support and opportunities. Although Eric ended up attending his lessons sporadically, the entire process he went through was seen as a success in the eyes of both Eric and staff at Creative Alternatives. The support and enthusiasm of everyone involved made a dream come true, and we strive to continue making dreams a reality for every one of our members.

October Community Intergration Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
3 Check Sunday Paper For a "JOB"	4 Education/Substance Abuse Group 10:00 CA Club 11:00 Recovery Luncheon 12 Noon Shella meet w/members @5pm	5 Washington D.C. Zoo with Sam & Adahila Bingo w/Michelle 11:00 Fells point w/Kate 10:00 \$	6 Health Awareness & Sobriety 10:00 Walk @ CA w/Megan 11:00 Library w/Barbara 11:00 Job Search	7 Relapse Prevention @ 10:00 S.C. Living 11:30 w/Carolyn	8 Job search w/Tonya 10:00	9 Read a good book
10 Don't Worry Be Happy!	11 Education/Substance Abuse Group 10:00 CA Club 11:00	12 Job training w/Jason M 11:00 Bowling w/Sam 10:00	13 Health Awareness & Sobriety 10:00 Walk in Dundalk Park w/Robin & Helen	14 Relapse Prevention @ 10:00 S.C. Living 11:30 w/Jay Job search w/Rachelle 10:00 Job application w/Kristie 11:00	15 Paperwork Day CA Closed Movies w/Ben 12:00 \$\$	16 Get a Good Night Sleep
17 List positive short term goals	18 Education/Substance Abuse Group 10:00 CA Club 11:00 Target w/Tiffany 12:00 \$\$ Waiste Watchers Wendy 10:30	19	20 Health Awareness & Sobriety 10:00 Job search w/Alan 11:00 Practice job applications w/TJ 11:30	21 Relapse Prevention @ 10:00 S.C. Living 11:30 w/Jay Online Job search w/Alicia Terri job search @ 10:00	22 Coffee Fells point w/Jason @ 11 Wal-Mart w/Jason T @ 10:30 Movies w/ Princee 12noon \$\$	23 Stay Positive
24 Read a good book	25 Education/Substance Abuse Group 10:00 CA Club 11:00	26	27 Health Awareness & Sobriety 10:00 Lunch @ Chucks w/Vince	28 Relapse Prevention @ 10:00 S.C. Living 11:30 w/Jay McDonald's w/Alicia 12:30 Movies w/Olu @ 12:30\$ Coffee w/Chris 1:00	29 CA Walk @ 11:00 w/Kim	30

2010

October's Community Integration Letter

September 27, 2010

Dear Members:

 *Welcome to Fall.* Hope all is well with you and you are progressing in your recovery and life goals. We will have our recovery luncheon here at CA on Monday 10/4/10 after CA Club.

There are lots of opportunities to get involved in on the Community Integration Calendar in October. CA is focusing on helping members to find jobs, so look at the calendar and come in for help with finding a job. I will try to meet with members again on Monday 10/4/10 at 5:00 pm to discuss program development – only one person came in September – I need many more members to participate. Thank you to Keith J. for coming in September.

We will have people from a mental health program in Iowa here visiting CA on Tuesday, 10/5/10 and Wednesday, 10/6/10. We will be training them about CA. On Tuesday 10/5/10 from 3:15 pm to 4:00 pm I need 4 members to come and talk with the people from Iowa about your experiences with CA. Please call me at 410-631-6148 if you are interested.

Healthy Tips for the Month

1. Get your flu vaccine
2. Stay home if you have a fever or flu symptoms and call your team for support
3. Eat fruits and vegetables
4. Take a 15 minute walk every day
5. Smile and laugh every day
6. Take 15 minutes every day to pray, mediate and relax.

In Recovery,

Sheila

Crisis Services

Adults with serious and persistent mental illness are prone to having periodic difficulties in various aspects of their lives. Creative Alternatives has found it essential to provide 24-hour on call telephone line service to meet the needs of the individual in crisis. Crisis intervention is done on many levels within Creative Alternatives.

The first line of intervention is prevention. Upon enrollment, the member and the PSC meet to develop a Crisis Plan based on member observations regarding previous crisis and record reviews. This information is shared with the entire treatment team. It is also used to teach the member to recognize early signs of trouble and new coping mechanisms.

Secondly, the PSC is able to rely on the rest of the program staff to assist in providing additional support to divert a serious crisis. Communication and flexibility in our responses allow Creative Alternatives to support the members in the community in the least-restrictive environment.

The range of services for prevention and intervention of crisis may include one or a combination of the following:

- 24-hour emergency on-call service
- Day, evening, weekend, and holiday staff coverage
- Telephone comfort calls
- Face-to-face assessment and crisis planning with the member
- In-home support services
- Crisis/respite care in a home other than their own
- Psychiatric Rehabilitation Programs & Adult Medical Day Cares
- Partial hospitalization
- Psychiatric hospitalization

These options are discussed at length with the member. Any decisions are made mutually, and with the member's comfort and safety issues addressed. The member's options and progress are then reviewed continuously by the team until the crisis is diverted and resolved.

-24 hour emergency on-call service- Creative Alternatives has 4 people on-call at all times, which include, 1 PSC per 2 Teams, 1 Back up Supervisor and 1 Psychiatrist. PSC's are on-call approximately once every 6-8 weeks depending on staffing. The on-call pager is rotated every 7 days.

- Day, evening, weekend, and holiday staff coverage is accomplished by on-call staff 365 days a year as well as by prescheduled "medication run" staff which are determined by the team and by each member's individual needs.

-Telephone comfort calls are often scheduled by the team for members who need less, intensive care but still need or request staff support during the day and evening hours. This method is often used by the team to help members transition off of the "medication run" or to help cope with difficult periods in their lives.

-Face to face assessment and crisis planning with the member is an integral part of crisis services. Creative Alternatives maintains a "level of care" system to assist members during periods of heightened impairment. The level of care of each member is adjusted based on their clinical, psychiatric, and medical needs

-In home support services- all members are required to be seen in their home at least 1x per month. However, more often than not it is a weekly activity. In home counseling often provides the member with a safe, normalized environment with which to express their concerns and needs. Additionally, assessing a members living environment can provide valuable insight into a member's life situation.

-The use of crisis or respite care has proven to be an invaluable tool in preventing psychiatric hospitalizations. Creative Alternatives uses both professional crisis facilities, (agencies that are licensed and often employ psychiatrists and/or medical personnel) and respite facilities which are not licensed as crisis facilities but are capable of assisting members with an increased level of need. Respite facilities are often smaller agencies or Assisted Living providers that meet Creative Alternatives standards of care. Fees are negotiated and vary depending on the providers' services, background (such as medical training) and availability.

-Creative Alternatives will utilize other community rehabilitation programs when a member presents with very specific needs. We have found day programming to be effective to address specific ADL's, obstacles to employment and to provide daily structure. During periods of heightened stress, the team can network with other rehabilitation programs to effectively double the support until the crisis resolves.

-Partial Hospitalization programs, or PHP's are occasionally used for members who need more intensive treatment during the day then a PRP or crisis facility can provide. PHP's offer medical personnel as well as increased security, and precautions to assist members as they transition to improved medical or emotional health.

-Psychiatric Hospitalizations are always the last resort but sometimes despite our best efforts, they can not be avoided. Once a member is admitted to a psych unit the team is required to see the member and their treatment team at the hospital daily. It is the teams' job to act as a liaison between the member and treating psychiatrist to ensure the hospital has all relevant medical/psychiatric information including all medical medications,

diagnoses and pertinent psycho-social information. The team's advice is absolutely essential to assist the member in their return to the community.

-In addition to community based crisis services. CA has implemented several policies to ensure potential crisis situations are prevented or resolved quickly while at the program. The first of which is what we call "the morning report". Each morning at 9:00 am a representative from each team is assigned to report on any potential problem situations that may occur throughout the day. All representatives meet in a conference room and detail their concerns to the other teams. That information is then left on the voicemail so everyone is aware.

-We also maintain a dayroom coverage list. We have found the presence of a CA staff member in our common area has reduced the number of incidences and altercations at the program. In the event of an altercation occurring, staff is paged overhead and the response to the situation is rapid.

- Nursing Services

A tremendous amount of ongoing physical assessment goes on as nurses' work with the whole person. Nurses are educating and monitoring staff routinely regarding health issues, appropriate care, warning signs, and preventative measure for best health outcomes. Nurses check orthostatic BP's listen to physical complaints, and assess what follow-up is indicated. In addition, the nurses do injections as ordered wherever the members will allow it. They have been done in bathrooms, at restaurants, in the home, at the program, or wherever else it is a safe and comfortable environment for both parties. Because there are fewer nurses on staff than PSC's health-related questions are a daily occurrence.

Medical care is an enormous part of many members follow-up. Due to the deaths that have occurred during members' participation in the project, there is a significant amount of oversight in the area of medical follow-up. Even though it is not required as an outcome, staff have been directed to record each medical follow-up appointment as an event to reflect the degree of effort in this area.

There is no doubt that a large number of members have never had health care of such high quality. Connections with a Primary Care Physician (PCP) is required within the first month of enrollment. Referrals for routine wellness for men and women follow national standards. Specialty care services are provided as indicated, and members are transported and accompanied or assisted to their appointments. Records are obtained to coordinate healthcare needs and comprehensive follow-up. Members who, in the past, have been very resistant to medical interventions with appropriate support chose to obtain the necessary follow-up. As always, it is their right to refuse treatment, but nurses and PSC's provide information regarding pros and cons of such a choice.

A female member who historically became belligerent and hostile, regularly refusing medical treatment, now looks forward to medical follow-up appointments with the reward of lunch with the PSC after each medical service. She has even asked, "Don't we have any appointments this week?" She has also successfully gone through three major surgeries in one year with intensive support and has been medically stabilized to the point of now taking the bus independently and beginning a job.

Since our program has now adopted the recovery model, emphasis is being placed on empowering the members to take control of their health. Staff is encouraging members to go to their own medical appointments. Staff is educating the members regarding diet, exercise, diabetes management, and other appropriate topics that will help the members to live healthier and have hope for a better life. We do "whatever it takes", but do not want members to depend on staff when they can become more responsible for their own medical follow up. Nurses are a vital component of the team.

Team I

From the beginning, Team I was very involved in program development, values clarification, naming the program, and visionary focus. This all happened as the team itself, and the program were simultaneously forming. Developing initial relationships with referrals, securing new enrollments, creating extensive resources development, staffing, and living through many growing pains and joys were all a part of the early Team I experiences.

The first 50 members were to come from long-term State hospital admissions and meet all of the following established criteria for referral:

1. Have an address in Baltimore City or Baltimore County prior to admission; and
2. Have a primary diagnosis of DSMIII-R, 295.00-295.99, DSMIII-R, 296-00-296.99, DSMIII-R 301.83, 301.20-301.22, or a primary borderline personality disorder diagnosis; and
3. Reside in a State psychiatric hospital for six consecutive months or longer.

Housing, employment, daily structure and socialization were all challenges these members faced. Medically, we were not expecting the acuity and morbidity of issues that we encountered. Community reaction and responses from State hospital staff to our project were often very negative, and attitudes towards members were stigma-laden. Over time, the anxiety melted away into better relationships with providers. When we were unable to work with some providers, the team sought other resources on the members' behalf.

Staff issues and needs were constantly changing, and caseload projections were being revised based on funds available and services needed. Current staffing is 1 R.N. Team Leader, 1 Lead Worker who is a R.N., 5 PSCs and 2 CSAs for the team's 47 members.

As a team we go to lunch monthly, do scheduling and have time to process issues and problem-solve our current challenges. Over the years we have become more successful at supporting members in the community and minimizing hospitalizations. We capitalize on the relationships we have with the members and strive to listen to what they really want. Because this is a very challenging, rewarding, draining, and yet enjoyable place to work, we regularly strive to laugh and have fun together. We are constantly tapping into our own creative juices to keep us energized and motivated.

Team II

Team II began in January 1996 with the hiring of the Team Leader, a Master's prepared psychiatric nurse. The process of recruitment and hiring of PSC's and CSA's soon followed. Initially, Team II enrolled some people who had been in the state psychiatric hospitals for six months or longer. Then they began working with and enrolling people who had been diagnosed with major mental illnesses and had four psychiatric hospitalizations and/or seven emergency room visits in a 2-year period.

At full capacity, Team II has 47 members. Similar to Team I, Team II's treatment team consists of a Psychiatrist, a Master's prepared Licensed Team Leader, a RN, five PSCs, and 2 CSAs. We also utilize the services of our Employment, Entitlements, Housing and Substance Abuse Coordinators, as well as 2 therapy interns.

The members on Team II are between the ages 20 and 70, with the majority of diagnoses being either schizophrenia, schizoaffective or affective disorders. Approximately half of the members have a substance abuse diagnosis; some are in recovery and others are actively using. A small number of members live in assisted living homes and with their families, while most members live independently. Many of Team II's members have worked or are presently working.

As anticipated, many of the members on Team II had previously been noncompliant with medications and traditional outpatient psychiatric treatment. These individuals used ERs and hospitals for treatment due to frequent decompensation and crises. They had burned their bridges with family, friends, and mental health providers. Our services have provided them with the support and outreach they so desperately need. Our goal is to help them become as happy, healthy, and independent as possible. We strive to stop the cycle of ER visits and psychiatric hospitalizations by teaching members about the choices they have in their lives besides hospital and ER visits. Thus far, we have been successful in reducing ER visits and hospitalizations. PSCs also use natural **consequences** and **member choice** as the cornerstones to service planning with members.

A great deal of emphasis is also placed on changing members' roles from "patients" to ones who can work, live independently, and form healthy, satisfying relationships. A few examples include a 21-year old woman with diagnoses of bipolar disorder and personality disorder who spent the majority of her adolescence in and out of institutions, now needing only a 2-day hospitalization in over two years. She has also worked off and on, and tried college. A 30-year old man with diagnoses of psychotic disorder, organic mood disorder and polysubstance abuse, who had multiple psychiatric hospitalizations since adolescence, not needing the ER or hospital in almost 2 years, living independently, staying clean, and working as a housekeeper. A woman in her 20s with diagnoses of schizoaffective disorder, substance abuse, mild mental retardation, and asthma who had several hospitalizations and ER visits yearly, needing only two brief psychiatric hospitalizations, being able to move from Assisted Living to her own apartment, forming a stable relationship with a man, eventually getting married to that man and doing well.

As a team, we will continue to focus on supporting members as they change their lives for the better by providing them with support, encouragement, "tough love," and choices. As a program, we believe in the mentality of "whatever it takes" in the context of the Recovery Model.

Team III

Team III began its formation in February 1998. The team adopted a slightly different structure, initiating a co-leadership between a Master's prepared mental health therapist and a Bachelor's prepared psychiatric nurse. Currently the team consists of a Master's prepared Licensed Professional Counselor, a R.N., a Psychiatrist, 5.5 PSCs and 1.5 CSAs.

Team III receives referrals from State and private hospitals and community sources, making the members a blending of Teams I and II. Most Team III members are diagnosed with Affective disorders, schizoaffective disorder, or Schizophrenia, with many having concomitant substance abuse issues.

The team has the wonderful distinction of being the first team to have had no psychiatric hospitalizations of its members for a full year. Team III strives to utilize the program values of "high risk/support and recovery to support its members in integrating, working and living successfully in the community.

Team IV

“Last but definitely not least...” That is what we can say about Team IV. Finishing out CAs expansion, Team IV was formed in October 2003. This task was not done without its share of obstacles. The team hired a new psychiatrist in November; remained short-staffed regularly and was without a team leader for quite some time. While some may have thrown in the towel because of this, Team IV used it to their benefit. The team psychiatrist works over 20 hours per week and has developed solid relationships with the members. Also, numerous staff have been promoted within the team due to their hard work and commitment.

The team leads the way in RECOVERY. Hope, Empowerment, Self-Responsibility and Meaningful Roles are not strange words in the Team IV area. Members are encouraged on a daily basis to “get a life.” The premise behind this is simple: if members have meaningful activities to participate in throughout the day then they don’t have time to focus on being a “mental health patient.” Staff work closely with each member and assist with reconnecting with family, employment, housing, financial planning, socialization and oh, yeah-symptom management/medication. Team IV strongly believes that we work with adults with mental illness, not mentally ill adults.

The team continues to work toward enrolling new members from state facilities as well as the community. So that existing and new members receive quality mental health treatment, the staff on the team strives to increase their skills. Through conference and in-service attendance, the team maintains a “think clinically” mentality.

Physician's Role

The physician is an important part of a multidisciplinary team of mental health workers at Creative Alternatives. Although ultimate responsibility for medication management rests with the physician, the PSCs spend a great deal of time with members, and the physician must rely on the diagnostic and assessment skills of the team regarding the member's mental state and progress in the community. The program challenges the physician to utilize his/her medical knowledge and skills in more innovative and effective ways. The unique opportunities for this type of physician practice are supported by the values of the program, as well as the flexible funding mechanism offered by Capitation.

Because Creative Alternatives encourages a "member-centered" approach to treatment, the physician must be willing to work with other staff on the treatment team to individualize care for the members. Psychotropic medication may be one component of treatment supervised by the physician staff. The physician is also available to work with the member and team to develop treatment plans to meet members' individual goals and needs. Because the well-being of members relates to all aspects of their living in the community, the physician must be aware of the successes and failures of members in their attempt to achieve maximum independence in the community. The physician may be required to observe a member in his environment to better view these unique challenges. Thus, traditional office-based treatment is replaced with outreach services that may include physician involvement in the field. Members may be seen in their home, at psychosocial and medical day care programs, or on the street.

Physicians play an important role in the initial assessment of the psychiatric and somatic problems of a very complicated member group. Review of the medical record, mental status examination and medical needs assessment are done at the time of initial contact with members.

Physicians attend team meetings, during which strategies are developed for more effective care of members. During these meetings, the physician can also address the somatic issues of the medically complicated members, and make recommendations for referral to primary somatic care as well as specialty care when necessary. Routine laboratory studies and other diagnostic tests are reviewed by the psychiatrist during team meetings on a regular basis. All members in the Creative Alternatives program are required to have a primary somatic physician and psychiatrist. The PSC assures that members are then seen by these providers for routine exams and any emergency treatment needed.

Capitated funding allow the psychiatrist to be more creative when addressing crisis or providing routine follow-up care. In-home support can be utilized more frequently because the physician can rely on the team to provide necessary structure needed to keep the member out of the hospital. The physician must be willing to interact with care providers, family members, and other individuals who relate to the member in the

community. Physicians who are used to working in the "traditional mental health system" must develop a fresh perspective that encompasses a new sense of the possibilities for creative treatment interventions afforded by the Creative Alternatives program.

Therapy

In support of Creative Alternatives mission statement and goals to provide comprehensive treatment for all members, therapeutic services are now provided within the program. These services are proposed to help the member move toward recovery and increased independence. Upon recommendation of the clinical team, therapeutic services are provided to help members who may experience distress from chronic issues as well as those who are in need of increased support to manage problematic stressors, crisis or in some cases the general anxieties of life.

The therapist and the member work collaboratively to develop a plan of treatment. Ideally, goals will be made addressing the concerns of the referring team, desires of the member and clinical needs as assessed by the therapist. The treatment team supports the member's therapeutic goals as well as maintains involvement in special interventions that may be necessary to encourage member's progress and maintain safety.

The members' treatment is individually designed to address their specific referral needs. Many members may have a difficult time with problem solving, managing anxiety, dealing with anger or coping with a traumatic event of the past. These members may benefit from brief and specific cognitive behavioral treatment interventions (i.e. cognitive restructuring, systematic desensitization, relaxation training and trauma focused CBT). Others may require more intensive therapy to manage chronic conditions.

From the treatment plan date the members' progress is assessed every 90 days. This ninety day review meeting always involves the active participation of the member as well as a representative from the referring team. Often times goals are assessed and completed and this moves the member one step closer toward termination from therapy.

Before a member is terminated from therapy the therapist will discuss plans with the clinical team. Since separation from therapy can be a difficult process. Termination is done gradually to assist the member in making the adjustment. Where a member may have been seen weekly, when termination is planned he or she is seen bi-weekly, then monthly if needed.

From start to finish, teamwork is employed and collaboration remains an active process between therapist, member and team.

Relapse Prevention

Relapse is a process, just as addiction is a process. Relapse does not begin with the drink or the drug taken after a period of abstinence, but begins long before the individual "picks up." Relapse starts with a series of progressive symptoms, usually outside the awareness of the person in relapse. Relapse PREVENTION involves bringing these symptoms into consciousness on a regular basis.

While the individual must maintain the disciplines that insure abstinence and recovery, there are ways in which others can help. Most people close to the addict can recognize cognitive and behavioral changes that indicate a return to addict mentality and behavior. This is when it is important to bring into the person's awareness his/her addictive traits. If the addict, and significant others, can recognize early on, the addict's personal relapse warning signs and symptoms of relapse, the addict can stop the process of relapse before it reaches the final stage of actual drug/alcohol use.

On the pages that follow, are the most commonly reported symptoms of relapse, and a relapse prevention action plan. Mental health care providers, who work with dual-diagnosed populations, need to become familiar with the symptoms of relapse. It is imperative that the addict be educated on the process of relapse. One teaching technique is to provide the addict with the following list of symptoms and ask him to identify his own personal relapse warning signs. Some addicts will identify and relate to all of the symptoms listed. Another technique for helping the addict to maintain recovery is to provide him with the following relapse prevention action plan. With education and support, the addict can learn how to utilize these tools of recovery, and remain clean and sober.

Relapse Prevention Action Plan

Cravings are a natural part of addiction and recovery. It is normal for people who have, or have had addiction problems, to think about using drugs and/or alcohol off and on. Cravings may even intensify during times of stress, depression or emotional pain. Cravings can also occur during times of celebration, such as holidays, birthdays, and even the beginning of spring or summer. The key to recovery is to have a plan of action in place to use when cravings occur.

When a craving occurs the goal is to ride it out until the craving passes. Cravings will occur, but they will also pass if given the time to. If handled correctly, cravings do not have to be part of the process of relapse. However, if cravings are minimized and not addressed, the person experiencing them will most likely be on the way to relapse and eventual drug/alcohol use.

The ACTION PLAN to short-circuit cravings should include the following:

LEAVE the situation in which the craving is occurring. Get away from the person, place, or thing that is causing it.

CONTACT a member of your support network immediately; someone who understands addiction and can talk you through the craving. (Always have phone numbers with you to call for support).

MENTALLY DETACH from the urge, and try to look at it as if you were an outside observer, Observe the craving from the perspective of "This is just a craving and it will pass" rather than, "The urge to use is too strong – I have to go use."

Pat, an alcoholic and compulsive cocaine and pot smoker, gives us this example:

"I still get cravings, but they're not as strong anymore. Now when I get them and notice what's going on with me at that moment, I say to myself, Oh I'M having a craving. It's probably connected to a feeling; What's the feeling? Once I note the feeling, I don't have to act on it. It doesn't drive me so much."

PLAN what you will do for the next several hours. How will you spend your time? Where will you go? With Whom?

GET TO A SELF-HELP GROUP MEETING IN THE COMMUNITY if possible, or read recovery literature. Get involved in something that will take your mind off the urge. For example, do physical exercises, eat something, or call someone in your support network (i.e. sponsor, counselor, N.A. hotline).

THINK PAST THE HIGH to what will happen if you give in and use. Focus on a negative memory or ugly reminder of your drug/alcohol use, rather than dwelling on pleasant memories (i.e. the "good old days"). DO NOT ENTERTAIN THE THOUGHT of using. DO NOT ROMANTICIZE THE HIGH.

Think of what would happen to you had you not gotten clean and sober when you did (i.e. jail, homelessness, death)

Personal Service Planning

The members that participate in Creative Alternatives historically have not responded to the traditional model of mental health treatment. For that reason, Creative Alternatives makes a concerted effort to provide services that look and feel different from the traditional system. One way to do this is to provide services, not treatment. The difference is a conceptual one that shifts the responsibility for "getting better" from the provider to the member. As an advocate or life coach, the staff is perceived as a collaborator instead of an adversary.

The Personal Service Plan (PSP) are written by both the PSC and the member to identify which services he/she desires based on his/her personal goals. The goals are written and/or reviewed every 6 months. These goals may or may not parallel a traditional treatment plan. It is possible to write a service plan that identifies problems or weaknesses not "owned" by the member and note that the member disagrees with that part of the plan, but the team can still monitor it as a goal. Creative Alternatives' service team can also assist the member in finding ways to reach their goals without forcing a member to sign off on plan that he/she does not feel is applicable to him/her. For example, a member who denies having a mental illness would not identify mental health or med compliance as personal goals; however, the member may have a goal to see children that were taken away because he/she couldn't care for them. The Creative Alternatives team could then address mental health issues based on the assumption that the court will not allow the member access to his/her children if he/she is unable to stay out of the hospital. In this way, Creative Alternatives is able to address traditional treatment goal by forming an advocacy relationship (i.e, us against the system) instead of a patient/provider relationship. This way, Creative Alternatives is able to respect the member's perception of strengths and needs while continuing to assess mental health, somatic and case management needs, and encourage necessary changes.

The blurring of boundaries necessary to provide services to the above mentioned member are essential to working with a group of people who do not like being "in treatment." It extends to being a friend, mentor, parent, banker, real estate agent, and, occasionally, therapist. When the service provider spends a lot of time in a member's home, it is counterproductive to maintain therapeutic distance. People don't invite therapists into their everyday lives; however, friends are a part of the big picture. It is this relationship that empowers the members to make goals and work for their successful accomplishment.

Creative Alternatives
Personal Service Plan

Cover/Signature Page

Additional Identifying Information:

Date of Birth: _____ Social Security Number: _____

Personal Coordinator: _____

Date of Completion: _____

Diagnostic Information:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Member Strengths:

Member Weaknesses:

Initial PSP Signatures:

Member

Team Leader

Psychiatrist

Personal Service Coordinator

Team Members

Family/Community/Additional/Team Members

Three-Month Review of PSP

Date

Member

Personal Service Coordinator

Psychiatrist

Team Leader

Creative Alternatives
Personal Service Plan

Areas of Focus (Circle One)
Behavioral, Medical/Dental, Social/Recreational, Financial
Vocational/Education, Community Integration, Housing
Family, Member Wants

Problem/Date: _____

Ultimately (Long Range Goal): _____

Towards that End (Short Term Objective): _____

Member Needs/Goals/Comments: _____

Member Will: _____

Team Will: _____

Family/Community Participant will: _____

Family Involvement in Treatment _____ Yes _____ No

Monthly Progress Notes: (date and sign all entries):

MONTH 1: _____

MONTH 2: _____

Employment

At Creative Alternatives, we focus primarily on a person's motivation to work. Building upon a member's desire, interests, and capabilities, we prioritize employment and not training or preparation. We have found that the best way for a person to know what it is like to work is to have a job and to work. Through providing different employment options members are allowed to select the job that best fits their needs.

Creative Alternatives offers a continuum of employment options. Some jobs are obtained through the development of contacts with local businesses. These jobs are in various community locations. Support is individualized based upon what a particular member needs to be successful in that placement. Other jobs are developed within Johns Hopkins Bayview Medical Center. These positions allow for direct, on-the-job assistance from the Creative Alternatives staff.

Whether employment is full time or part time, integrated into the community or on our program's site, work expectations are normalized. Members are expected to work, be productive, and contribute. No special consideration is given to them because of their disability. Through normalizing expectations, members stop seeing themselves as patients and begin seeing themselves as contributing members of the community.

Working can be a frightening and overwhelming decision for someone who has limited previous experience and success in jobs. Creative Alternatives provides consistent and individualized support to each member. Employment specialists, PSC's, team members, family and friends are all involved in identifying what supports are needed and who will provide them. Examples of specific support included:

- Assistance with purchasing work clothing
- Wake up calls
- Setting financial goals
- Assistance in arranging changes in daily routines (chores, meals, medications, appointments, etc)
- Identifying effects of working on Social Security and other entitlements
- Job coaching

In our society, having a job defines who a person is and the role they have in their community. Employment provides purpose, direction and meaning to an individual's life. All too frequently, mentally ill adults are denied the opportunity to work. Employers have been fearful. Mental health programs have been slow to incorporate employment services in their service delivery system. Traditional vocational programs have emphasized extensive evaluation and training which result in delays, frustration, and eventually people dropping out of programs. At Creative Alternatives if the first, second or third attempt at employment has not been successful, the member is encouraged to try again. With patience, persistence and encouragement, the mentally ill can successfully work.

Employment Program

Creative Alternatives' Employment Program is an innovative component that serves adults who have serious and persistent mental illness and have not benefited from traditional services. The program combines Supported Employment, Transitional Employment and Job Readiness Training as the means for individuals to be competitively employed. Members who have interrupted, intermittent, or little competitive work history are encouraged to make their own employment decisions and career choices. Jobs are at safe, competitive work sites where Job Coaches provide teaching and support for the worker. Overall, the design is flexible in order to assist members with achieving their employment goals.

Supportive Employment is defined as competitive work in an integrated work setting with ongoing support services for individuals with severe handicaps for whom competitive employment has not occurred, or has been interrupted or intermittent. A competitive job placement is performed on a full-time or part-time basis, with the supported worker being compensated in accordance with the Fair Labor Standards Act.

Transitional Employment is one type of Supported Employment which requires continuous temporary sequential job placements until job permanency is achieved.

Job Readiness consists of volunteer work and individual discussions on appropriate work behaviors. Members are trained on interviewing skills, dressing appropriately, and interacting with fellow employees. Discussions concerning employer expectations are done individually and in groups.

The Employment Program uses the following mechanisms for the individual's immediate support:

1. An individualized Service Plan, which addresses service needs and necessary levels of support.
2. Systematic planning of instruction in work skills and behaviors to be learned.
3. A Team approach to ensure identification of the individual's non-work needs, which may affect their level of functioning.
4. Meetings between member and Team that match their expressed interests and competencies with elements of the employment situation such as skill requirements, opportunities for social integrations, benefits, and wages.
5. Advisement on financial impact of employment on disability and other benefits.

The goal of this program is to transfer supported worker supervision from the Job Coach to the employer when that time becomes appropriate.

At Creative Alternatives, we focus primarily on a person's motivation to work. Building upon a member's desires, interests, and capabilities, we prioritize employment and not training or preparation. We have found that the best way for a person to know what it is

like to work is to have a job and to work. Through providing different employment options, members are allowed to select the job best fits their needs.