



# **Home and Community Based Services**

## **Mental Health Waiver**

*Working for Integration Support and Empowerment*

**Annual Report  
To the Legislature  
Waiver Year 1  
Period ending March 31, 2010**

**Mental Health Waiver**  
***Working for Integration Support and Empowerment***

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## **Introduction**

The Mental Health Home and Community-Based Services (HCBS) Waiver is designed for adults with serious mental illness who are being discharged or diverted from nursing home care. This Medicaid Waiver provides participants with the medical and psychiatric services and supports necessary to live independently in the community. The Waiver, as authorized, will serve 216 individuals who are currently in nursing facilities or who are at risk for this level of care. Waiver services are provided face to face, in the participant's home or in other community settings (non-office based). Individualized assessment, Recovery Plan development, and service delivery emphasize participant strengths and assets, utilization of natural supports and community integration. In other words, service delivery emphasizes psychiatric rehabilitation and recovery from the disabling effects of psychiatric disorders. The Waiver is operated by the Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid.

## **History of Mental Health Waiver**

This Medicaid Home and Community-Based Services (HCBS) waiver represents an historic opportunity to divert and discharge adults with serious mental illness from Connecticut nursing homes. It offers great promise in establishing a package of community based long term care services as an alternative to nursing home care.

This waiver builds on two decades of work that Connecticut has undertaken to reduce our reliance on institutional long term care services, in favor of community based services and housing supports. The first use of home and community based services (HCBS) in the State of Connecticut occurred in 1987, when the elder waiver and the waiver for people with developmental disabilities (DDS waiver) were created. For the first time, those persons who participated in Medicaid were given a choice of where they received their services and support. As the supply of HCBS increased and as more people became aware of their long term care options, the reliance on institutional care decreased. This inverse relationship between increased utilization of HCBS and the resulting decrease on reliance of institutional care is called rebalancing.

Increases in the supply of HCBS continued to offer choice and decrease reliance on institutional care throughout the 1990s. Additional HCBS waivers were funded, including the personal care assistance waiver (PCA waiver) and a waiver for persons with acquired brain injury (ABI waiver). These waivers marked the first steps towards self-direction. Both waivers provided opportunities for the participant to hire and manage staff with payroll assistance from a fiscal intermediary.

In 1998, the legislature created the Long-Term Care Planning Committee to address both coordination concerns between state agencies relative to long-term care, and also to initiate a proactive planning process. In 2004, LTCPC introduced a single plan for all elders and disability categories with a unifying vision: *To assure Connecticut residents access to a full range of high-quality long-term care options that maximize autonomy, choice and dignity.* This plan was the first to include rebalancing benchmarks for the State of Connecticut.

To date, a series of initiatives funded by the Centers for Medicare and Medicaid Services (CMS) have supported some of the infrastructure and service delivery changes necessary to achieve the rebalancing benchmarks identified in the State's Long-Term Care Plan. Connecticut has been successful in obtaining a total of 9 different systems change grants to support rebalancing. Funding directed towards the Governor's rebalancing initiatives and associated benchmarks indicating progress towards rebalancing will be reported under Connecticut's Money Follows the Person Rebalancing Demonstration. Money Follows the Person represents the Department's latest broad based initiative to support rebalancing, by focusing on individuals who have been in nursing homes for more than 6 months, and who are either elders or persons with any of a broad range of disabling conditions. Each individual will receive MFP services for one year and then must have the option of continuing to receive their home and community services under a waiver. This 1915(c) will thus play a critical role in supporting the provision of ongoing services to individuals with mental illness who transitioned out of nursing homes under MFP.

### **Legislative, Stakeholder and Public Input**

During the 2005 legislative session, the Connecticut General Assembly passed PA 05-280 (HB 7000) "An Act Concerning Social Services and Public Health Budget Implementation Provisions." Section 85 of the Act called for the Commissioners of Social Services and Mental Health and Addiction Services to jointly convene a Taskforce to study the feasibility of obtaining a Medicaid Home and Community-Based Services Waiver for adults with serious mental illness being discharged or diverted from nursing home care. The Taskforce<sup>1</sup> concluded that a HCBS Waiver was feasible and recommended that such a program be established. Subsequently, in 2006, the legislature gave permission for DSS to pursue a waiver in order to establish and implement a Medicaid Home and Community Based waiver for adults with severe and persistent mental illness diverted or discharged from nursing homes (see S.B. No. 703, Sec. 32). Finally, in 2008, a study of Connecticut's long term care needs funded by the General Assembly recommended the State "provide access to and financing for comprehensive community-based mental health care services" such as those needed to facilitate discharge of people with mental illness currently residing in nursing homes.<sup>2</sup> The draft HCBS Waiver application was disseminated for public comment in connection with its review by the Connecticut General Assembly. Public comments were reviewed and incorporated as appropriate into the final Waiver document.

### **Overview of Mental Health Waiver**

The waiver program for individuals with serious mental illness encompasses the recovery orientation adopted by the Department of Mental Health and Addiction Services (DMHAS), but also signals new directions in the community treatment of people with serious psychiatric disabilities because of its emphasis on:

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<sup>1</sup> The Taskforce included state legislators, state agency representatives, mental health clients and service providers, and other community members.

<sup>2</sup> Connecticut Long-Term Care Needs Assessment – Focused Report II: Identifying the Long-Term Care Needs of People with Mental Illness. March 2008, University of Connecticut Health Center.

- Intensive psychiatric rehabilitation provided in the participant's home, and in other community settings;
- Attention to both psychiatric and medical needs;
- Emphasis on wellness and recovery;
- Person-Centered Planning leading to development of an individualized Recovery Plan; and
- Use of peer supports provided by people trained and certified in rehabilitative care, who know from first-hand experience about recovery from mental illness.

The waiver program, authorized in §1915(c) of the Social Security Act, permitted the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutional care. The State had broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs as well as natural supports that families and communities provide.

The Waiver will serve 216 individuals (72 new participants each year) who are currently in nursing facilities or who are at risk for this level of care. The Waiver is operated by DMHAS with oversight by the Department of Social Services (DSS).

## **Overview of Money Follows the Person Program**

The Money Follows the Person program (MFP) was created by Section 6071 of the Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), which authorized \$1.75 billion to support efforts to move nursing home residents back into their communities. MFP is a Demonstration Project administered by DSS in partnership with other state agencies. The goal of Connecticut's MFP is to rebalance Connecticut's long-term care systems with an emphasis on home and community-based services rather than nursing home care. MFP provides services to a broad range of persons with disabilities including persons with intellectual disabilities, persons with physical disabilities, persons with brain injuries, persons who are elderly, and persons with mental illness. Eligibility for services funded by MFP is based on Medicaid eligibility and a minimum 6 month length of stay in an institution. MFP funded services for persons who have a mental illness include a) home and community based services identical to those available under the MH Waiver, b) services otherwise authorized by the Medicaid State Plan and c) demonstration services not authorized under any waiver. Once an MFP participant with mental illness has received MFP services for 365 days, the participant will automatically transition to the MH Waiver program.

MFP was initiated in December 2008 and the MH Waiver began April 1, 2009.

## **Program Organization**

Connecticut Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid, operates the Mental Health Waiver program and the MFP (Money Follows the Person) program. The MH Waiver authorized in Section 1915(c) of the Social Security Act permits the Secretary of the U.S.

Department of Health and Human Services to set aside Medicaid regulations and to allow funding to provide a variety of home and community based services (excluding room and board) to individuals with serious mental illness who would otherwise require nursing home care. This MH Waiver enables Medicaid to cover the cost of services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

DSS and DMHAS contract with a Fiscal Intermediary who serves as the Connecticut Medicaid Billing Provider for MFP/MH Waiver Services and Credentialing. MFP/MH Waiver Services are available to adults with serious mental illness that are being discharged or diverted from nursing home care and are receiving Connecticut Medicaid benefits.

## **MH Waiver Admission and Service Provision**

### **Eligibility Criteria**

Criteria set forth in the waiver application permit voluntary enrollment of Medicaid eligible adults who meet requirements for care in a nursing home and have a diagnosis of serious mental illness. These individuals may be: A) currently residing in a nursing home (potential discharges), B) living in the community but have an active psychiatric disorder are being considered for nursing home placement (potential diversions), or C) have already been discharged from a nursing home under the Medicaid Money Follows the Person (MFP) program.

In addition, the person must: A) have two or more serious life problems due to mental illness, B) not be in need of emergency psychiatric hospitalization, and C) need rehabilitation and professional assistance in developing and implementing their plan for recovery

### **Referral/Screening Process**

Individuals may apply for services by calling the DMHAS toll free number or completing the Waiver Request Form and faxing it to the DMHAS Waiver Staff for review and follow up. Entrance into the Waiver is on a first come-first served basis for those who meet eligibility criteria. The exception to this first come-first served policy is those individuals who meet these criteria and participants in the State's Money Follows the Person (MFP) initiative.

### **Eligibility Determination**

The initial request for Waiver Services is reviewed to determine if the individual is Medicaid eligible and has a reported diagnosis of serious mental illness. Medicaid eligibility is determined by DSS. Once these criteria are established, a DMHAS Community Support Clinician will schedule a face to face interview to continue Level of Care determination.

The Community Support Clinician conducts a level of care assessments to evaluate whether an individual needs nursing facility level of care.

## **Individual Assessment**

A series of individual assessments are completed by the DMHAS Community Support Clinician to develop a comprehensive recovery plan and to determine the most appropriate services to assist the participant to live in the community.

## **Recovery Plan**

The initial Recovery Plan includes the following:

- A summary of strengths, needs, and preferences indicating the need for services;
- Client's desired outcome;
- Specific short-term objectives and long-term goals,
- A description of risk factors and special procedures recommended for the health and safety of the client.

In addition, the Recovery Plan includes the specific services to be provided and the frequency of services. The plan identifies all services and supports needed by the individual regardless of the payer. It also identifies (when applicable) the specific organization that will be requested to offer more formal treatment and support services.

## **Service Monitoring**

The DMHAS Community Support Clinician is responsible for monitoring the Recovery Plan quarterly or more frequently if needed to determine whether:

- Services are furnished in accordance with the Recovery Plan;
- Participants have access to MFP/waiver services identified in the service plan;
- Services continue to meet the needs of the participant;
- Back-up plans are effective;
- Participant health and welfare is assured;
- Participants continue to be offered and exercise free choice of providers; and,
- Participants have access to non-waiver services identified in the Recovery Plan, including access to health services.

The meetings also review the service implementation status, care efficacy, and participant progress. Participant safety, and health and welfare are also reviewed. At these meetings, Recovery Plans are adjusted congruent with client needs.

## **Waiver Service Package**

Each person enrolled in the waiver participates in a *Person-Centered Planning* process leading to the development of an individualized *Recovery Plan*. The plan, developed collaboratively with the participant and a DMHAS Community Support Clinician, include one or more of the following services:

## ***REHABILITATIVE SERVICES:***

**Assertive Community Treatment (ACT)** is a recovery focused, high intensity, community-based service for individuals discharged from multiple or extended stays in hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, rehabilitative community support, crisis, and treatment interventions/services that are available 24-hours/7days a week.

ACT includes a comprehensive array of rehabilitative services integrated with medical care, most of which are provided in non-office settings by a mobile multidisciplinary team. The team provides community support services, interwoven with treatment and rehabilitative services, and regularly scheduled team meetings to no fewer than 60 active participants.

The ACT team provides nearly all the treatment needed by the participant. ACT community and clinical services are guided by the participant's strengths and preferences. The service involves an assertive approach, individually tailored programming, ongoing monitoring, variable support, *in vivo* service, relating to participants as responsible citizens, utilizing a variety of community resources and collaborating with the family. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her actual living environment. The team is persistent in engaging the participant, doing whatever is necessary to keep the individual involved in community life and active in treatment.

### ***Covered services***

ACT services of at least 15-minutes duration provided to the participant by a direct-care member of the ACT team in the participant's home and in other community settings. These services include:

1. Mental health services, including:
  - a. Comprehensive Assessment that contains a psychiatric history, risk assessment, functional mental status examination, and diagnosis; and assessments of physical health; use of drugs and alcohol; education and employment; social development and functioning; activities of daily living; family structure and relationships; and environmental supports;
  - b. Treatment and rehabilitation planning, including a timeline of past events;
  - c. Service coordination;
  - d. Crisis assessment and face-to-face or telephonic crisis intervention and monitoring;
  - e. Symptom assessment and management;
  - f. Development of skills for recognizing stressors, and building coping mechanisms and recovery strategies;
  - g. Medication prescription, administration, monitoring and education (Note: These services may be provided in an office setting);
  - h. Counseling and psychotherapy history,
2. Co-occurring substance abuse services, using the Integrated Dual Disorders Treatment (IDDT) model;

3. Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports (**NOTE:** Documentation shall be maintained in the file of each participant receiving work and education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.));
4. Motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems;
5. Skill building and support for Activities of Daily Living, including:
  - a. Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
  - b. Other skill development activities directed at reducing disability, restoring functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan;
  - c. Social/interpersonal relationship and leisure-time skill training;
6. Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the treatment of the participant;
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator;
8. Travel with a participant or family member when the ACT Service provider is also engaged in a qualifying waiver service activity; and
9. Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #1-G through #5-C, above. (**NOTE:** Group rates are 30 percent of the individual ACT rate. See applicable rate schedule for details).

**Community Support Program (CSP)** consists of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.

CSP includes a comprehensive array of rehabilitation services, most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

### ***Covered services***

CSP services of at least 15-minutes duration provided to the participant by a direct-care staff member of the CSP team in the participant's home and in other community settings. These services include:

1. Rehabilitation assessment and development of the rehabilitation plan;
2. Re-evaluation and adjustment of the rehabilitation plan;
3. Crisis response services either face-to-face or telephonic;
4. Psycho-education services for rehabilitation from psychiatric or substance abuse disorders;
5. Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports. (NOTE: Documentation shall be maintained in the file of each participant receiving work or education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.);
6. Residential supports, such as motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems;
7. Skill building and support for Activities of Daily Living, including:
  - a) Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
  - b) Other skill development activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan;
  - c) Teaching of recovery skills in order to prevent relapse such as symptom recognition, coping with symptoms, emotional management, relaxation skills, self administration and appropriate use of medications, and preparation of illnesses related advance directives;
  - d) Development of self-advocacy skills for the purpose of accessing natural supports, self-help, and other advocacy resources; and
  - e) Health and wellness education.
8. Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the rehabilitation treatment of the participant;
9. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator;
10. Travel to an appointment with a participant or family member when the CSP provider is also engaged in a qualifying waiver service activity; and
11. Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #4 through #7 above. (NOTE: Group rates are 30 percent of the individual CSP rate. See applicable rate schedule for details).

**Peer Support** – is available as a step-down from more intensive waiver services such as Assertive Community Treatment (ACT) or Community Support Program (CSP), when an ACT or CSP level of care is no longer needed. Peer support includes face-to-face interactions that are designed to promote ongoing engagement of persons covered under the waiver in addressing residual problems resulting from psychiatric and substance use disorders, and promoting the individual’s strengths and abilities with respect to socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with behavioral health services providers and others in support of the participant.

***Covered services***

Peer Support services of at least 15-minutes duration provided face-to-face with the participant in his/her home and in other community settings. These services include:

1. Coaching and support related to:
  - a. Continued use of recovery skills;
  - b. Involvement in community activities and positive relationships with family and friends;
  - c. Attention to personal hygiene and appropriated dress;
  - d. Involvement in vocational, volunteer or educational activities;
  - e. Follow through on personal obligations and commitments;
  - f. Self advocacy during self-help, peer support and community meetings;
  - g. Self advocacy during meetings with providers to facilitate linkage, communication and improved continuity of care;
  - h. Development of natural supports;
  - i. Filing complaints and follow-up with proposed resolution as needed, finding resources;
2. Assisting with avoidance of:
  - a. Behaviors that might lead to a psychiatric crisis;
  - b. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities);
  - c. Substance abuse;
  - d. Overspending;
  - e. Unnecessary conflict;
3. Mentoring and advice to facilitate development of effective decision making and problem solving skills;
4. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
5. Travel with the participant when the Peer Support provider is also engaged in a qualifying waiver service activity.

**Supported Employment** – Services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in

a variety of settings; particularly work sites where persons with disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

### ***Covered services***

Supported Employment services of at least 15-minutes duration provided to the participant face-to-face or telephonically in the participant's home, employment location, or other community settings. These services include:

1. Training, skill building and support to assist the participant with managing his/her symptoms or other manifestations of disability in the workplace or job interview;
2. Assessment of the participant's:
  - a. Individualized career development goals and employment ideas/preferences; and
  - b. Work related skills and vocational functioning;
3. Assistance in developing and periodically evaluating the individualized employment services component of the participant's waiver Recovery Plan.
4. Support and guidance through the process of obtaining and maintaining employment, including:
  - a. Teaching strategies to explore career development, write a resume, conduct job networking, pursue job leads, complete job applications, obtain interviews, and succeed in obtaining and maintaining employment;
  - b. Training and skill building regarding proper work habits, and appropriate interactions with coworkers and the public;
  - c. Advocating for the participant with potential and current employers; and
  - d. Assisting with and reinforcing work-related problem solving skills;
5. Reinforcement of recovery skills designed to promote job retention and success in the workplace, including:
  - a. Healthy habits (e.g., healthy diet, exercise, medication management and behaviors designed to alleviate stress);
  - b. Fulfillment of personal and work-related commitments (e.g., adherence to the work schedule, avoidance of unnecessary tardiness and absences from work); and
  - c. Identification and use of natural supports;
6. Assistance to support self-employment, including:
  - a. Aiding the participant to identify potential business opportunities;
  - b. Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;
  - c. Identification of the supports that are necessary in order for the participant to operate the business; and
  - d. Ongoing assistance, counseling and guidance once the business has been launched.
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and

8. Travel with a participant when the Supported Employment provider is also engaged in a qualifying waiver service activity.

### ***SUPPORT SERVICES:***

**Recovery Assistant** - A flexible range of supportive assistance provided face-to-face in accordance with a Waiver Recovery Plan that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and; providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant, and short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief.

#### ***Covered services***

Recovery Assistant services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Performing the following tasks if the participant (by reason of physical or psychiatric disability) is unable to perform them, or assisting, or cuing the participant to perform them:
  - a. Meal planning and preparation, shopping, housekeeping (e.g., changing linens, washing dishes, vacuuming/dusting, laundry, mending clothing repairs), basic household tasks (e.g., regulating home temperature, storing food appropriately, resolving issues about bill paying).
  - b. Dressing, personal grooming and hygiene (e.g., bathing, dressing, and oral care).
  - c. Appropriate use of emergency medical services.
2. Assisting or cueing the participant to perform or become engaged in:
  - a. Family, social, and recreational activities.
  - b. Appropriate use of natural community supports (e.g., social clubs, faith-based supports).
  - c. Appropriate use of routine medical/dental services.
  - d. Use of medications as prescribed, including self administration of medications.
  - e. Healthy habits (e.g., healthy diet, exercise, and behaviors designed to alleviate stress).
  - f. Fulfillment of personal commitments, and adherence to scheduled appointments/meetings (e.g., clinical, vocational, educational, and judicial/court).
3. Assisting or cuing the participant to avoid:
  - a. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
  - b. Substance abuse.
  - c. Overspending.
  - d. Unnecessary conflicts.

4. Supportive and problem solving-oriented discussions with the participant.
5. Establishing and maintaining a helpful, supportive, companionship relationship with the participant that involves such activities as:
  - a. Escorting the participant to necessary medical, dental, or personal business appointments;
  - b. Reading to or for the participant;
  - c. Engaging in or discussing recreational, hobby, or sport-related activities;
6. Other activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence;
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
8. Travel with a participant when the Recovery Assistant is also engaged in a qualifying waiver service activity.

**Transitional Case Management** – Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting. These services also assist participants with other aspects of the transition to community life by helping them gain access to needed waiver and other state plan services, as well as medical, social, housing, educational and other services and supports, regardless of the funding source for the services or supports to which access is gained. The state shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 180 days.

### ***Covered Services***

Transitional case management services of at least 15-minutes duration include:

1. Referral and related activities to help an participant obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
2. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the waiver Recovery Plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as:
  - a. Whether services are being furnished in accordance with an individual's Recovery Plan;
  - b. Whether the services in the Recovery Plan are adequate; and
  - c. Whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the Recovery Plan and service arrangements with providers.
3. Face-to-face, telephonic and other contacts with the participant to assist preparation for discharge from an institutional setting and adjustment to community life immediately following discharge;

4. Contacts with landlords and vendors designed to locate and secure suitable housing, and make preparations necessary for the arrival of the participant, including such items as assuring:
  - a. A lease is signed and a security deposit is made, if needed;
  - b. Utilities or service access is obtained (telephone, electricity, heating and water);
  - c. Essential home/apartment furnishings are obtained and in place;
  - d. Other basic essentials are obtained and are in place, including window coverings, food preparation items, bed and bath linens, and personal care items;
5. Introducing the participant to other professionals or paraprofessionals involved in the waiver Recovery Plan;
6. Providing information, education and training for the participant regarding:
  - a. Household budget, living costs, and lease and utility arrangements;
  - b. Security features and the safe operation of appliances in the home, and
  - c. Availability and how to access community resources;
7. Assisting with or making arrangement for setting up the new home, including procuring, moving, and arranging finishing, appliances, and other household items;
8. Supervised visits with the participant to the participant's home, or to locate a suitable home during the transition from an institutional setting;
9. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
10. Travel with a participant or family member(s) when the Transitional Case Manager is also engaged in a qualifying waiver service activity.

**Short-term Crisis Stabilization** - consists of face-to-face mental health and substance abuse services provided to individuals within the home and community. The service involves brief, concentrated interventions to stabilize psychiatric conditions or behavioral and situational problems including substance abuse, prevent escalation of psychiatric symptoms, reduce the risk of harm to self or others, avert loss of housing, and wherever possible, avoid the need for hospitalization or other more restrictive placement. Services and interventions are highly individualized and tailored to the needs and preferences of the participant, with the goal of maximizing independence and supporting recovery.

***Covered services***

Short-term Crisis Stabilization services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Observation, evaluation and monitoring in order to reduce the participant's risk of harm to self or others, and to determine whether additional supports are necessary;
2. Practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis;
3. Crisis intervention and supportive counseling designed to stabilize functioning, reduce stress, calm the participant and prevent further deterioration;
4. Communication with supervisory staff to report the participant's condition and determine whether any additional assistance is needed;
5. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and

6. Travel with a participant when the Short-term Crisis Stabilization provider is also engaged in a qualifying waiver service activity.

**OTHER ANCILLARY SERVICES:**

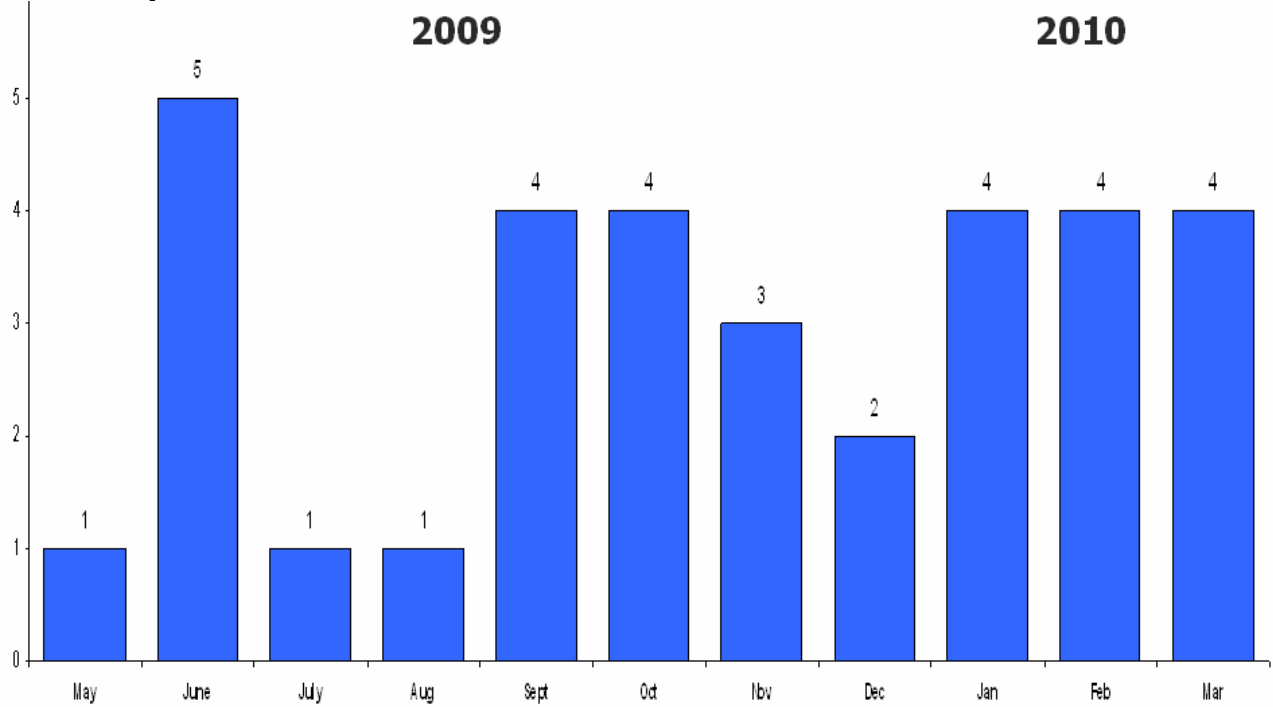
**Specialized Medical Equipment**  
**Home Accessibility Adaptations**  
**Non-medical transportation**

**Service Utilization**

DMHAS began accepting referrals from MFP in January 2008. All referrals were assessed for eligibility. Individuals meeting the eligibility criteria were engaged in Person Centered Planning and the development of a Recovery Plan to guide service utilization and delivery in the community. The table below outlines status of referrals received and processed from January 1, 2009 – March 31, 2010. Individuals enrolled were discharged from a long term care facility or diverted from admission to a nursing facility. Cases closed represent individuals who were found eligible for participation that later chose to withdraw from participation, chose alternate service settings, or were determined no longer eligible.

	<b>MHW</b>	<b>MFP</b>	<b>Total</b>
<b>Referrals</b>	24	209	<b>233</b>
<b>Eligible</b>	14	78	<b>92</b>
<i>Enrolled</i>	6	24	30
<i>Enrolled &amp; Discharged</i>	1	2	3
<b><i>Enrolled YTD</i></b>	<b>7</b>	<b>26</b>	<b>33</b>
<i>Planning -pre enrollment</i>	5	32	37
<i>Closed</i>	2	20	22
<b>Not Eligible</b>	10	131	<b>141</b>

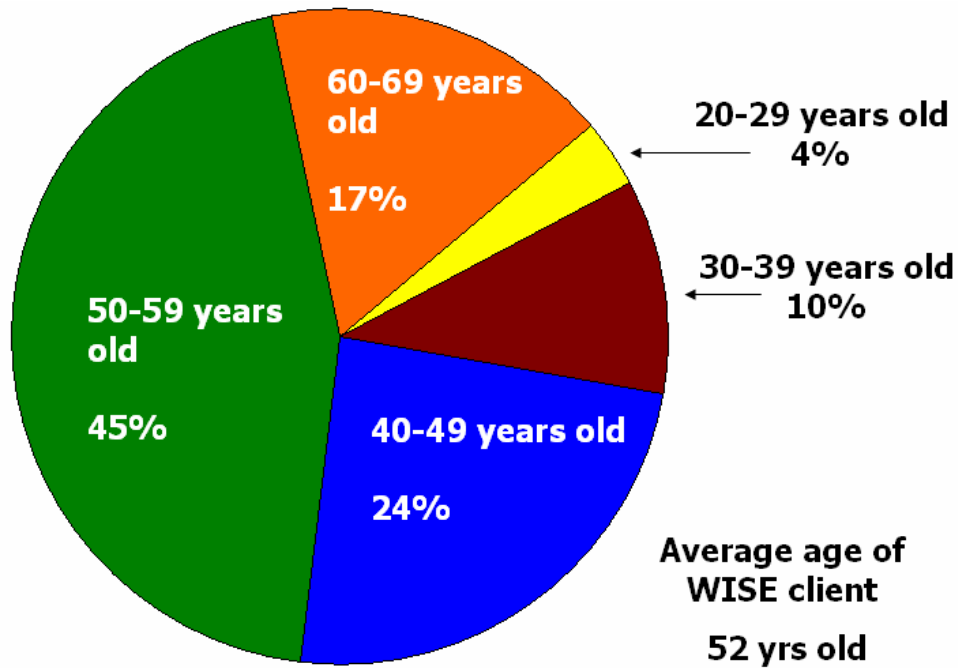
### Enrolled by Month



### Client Characteristics

The average age of individuals enrolled on the Mental Health Waiver is 52. Sixty one percent of participants are female while 39 percent are male. Demographic breakdown is further outlined in the following graph.

### Ages of Enrolled WISE Clients



## Service Delivery

	Number of Units billed	Unduplicated Clients	Amount Paid
<i>Rehabilitation Services</i>			
ACT	40	1	\$4021.26
Community Support Program	590	17	\$58611.52
Peer Support	0	0	0
Supported Employment	0	0	0
<i>Support Services</i>			
Recovery Assistant	2014	24	\$123,988.17
Transitional Case Management	75	8	\$5,501.60
Short Term Crisis Stabilization	0	0	0
<i>Ancillary Services</i>			
Specialized Medical Equipment	64	13	\$3,667.83
Home Accessibility Adaptations	4	3	\$2,132.50
Non-medical transportation	0	0	0
Totals	2767	27	\$197,922.88

## Cost Neutrality

Cost containment will be accomplished through utilizing an aggregate cap for the overall waiver. In other words, the total cost of the waiver would never exceed what it would have cost the State if the individuals served had remained in institutions, rather than receive community-based services. Under Medicaid regulations, states may select either an aggregate or an individual cap for the overall waiver, to achieve the required federal cost neutrality. An aggregate cap was selected as it is anticipated that service needs for some people with serious mental illness will diminish as they adjust to community life. Utilizing an aggregate cap will allow Connecticut to serve individuals who initially require a very high level of services while still containing costs across the entire waiver population.

The following table outlines plans developed for individuals enrolled as of March 31, 2010. This does not represent actual services received, rather proposed cost.

Period Ending March 31, 2010	Waiver Service Package	State Plan Services	Total
Maximum Plan Developed	\$78,355	\$4,864	\$83,219
Minimum Plan Developed	\$23,234	\$7,390	\$30,624
Average Plan Cost	\$50,792	\$11,314	\$62,106
<b>Cost Neutral</b>			\$68,160

## Service System Development

### Provider Recruitment

DSS and DMHAS contracted with a fiscal intermediary to perform various administrative functions and assist participants who choose to direct recovery assistant services. The fiscal intermediary (FI) serves as the Medicaid Billing Provider for all Waiver services. Additionally the fiscal intermediary developed a network of waiver service providers by recruiting and credentialing qualified providers. A total of 35 providers were credentialed as of March 31, 2010. The following table summarizes this activity.

<b>Service Type</b>	<b>Number of Providers</b>
Transitional Case Management	14
Assertive Community Treatment (ACT)	2
Community Support Program (CSP)	17
Recovery Assistant (RA)	13
Short Term Crisis Stabilization	7
Supported Employment	10
Peer Support	0
Specialized Medical Equipment	1
Home Adaptations	7
Non Medical Transportation	0

### Recovery Assistants

Using the concepts of Recovery and Psychiatric Rehabilitation, a unique service provided by Recovery Assistants was designed for use by the participants of the Mental Health Waiver. As previously described, Recovery Assistants encourage individuals to work towards their personal goals, dreams, hopes and aspirations. The Recovery Assistant combines the job function of homemaker, personal care assistant, respite worker and companion. The focus of work centers on teaching, coaching, cuing and training individuals to increase capacity for recovery and independence.

A rigorous two day curriculum was developed for Recovery Assistant training and certification. See Appendix A-1 for curriculum, Appendix A-2 for training dates and Appendix A-3 for Recovery Assistant Training evaluations.

In summary, the Mental Health Waiver incorporates several new services such as the Recovery Assistant which emphasizes recovery rather than maintenance.

## **Quality Improvement System**

The Quality Assurance plan for the Mental Health Waiver is a system that continuously monitors the unique needs and range of services provided to our clients.

The Quality Assurance System has four components:

1. The Quality Review Team provides ongoing monitoring of programs, services and client satisfaction. Through on site visits, record reviews and reports, the team records and reports:

- Participant accessibility and eligibility process
- Participant's involvement in planning of services
- Provider Agencies' qualifications, service planning and delivery, safeguards, fiscal integrity and client satisfaction.

DMHAS, in collaboration with the Fiscal Intermediary, developed a data system that examines a range of indicators including clinical, medical, legal, functional, living status, and others in order to monitor how the Waiver Services can better support program participants. Data is submitted from providers on a monthly basis according to established contractual requirements. On-site visits to providers are conducted which include client record review and face to face interviews.

2. The Mental Health Waiver Project Team reviews Provider Agency reports and data, client feedback, issues and trends. In collaboration with DSS in quarterly Quality Assurance meetings, recommendations are addressed. Please refer to Appendix B- 1 for Annual Quality Assurance report

3. The Mental Health Advisory Council meets quarterly to review issues and trends and make recommendation for system improvements. The Council is comprised of clients, families, a DSS representative, Waiver staff and community providers. Please refer to Appendix B-2 for Advisory Council members.

4. Research and Evaluation of the program is formally being conducted by designated staff from the University of Connecticut. Please see Appendix B -3 for details.

## **Quality Assurance Summary Statement**

In an effort to improve the quality of psychiatric rehabilitation services provided to WISE clients, Quality Assurance (QA) allows for continual examination and improvement. During the process of implementation, QA, along with the flexibility and assistance of staff, providers, and advisory counsel members, has produced immediate systemic improvements. The development of the QA process in itself was a relatively novel piece that involved the creation of auditing, chart review, claim and encounter note review, client and provider satisfaction survey, and appropriateness of care procedures and tools.

Once these pieces were in place, a transparent and productive process led to the development of ideas for improvement as well as solutions and actions for many of the issues that presented during the first year of WISE. One such issue was the unexpectedly low number of referrals which led to the creation of a marketing plan and log to reach out to the community in new and creative ways. At the suggestion of the Advisory Counsel, a plan was made to visit local probate courts to reach any potential consumers. These efforts led to the familiarity of mental health agencies with WISE, as well as increased awareness of the program as a treatment option available to clients.

In another effort to improve the physical and mental health of WISE clients, a section of the Recovery Assistant training was explicitly devoted to overall health and wellness of the clients, with emphasis on familiarizing trainees with common physical health problems found in individuals with mental illness. The next step in focusing on the general health of the clients is the development of a Wellness Workbook. The workbook will consist of modules of health living that can be used either as a transition tool for clients leaving a nursing facility, or at any time that a client is considering eliminating an unhealthy habit.

These efforts underscore the importance of QA measures and the continued examination of the program. While the quantity of data from the first year was too low to confidently draw any conclusions about the effectiveness of psychiatric rehabilitation, anecdotal evidence from clients and providers suggests that the WISE program is having a positive impact in clients' lives. Objective measurement of this performance will be a main goal in the coming year.

## **Conclusion**

The Mental Health waiver program in Connecticut is one of several initiatives by the Departments of Social Services and Mental Health and Addiction Services designed to help divert and discharge people with serious mental illness from long term care facilities. While long term care may be necessary for some individuals with psychiatric disabilities who have co-occurring physical conditions, their stay in these facilities should not be prolonged beyond the period necessary for recovery from their medical condition. The Mental Health waiver provides valuable psychiatric rehabilitation services to support individuals in the community.

APPENDIX A -1

**Recovery Assistant Training Curriculum**

**Day One**

Welcome Pre-Test	FI Manager
Overview MH Waiver and MFP	FI Manager
Day in the Life of an RA: Documentation	FI Manager
Break	
Role of the Recovery Assistant in Recovery	DMHAS OOC
Video “Inside Outside” Patricia Deegan	
Lunch	
Understanding Mental Illness Video: Ayers and Lopez	DMHAS Director
Providing Support: Learning Assistive Techniques	DMHAS Staff
Break	
Providing Support: Group Activities	DMHAS Staff
Review/Evaluation of Day One	FI Staff

Learning Objectives

1. Participant will be able to explain the role of the Recovery Assistant in facilitating the client’s recovery.
2. Participant will understand the concepts and operations of a Home and Community Based waiver.
3. Participant will be able to identify emotional and practical challenges of people with serious mental illness leaving institutional care.
4. Participant will be able to discuss common symptoms of mental health conditions.
5. Participant will be able to discuss the role of the recovery Assistant in performing, assisting and cueing clients in homemaking, personal care, respite and companion services.

*Certification will be awarded to participants who complete both days of training and receive at least an 80% on the exam.*

## Recovery Assistant Training Curriculum

### Day Two

Welcome and Review Recovery Assistant Documentation	FI Manager DMHAS Manager
Recovery Story	Consumer
Break	
Health and Wellness	FI Manager DMHAS Manager
Working as a Recovery Assistant	FI Manager DMHAS Manager
Lunch	
Client Rights	Client Right's Officer
Ethics and Boundaries	FI Manager
Break	
Review/Q&A	FI Manager
Test	FI Manager
Evaluation	

#### Learning Objectives

1. Participant will be able to identify boundary violations in working with people with mental conditions.
2. Participant will be able to identify ethical breaches in working with people with mental conditions.
3. Participant will be able to discuss client rights and understand how they apply to a variety of situations.
4. Participant will have a minimal understanding of Recovery in Mental Health.
5. Participants will be able to maintain accurate, complete and timely records that meet Medicaid requirements.

*Certification will be awarded to participants who complete both days of training and receive at least an 80% on the exam.*

## APPENDIX A-2

### Recovery Assistant Training

There were 12 Recovery Assistant trainings held in the first year. Trainings were also offered to individual agencies upon request. The number of certified Recovery Assistants is outlined in the table below.

Date	Location	RA's certified
<b>2009</b>		
May 26 and 29	CVH- Page Hall	21
June 22, 26, and 29 *	ABH- Wilcox Room	22
August 4 and 6	CVH- Beers Hall	22
August 28**	Companions & Homemakers	5
September 21 and 23	ABH- Wilcox Room	22
October 5 and 6	CVH- Page Hall	14
November 4 and 6	CVH- Page Hall	12
December 4	Companions & Homemakers	6
<b>2010</b>		
January 6 <sup>th</sup> and 8 <sup>th</sup>	CVH- Beers Hall	24
February 12	Companions & Homemakers	7
February 22	InterCommunity	4
March 29 <sup>th</sup> and 31 <sup>st</sup>	CVH- Page Hall	25
<b>TOTAL CERTIFIED</b>		<b>184</b>

## APPENDIX A-3

### Recovery Assistant Evaluation

In an effort to assess if the RA training accomplishes its learning objectives and responds to the learning needs of the participants, evaluations are conducted at the conclusion of the two day training. Results of the evaluation are reported in the table below.

Date	Location	Evaluation Score
<b>2009</b>		
May 26 and 29	CVH- Page Hall	4.37
June 22, 26, and 29 *	ABH- Wilcox Room	4.48
August 4 and 6	CVH- Beers Hall	4.57
August 28**	Companions & Homemakers	4.35
September 21 and 23	ABH- Wilcox Room	4.80
October 5 and 6	CVH- Page Hall	4.89
November 4 and 6	CVH- Page Hall	4.68
December 4	Companions & Homemakers	4.35
<b>2010</b>		
January 6 <sup>th</sup> and 8 <sup>th</sup>	CVH- Beers Hall	4.61
February 12	Companions & Homemakers	4.87
February 22	InterCommunity	5.00
March 29 <sup>th</sup> and 31 <sup>st</sup>	CVH- Page Hall	4.59
<b>AVERAGE EVALUATION SCORE</b>		<b>4.63</b>

### Recovery Assistant Training evaluation comments:

6/22/09: *“I enjoyed the training very much and I found it very beneficial because it gave us a better understanding of recovery, the steps and the process of developing hope, positive and a meaningful sense of our participants identity & recovery. It's all about giving them hope in themselves, giving them hope in a better life. It's also about giving our participants another chance living a meaningful life.”*

6/26/09: *“Thank you for the presentation- It is an exciting prospect. Some people who may have thought they would never be in the community can be given this chance. Thank you again.”*

5/28/10: *“This was an incredibly interesting & informative class taught by very knowledgeable people. I learned a lot and feel very comfortable working with this population. The only thing I would add would be guest speakers who are actual consumers of this program.”*

APPENDIX B - 1

**DMHAS MH Waiver/MFP**  
***Working for Integration Support and Empowerment***  
**Quality Improvement Report**

Waiver Year 1  
April 1, 2009 – March 31, 2010

**Enrollment Status**

YTD Total Enrolled – 33                      MFP - 26                      MHW - 7  
Change of status:    YTD - 3 un-enrolled  
                                 1 returned to Nursing Facility, 1 chose Residential Care Home,  
                                 1 chose not to receive services

**Record Documentation**

*Case Record Audits -*  
YTD – 16 completed – 81% compliance (3 charts missing forms created post d/c)

**CMS Compliance**

*Critical Incidents*  
YTD - 0

<i>Recovery Planning</i>	<i>Initial Plan</i>	<i>Quarterly Review</i>
YTD -	100% compliance	100% compliance

**DMHAS Quality Indicators**

*Enrolled clients maintained or increased their level of independence in living situations as evidenced by decrease in Recovery Assistant Services Authorized.*  
YTD - Data not yet available

*Enrolled clients were not readmitted to the same or higher level of care.*  
YTD - 70% on clients remained at lower level of care (10 unduplicated clients hospitalized -17 episodes 13 medical, 4 psychiatric)

*All enrolled clients will have a psychiatric prescriber appointment within 14 days of discharge from a Nursing Facility.*  
YTD - 100% compliance

*Clients will be offered Supported Employment services at quarterly Plan Review meetings.*  
YTD - 100% compliance

**Fiscal Intermediary Quality Indicators**

*ABH has met contractual obligations for Quality Management as outlined in the DMHAS/DSS contract and approved Quality Management Plan*  
YTD - 100% compliance

APPENDIX B – 2

<b>MENTAL HEALTH WAIVER ADVISORY COUNCIL MEMBERS</b>	
<p>Laurel Reagan, APRN DMHAS, Director of Older Adult Services and The WISE Program <a href="mailto:Laurel.reagan@po.state.ct.us">Laurel.reagan@po.state.ct.us</a> (860) 262-6991</p>	<p>Megan Goodfield, LCSW DMHAS, Program Manager for the WISE Program <a href="mailto:Megan.goodfield@po.state.ct.us">Megan.goodfield@po.state.ct.us</a> (860) 262-6953</p>
<p>Kathy Bruni, LCSW DSS, Manager of A.C.U. <a href="mailto:Kathy.a.bruni@ct.gov">Kathy.a.bruni@ct.gov</a> (860) 424-5177</p>	<p>Alicia Woodsby NAMI CT <a href="mailto:publicpolicy@NAMICT.org">publicpolicy@NAMICT.org</a> (860) 287-3565</p>
<p>John Fecteau DMHAS, Health Care Manager <a href="mailto:John.fecteau@po.state.ct.us">John.fecteau@po.state.ct.us</a> (860) 299-6163</p>	<p>Sue Niemitz, LCSW CRMHC, Director of Managed Services <a href="mailto:Susan.niemitz@po.state.ct.us">Susan.niemitz@po.state.ct.us</a> (860) 207-0917</p>
<p>Florence Schroeter Volunteer, DMHAS Research Division <a href="mailto:Florence.schroeter@po.state.ct.us">Florence.schroeter@po.state.ct.us</a> (860) 418-6840</p>	<p>Janina Pentone Volunteer, Berlin (860) 930-7419</p>
<p>Cynthia Murray Volunteer, Enfield</p>	<p>Brenda Senesac, LCSW DMHAS, WISE Clinician <a href="mailto:Brenda.senesac@po.state.ct.us">Brenda.senesac@po.state.ct.us</a> (860) 262-6954</p>
<p>David Dilmaghani Volunteer, Manchester</p>	<p>Patti Walker, MSW Continuum of Care, CEO <a href="mailto:pwalker@continuumct.com">pwalker@continuumct.com</a> (203) 562-2264 x131</p>
<p>Kristie Scott ABH, Project Manager <a href="mailto:kscott@abhct.com">kscott@abhct.com</a> (860) 704-6211</p>	<p>Robert Burke, LCSW ICARE, Dir. Of Psychosocial Services <a href="http://www.icaremanagement.com">www.icaremanagement.com</a> (860) 570-2140 x44</p>
<p>Linda Frisman, Ph.D. DMHAS, Director of Research <a href="mailto:Linda.frisman@po.state.ct.us">Linda.frisman@po.state.ct.us</a> (860) 418-6788</p>	<p>Cheri Bragg Volunteer, Keep The Promise <a href="mailto:B52irish@oal.com">B52irish@oal.com</a> (860) 882-0236</p>
<p>Robert Davidson Eastern Reg. Mental Health Board Director <a href="mailto:ermhb@downcity.net">ermhb@downcity.net</a> (860) 886-0030</p>	

## APPENDIX B- 3

### **Evaluation of the Mental Health Waiver *Working For Integration, Support, and Empowerment***

Background. The Medicaid Home and Community-Based Services (HCBS), or Mental Health waiver, represents an opportunity to discharge adults with serious mental illness from Connecticut nursing homes and to provide community based long term care services as an alternative to nursing home care. Some of those involved will also be part of the Money Follows the Person (MFP) program. The Connecticut Department of Mental Health and Addiction Services (DMHAS) has a team dedicated to transitioning people to the community, and is training community agency staff to provide services and supports to ensure their success. This program is called WISE. The DMHAS Research Division is working to evaluate the effectiveness of these community based long term care services.

How will WISE clients be asked to participate in the evaluation? Designated staff will inform eligible persons about the study, and will then fax a referral form to the evaluation's project manager. If the individual has given permission, research staff will contact the person and/or treatment staff in order to set up an appointment for the baseline interview.

What will study participants be asked to do? If the individual meets study criteria and gives informed consent, he or she will be asked to participate in 4 face-to-face interviews over a 12-month period. The baseline interview will be completed up to 3 weeks prior to the transition into the community. There will be additional interviews at 4, 8, and 12 months following baseline. Participants will be paid \$20 for each interview. In addition, evaluators will request permission to contact a family member for the family portion of the study. If the consumer consents, a family member will be approached, and with informed consent, will be interviewed over the phone at baseline, 6 months, and 12 months. All interviews and research processes will meet DMHAS IRB approval; data collected will be used for research purposes only, and will not be shared with anyone else except in aggregate form.

What outcomes are being assessed? Using administrative data sets, we will track costs of services. Using information from family members, we are measuring family burden and level of worry, and service satisfaction. From the client interviews, we will assess:

- Living situation/homelessness
- Satisfaction with living situation
- Mental & physical health
- Medication adherence
- Hospital & crisis service utilization
- Safety
- Alcohol & drug use
- Need for assistance in daily living
- Isolation
- Social support
- Quality of Life
- Choice & sense of empowerment

Is there a comparison group? No; each person will serve as his or her own control. We will compare what happens to people before program involvement to one year later.

When will the study begin? Study recruitment began May 28, 2009, and will continue for approximately 12 months.