Significant Achievement Awards

Providing Flexible, Individualized Services to the Underserved—The Baltimore Capitation Project

In early 1993 Baltimore Mental Health Systems, Inc. (BMHS), the local mental health authority for Baltimore City, established a planning group to address the needs of individuals with serious and persistent mental illness who had not been well served by the community-based public mental health system. The most severely ill of these individuals typically have unstable housing, frequent or extended hospitalizations, poor access to medical care, and poor psychosocial functioning, and many have serious substance use disorders.

The planning group proposed the development of a mental health capitation demonstration project involving a single payment rate per patient that would integrate state and Medicaid funds, have well-defined performance outcomes, encourage flexible individualized services, have built-in incentives, and target 300 of the individuals who are most in need. The funding mechanism was designed to avoid the restrictions associated with fee-for-service programs. Specific goals of the project were to enhance community treatment and the quality of care, to improve the quality of life of these individuals, to use resources efficiently, to expand the continuum of services, and to reduce the number of expensive psychiatric bed-days by providing appropriate individualized community services.

In late 1993 BMHS selected two Baltimore outpatient mental health providers: Chesapeake Connections of the North Baltimore Center and Creative Alternatives of the Johns Hopkins Bayview Medical Center. The first clients were enrolled in April 1994, and by June 2001 the two programs had 287 enrollees, or members.

The first group of members was drawn from state hospitals. The programs' admission criteria included hospitalization for more than six consecutive months, although most individuals had been in the hospital for more than six years on average before enrollment. Some had been institutionalized for ten or 20 years, and most displayed significant psychotic symptoms and poor overall functioning. The capitation project took on the ambitious task of bringing these people out into the Baltimore community.

The second and subsequent cohorts included some of the most dysfunctional individuals from the community who in the previous two years had either been hospitalized at least four times or had visited emergency rooms for psychiatric reasons more than seven times. About 60 percent of the current members came from state hospitals and have an average Global Assessment of Functioning (GAF) score of 35 to 40. (Possible scores range from 0 to 100, with higher scores indicating better functioning.)

The programs operate with the slogans "Anything is possible" and "Whatever it takes." Members are assigned to treatment teams consisting of a psychiatrist, a team leader (usually a nurse, social worker, or case manager supervisor), personal service coordinators or case managers, and community support staff. In addition, each program employs specialists in employment, social recreation, housing, entitlements, and substance abuse, and psychotherapy who work with the treatment teams and members. The program employs up to 47 full-time equivalents (FTEs) and up to two FTE psychiatrists. The staff includes up to five nurses, 22 case managers, 12 paraprofessionals, 12 specialists, four managers or supervisors, and five clerical assistants.

Each member works primarily with one professional staff member, who carries a small caseload of eight or nine clients. Over time, each staff member gets to know every client well. The average number of visits per enrollee per month is between 12 and 16, and no one is seen fewer than four times a month. Members are seen by medical providers an average of seven times a year.

Visits take place at various locations, including the program site, members' homes, public meeting places, and restaurants. Members are also visited when they are in the hospital. Whenever possible, members' families are included in meetings in members' homes. Both programs also have social events to which families are invited.

The psychiatrist is an integral part of the team and participates in all aspects of treatment, including social, educational, medical, and environmental aspects. Psychiatrist turnover is low: many of the psychiatrists who were hired in 1994 are still involved with the programs.

BMHS employs a part-time medical director, who is a board-certified psychiatrist, to oversee clinical issues. Before a prospective client is referred, the medical director convenes a screening committee that includes a physician certified in internal medicine to review the clinical history and identify issues that may put the client at risk. Suggestions for individualizing the service plan are made, and often follow-up is requested.

Reports written by a case manager are sent weekly by e-mail to the medical director about enrolled members who are at high risk of complications. The medical director provides feedback and monitoring, and regular communication takes place between program staff and the medical director to ensure that all possible interventions have been considered. In cases of

negative outcomes such as the disenrollment or death of a member, the medical director reviews the case carefully and makes recommendations for program improvements.

Each member is treated as the driver of his or her own treatment. Members are asked what they want, and their responses are included in their service plan. Members' wants may be as simple as an air conditioner for their apartment or as complex as the opportunity to attend college or pursue a career. Funding is flexible, so goods and services that would not usually be available to people on fixed incomes can be supplied along with the required mental health services.

Specific client outcomes are evaluated annually by an independent evaluator. Each program receives a grade that determines whether it will receive incentive funds. The program must attain at least a B grade to earn these funds. Outcomes that raise a program's grade include success in enrolling clients, acquisition and retention of housing and employment, family involvement, linkage to medical care, attendance by members at skills training sessions, and members' use of community resources. Outcomes that lower a program's grade include disenrollment, hospitalization and emergency room visits, jail days, and homelessness or use of homeless shelters. In addition, interviews with enrollees and their families are conducted to determine how satisfied they are with the programs. Satisfaction is high for both programs, averaging more than 90 percent.

Overall, both programs have performed very well. The proportion of members attaining independent housing increased from 15 percent in the first year of the project to 50 percent in the fifth year; of these members, 90 percent retained their independent housing. Family involvement increased from an average of 50 percent in the first year to 100 percent in the fifth year. Whereas fewer than 10 percent of enrollees held some type of employment in the first year, almost 60 percent now are employed for at least part of the year. One-third to one-half of the members attain improvements in their GAF score in any given year. The average number of hospital days is less than three per member, and fewer than 30 percent of members are hospitalized in any given year. Disenrollment and the use of homeless shelters rarely occur.

BMHS receives a single stream of funding from the Maryland Mental Hygiene Administration, which combines state general funds with Medicaid funds. Payments are based on the number of enrollees. Total funding for fiscal year 2000 was $7,213,435, of which $6,342,080 was from the state and $871,355 came through Medicaid. Individual members are expected to use their entitlements to help cover their living costs, and these funds are counted in calculations of each program's gross revenue. However, the individual's living costs and spending money are usually subsidized by program funds as well.

Maryland mental health officials are seeking to expand capitation as a means of decreasing state hospital expenditures. The cost of hospitalization in Maryland's state hospitals ranges from $72,000 a year to more than $100,000. Residential rehabilitation costs range from $28,000 to $71,000 a year, and the average expenditure is about $53,000 a year. Capitation compares favorably at an annual rate per member of $27,121.

The Baltimore Capitation Project continues to be supported by Maryland's funding authorities as a viable and important component of the state's mental health system. A modest expansion beyond the initial target of 300 enrollees has already occurred: funding for 310 enrollees was approved for fiscal year 2001. Representatives from other states have visited Baltimore, and the two programs are used as models for similar programs in other U.S. cities.

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An Integrated Program of Culture-Sensitive Health Care for Refugees and Immigrants—The Mental Health Division of the Community-University Health Care Center in Minneapolis

Providing mental health care can be a complex endeavor. Providing mental health care for refugees and immigrants from diverse ethnic and cultural backgrounds presents additional and unique challenges.

These challenges are confronted on a daily basis at the mental health division of the Community-University Health Care Center in Minneapolis. The center has become a haven for people whose lives have been fragmented by war, dislocation, poverty, cultural isolation, or illness. Many of these individuals come from cultures with little or no psychiatric tradition and bring with them exceptional challenges and barriers to the effective provision of services. By offering an array of targeted programs and treatments, the center serves as an integrated source of support for a population whose often overwhelming physical and mental health needs would otherwise be unmet or underserved.

Founded in 1966 as an outreach initiative by the University of Minnesota, the center represents a joint academic and community enterprise. The university chose to locate the center in South Minneapolis because the residents there had—and continue to have—some of the highest medical and social risk factors in the area. Many of them live below the federal poverty line, and most have inadequate or no health insurance. The mission of the center's multidisciplinary, multicultural staff is to provide these individuals with accessible, affordable, high-quality, and culturally appropriate health care.

The center's mental health division offers a full complement of outpatient services, including psychotherapy, medication management, psychological

assessment, case management, day treatment for adults with serious mental illness, and youth support groups to prevent substance abuse and violence. These services might be considered somewhat standard—except for the fact that all of them are offered in Hmong, Lao, Cambodian, Vietnamese, Somali, and Spanish as well as English. This diversity reflects the demographic makeup of the center's patient base: of the 7,800 clients served in 2000, 30 percent were Southeast Asian, 27 percent were white, 24 percent were black, 7 percent were American Indian, and 5 percent were Hispanic.

Sixteen years ago, the mental health division began offering psychiatric services to the first wave of Southeast Asian populations arriving in the Twin Cities area. Over the next two years, primary care physicians in the health care center began to recognize that many patients who complained of undifferentiated body pain were displaying symptoms of posttraumatic stress disorder and depression. To treat these symptoms in a culturally competent manner, the mental health division initiated an acupuncture program so that patients could receive acupuncture and psychiatric treatment simultaneously.

During the following decade, the influx of refugees and immigrants to the area increased dramatically. Doctors at the clinic were seeing more patients from these populations, and they were also seeing symptoms of a wider range of disorders, including schizophrenia and bipolar disorder. In response to the growing needs of these patients, the mental health division established ethnic-specific day treatment programs to serve its Hmong, Lao, Cambodian, Vietnamese, and Latino clients.

Although most of the day treatment groups follow the basic program components of group therapy, socialization, and independent living skills, each group incorporates psychosocial activities that reflect the culture of the clients it serves. Such activities may include meditation, ethnic dance, or the preparation of ethnic food.

The mental health division has recently expanded to provide direct services and outreach to Latinos—the fastest growing minority population in the state—and to refugees from Somalia and other East African countries torn by civil war. Somalis constitute the newest group of immigrants to Minnesota, and they have the greatest needs for health care system advocacy. The center's Latino and Somali day treatment groups are the only ones of their kind in the state of Minnesota.

The health care center has also developed a series of advocacy outreach programs that address universal issues, such as sexual assault, child abuse, battery, and chemical dependency, in a culture-specific context. In addition to providing support for individual victims, the programs build solidarity among community members, who may feel isolated or alienated because of their victimization or mental illness. Case management and other programs, such as the Street Caseworker program, bring services to the client and the extended family when appropriate.

The clinical staff of the mental health division consists of three psychiatrists, four clinical nurse specialists, eight licensed psychologists and social workers, and 13 bilingual-bicultural workers. Faculty and residents from the University of Minnesota provide psychiatric services at the clinic. In addition to determining the appropriate medical treatment, they spend considerable time educating clients about their symptoms, medications, and treatment plans.

The clinical nurse specialists offer medication management and client education. Because these specialists can meet frequently with clients, they serve as physician extenders for psychiatric services. The program is able to reduce the frequency of psychiatric visits by interspersing them with clinical nurse visits. The licensed psychologists and social workers provide child, adult, and family therapy, as well as couples counseling and psychological assessment.

The bilingual-bicultural workers play a pivotal role in developing treatment plans and providing mental health services to clients. During psychiatric interviews they act as cultural "negotiators," a role that far exceeds that of traditional interpreter. The psychiatrists collaborate with the bicultural staff to understand the client's cultural dynamics and to determine which medicines to administer. The nurse specialists consult with them about medication management and follow-up. The bicultural staff also assist clients in finding housing and employment and in securing resources or seeking additional community support services. They advocate for clients who may have been misdiagnosed or mistreated at other facilities.

The Community-University Health Care Center has effectively established many formal and informal collaborations with other public and community agencies. For example, it partners with the Minneapolis public schools system and with Rise, Inc., a nonprofit organization that provides job placement and training for mentally ill and disabled clients in the Twin Cities. The center also collaborates with several mutual assistance agencies and nonprofit social service organizations created by and for immigrant communities.

The center serves as a continuing education site for residents in internal medicine, pediatrics, and obstetrics and gynecology as well as psychiatry. The availability of residents makes it possible for the clinic to extend its psychiatric services, and the residents, in turn, receive valuable training in a cross-cultural, community-based setting. If a medical resident refers a patient to psychiatric services, the resident attends sessions with the patient. This intensive training allows all residents to study and understand the cultural issues involved in mental health and the provision of psychiatric services.

The health care center uses a multimodal approach to evaluate program outcomes and conduct quality assurance activities. Demographic data are collected when a client registers at the clinic. The provider and the client collaborate to design an individual plan that identifies assets and psychosocial stressors and defines mutually acceptable goals for the duration of the relationship. Pre- and posttreatment outcomes are measured and tracked with the Global Assessment of Functioning Scale and the Severity of Psychosocial Stressors Scale (axis IV). Clients who have received treatment are more likely to develop positive lifestyles and maintain stable living arrangements; they are also less likely to exhibit violent behavior or to be admitted to a psychiatric hospital.

The center's success in filling the critical need for culturally competent mental health services has enabled it to attract and sustain substantial sources of public funding and to obtain ongoing contracts at the county, state, and federal levels. Private donors and corporate sponsors contribute seed money to fund new program initiatives. Partnerships, such as those with Rise, Inc., and the Minnesota public schools, have resulted in several shared funding streams.

The clinic has obtained the Essential Community Provider Certification in Minnesota, which means that it can negotiate contracts with managed care programs. Its status as a federally qualified health center—by virtue of its affiliation with the primary care clinic—helps offset the difference between managed care payments and the actual cost of delivering services.

In calendar year 1999, half of the mental health division's $2.2 million budget came from public funding; third-party reimbursements accounted for about a quarter, as did private funding, partnerships, and patient fees combined.

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A Unique Approach to Mental Health Care for Young Children—The Multnomah County, Oregon, Early Childhood Mental Health Program

In 1990, Ronnie Herndon, a director of the Department of Health and Human Services' Head Start program, concluded that the children in his program who had significant mental health problems were unlikely to receive conventional mental health services. A needs assessment was conducted, and the Multnomah County (Oregon) Early Childhood Mental Health (ECMH) program was founded. The program places early-childhood mental health clinicians and child psychiatrists in public community agencies that serve young children and their families—schools, day care centers, housing complexes, churches, and community service agencies. These clinicians work in tandem with families and staff from the early-childhood community, creating a mental health care system for children that embraces the principles of prevention through intervention.

The program became fully operational in September 1994, expanding to two Head Start programs. It now operates in four Head Start programs, one Early Head Start program, two public school district special education programs, a public school prekindergarten program, and a nonprofit child care resource and referral agency.

Nine host early-childhood organizations in Multnomah County—the most populous county in Oregon, which includes the city of Portland—serve as the program's physical facilities. These organizations provide child care and education and early intervention in 38 public schools, 11 housing complexes, nine child care centers, five community service providers, four churches, and numerous home-based child care settings. Because the ECMH program operates out of these facilities rather than having its own premises, resources that would otherwise have gone toward capital expenditures can be dedicated to the provision of services.

Disruptions to emotional development in early childhood can have serious long-term consequences. Early-childhood mental health care has been shown to optimize the ability of children to participate in school and other community programs. Early-childhood programs that combine a strong child-focused program with a strong family component are particularly effective. However, families are often reluctant to label a young child as having a mental health problem. For children from low-income families and children with developmental disabilities, there is an even greater risk that mental health problems will go undetected and untreated, and these children are more vulnerable to these kinds of problems than are other children. Even when it is recognized that a child requires mental health care, many families find that traditional services do not fit their needs. Transportation and scheduling constraints can also limit access to mental health care services for children.

By making mental health services available in schools, child care facilities, and homes, the Multnomah County ECMH program overcomes these access barriers. Children and their families can move seamlessly between the various preventive and interventional services that the program provides in a familiar environment, as a natural extension of their current child care or educational program. This integration of mental health care services with existing early-childhood services is the primary innovation of the ECMH program.

One of the benefits of providing mental health services alongside other child care and family services is the elimination of the stigma that is often associated with traditional, clinic-based mental health services. Another key strength of this approach is its ability to involve family members in the child's mental health care. Mental health interventions that are integrated into a child's daily routine can enhance the partnership between the family and the early-childhood program, promote coordination of services, and invite collaboration by parents. The Multnomah County ECMH program involves family members fully in consultations, assessments, and treatment and even in the hiring of mental health professionals.

The "typical" child treated through the Multnomah County ECMH program has a score of 53 on the Children's Global Assessment of Functioning Scale (CGAS), which indicates variable functioning with sporadic difficulty. (Possible scores on the CGAS range from 0 to 100, with higher scores indicating better functioning.) The range of scores among children targeted by the ECMH program is from 39, which represents major impairment in functioning, to 79, which represents only slight impairment.

The program is staffed by 17.5 full-time-equivalent (FTE) positions: mental health consultants (12.5 FTEs), subcontracted outpatient therapists (2.5 FTEs), a county child and adolescent psychiatrist with early-childhood expertise (.05 FTE), a subcontracted outpatient project supervisor (.5 FTE), an office assistant (.4 FTE), and a subcontracted outpatient child and adolescent psychiatrist (.1 FTE). The program's director is Barbara L. Brady, L.C.S.W., who is also the administrator of the county's early-childhood and child abuse mental health programs, and the program's county supervisor is Bruce Spilde, L.C.S.W. The subcontracted agency is Morrison Child and Family Services, with Margie MacCloud, L.C.S.W., as clinical director and Kathryn Falkenstern, L.C.S.W., as project supervisor.

The mental health consultants provide both primary prevention services—contributing to each school or center's programs and curricula and working with parents—and secondary prevention services—consulting with staff and families about specific children who exhibit social, emotional, or behavioral difficulties. They also provide assessment and treatment, working closely with agency staff and administrators. The county child and adolescent psychiatrist provides clinical consultation and training to these mental health consultants. The outpatient psychiatrist provides evaluations and consultations for referred children. The benefit of a psychiatrist's perspective has the potential to enhance the staff's future interactions with the children and their families.

In addition to conducting on-site evaluations of children, the ECMH program provides counseling, abuse prevention services, parenting education, and information and referral services and facilitates parent-child activities and child development activities.

The annual budget for the program was $1,224,764 in fiscal year 2000–2001, the bulk of which ($1,072,702) was provided by the county. Other sources of funding included a grant from the Portland public school system and funding from each of the nine host programs. Mental health consultants who are employed by the county and its subcontractors are funded jointly by the county and the various early-childhood programs through which the ECMH program operates. Funds earmarked for program expansion have been used to provide cash enhancements to Medicaid- and county-funded outpatient agencies to enable these agencies to visit the children and their families in their homes, classrooms, and child care centers and to improve the frequency, intensity, and flexibility of services. In fiscal year 2000–2001, a focus on staff productivity enabled the program to expand its target population by more than 70 percent while increasing the number of FTEs dedicated to the program by only 24 percent.

From an initial population base of 220 children in 1990, the Multnomah County ECMH program has expanded to serve more than 7,000 children. In fiscal year 1999–2000, the program provided direct clinical services to 130 children, consultations for 816 children, and primary prevention services to more than 3,000 children through its school and community sites. Another 4,000 children and their families benefited from the program as a result of its collaboration with the local child care resource and referral centers. During fiscal year 2000–2001, direct clinical services were provided to about 230 children. These numbers represent a significant contribution to the mental health field given that these children and families would not otherwise have received mental health services.

Multnomah County is unique in its implementation of this model of service delivery in such a large metropolitan area and across such a broad spectrum of the early-childhood community by using a blend of state, local, and federal funds. Unlike in the Midwest and the East, where there is a history of private child care institutions, Oregon and other western states have relied almost entirely on government agencies to provide these services.

Last year, the model of service delivery embodied in the Multnomah County ECMH program generated the formation of the Early Childhood Mental Health Partnership. Through this partnership, the executive leadership of all the major early-childhood organizations work together to encourage policy makers to improve the system of care for young children. The ECMH program is well known and well regarded in the early-childhood community and is requested by additional educational and child care organizations each year—for example, five new organizations sought involvement with the program in fiscal year 1999–2000. The program was presented to the National Head Start Conference in July 2000 and to the American Academy of Child and Adolescent Psychiatry's System of Care Workgroup in October 2000.

Surveys of families and participating agencies have revealed a high level of satisfaction with the program: an average of almost 100 percent of families and almost 100 percent of agency staff that were recently surveyed indicated that they were satisfied. Ninety-nine percent of children who receive direct services are maintained within their educational care setting without disruption to their care or to their education. This is a significant indicator that problems are being addressed adequately. Quarterly utilization and quality assurance reviews by the management staff of the various participating agencies have shown that the care provided through the program is appropriate to the assessed needs, that care is provided at a frequency and intensity appropriate to the assessed needs and risks, and that coordination of services with families and early-childhood caregivers and educators is excellent.

Over the next several years the program plans to expand services to all the local Head Start and child care programs, as funding allows. The program's collaborative structure for management, evaluation, and services has formed the basis of three recent requests for federal grants to expand services into more child care and Head Start settings. The county is exploring the possibility of obtaining an increase in federal financial participation toward that same end.

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