



Insufficient Information Available to Fully Assess the Success of the Self-Directed Care Program

at a glance

The Department of Children and Families' Self-Directed Care program provides mental health treatment and support services to adults who have a serious mental illness. The program seeks to help participants move toward recovery and independence by allowing them to have more control over decisions regarding their treatment. Program participants can use individual budgets to purchase traditional mental health care services such as mental health counseling and medications, as well as non-traditional services that are not typically provided by the department's community mental health programs. During the first six months of Fiscal Year 2009-10, the majority (81%) of participants' purchases were for non-traditional services, such as transportation, housing, and computers.

In Fiscal Year 2008-09, it cost, on average, \$4,313 to serve each participant in the program. These costs include direct expenditures for participant purchases, as well as costs to operate the program. While the state has not appropriated additional funds to operate the program, it is not cost-neutral as the department spends more, on average, to serve these participants than the average cost to serve adults with serious mental illnesses in the traditional community mental health system. The department needs to develop a stronger accountability system to monitor how well the program is helping participants achieve their personal and recovery goals.

Scope

As required by Ch. 2008-91, *Laws of Florida*, OPPAGA reviewed the Department of Children and Families' Self-Directed Care program for adults with serious and persistent mental illness. This report addresses five questions.

- What criteria are used to determine eligibility for the program and what are the characteristics of participants?
- What services are available to participants and what do they purchase?
- How much does it cost to serve participants in the program and is it cost-neutral?
- Does the program have an adequate accountability system for determining if it meets its goals?
- What options could the Legislature consider for the program?

Background

In 2001, the Legislature authorized the Department of Children and Families to establish a Self-Directed Care program to provide mental health treatment and support services to adults with serious mental illnesses. The program enables participants to control funds allocated for their care and purchase mental health treatment and support services that can best meet their needs. The program is

intended to help participants move toward recovery and independence by allowing them to have control over decisions regarding their treatment.

Participants’ budgets are based on their eligibility for other mental health benefits. Participants who qualify for Medicaid, Medicare, Veteran’s benefits, or other publicly funded mental health benefits receive an allocation of \$1,673 annually. Participants who do not qualify for other publicly funded mental health benefits receive a larger amount, \$3,194 annually.

The program is managed by the Department of Children and Families, which contracts with local entities to serve as fiscal intermediaries in operating the program. The fiscal intermediaries assess eligibility, enroll participants, and approve and process payments for the participants’ expenditures. The fiscal intermediaries also hire life coaches that help participants develop written life action plans. These plans set goals for the participants’ mental health recovery, identify services necessary to achieve these goals, and develop individual budgets to purchase these services.

The program operates in 2 of the department’s 20 circuits. It has operated in Circuit 4 (the Jacksonville area) since 2002 and in Circuit 20 (the Fort Myers area) since 2005.¹ The program is funded with general revenue and a federal block grant.² In Fiscal Year 2008-09, the program served 330 participants, with over two-thirds of these persons in Circuit 4, and expenditures totaled \$1.4 million. (See Exhibit 1.) In addition to participant budgets, expenditures included costs associated with operating the program, namely life coach salaries and fiscal intermediary expenses.

¹ Circuit 4 consists of Nassau, Duval and Clay counties, and Circuit 20 consists of Charlotte, Collier, Glades, Hendry, and Lee counties.

² The program is funded like all adult mental health services, with a federal block grant and the state’s maintenance of effort funding which consists of state general revenue and local funds.

Exhibit 1
In Fiscal Year 2008-09, the Self-Directed Care Program Served 330 Participants at a Cost of Over \$1.4 Million

Circuit	Participants Served	Program Expenditures
Circuit 4	233	\$953,373
Circuit 20	97	470,000
Total	330	\$1,423,373

Source: OPPAGA analysis of Department of Children and Families’ data.

Questions and Answers –

What criteria are used to determine eligibility for the program and what are the characteristics of participants?

To participate in the Self-Directed Care program, individuals must reside in Circuits 4 or 20 and meet specific criteria. These include being 18 years of age or older, having a severe and persistent mental illness, and being legally competent to direct one’s care.³ Participants must also meet income requirements to qualify for public assistance programs.⁴ In addition participants must have the desire to take control of their recovery.

In Fiscal Year 2008-09, most (79%) of the participants were Caucasian and the majority (62%) were women. Nearly all participants were living independently and were single, and just over half (52%) were eligible for Medicaid.^{5,6} As shown in Exhibit 2,

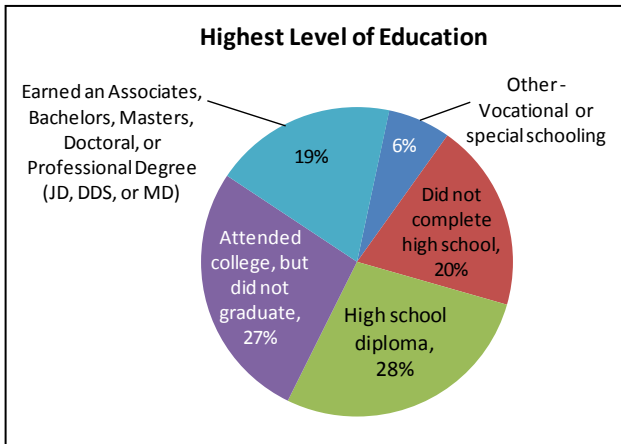
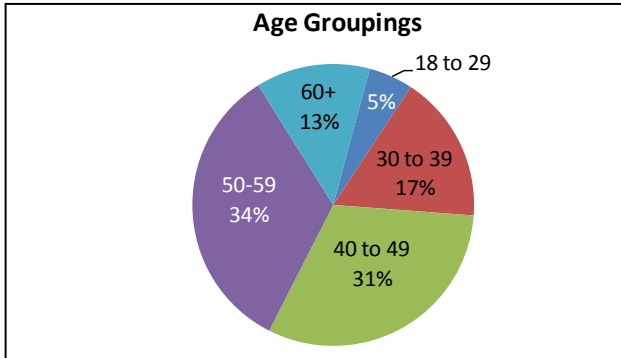
³ Individuals with a severe and persistent mental illness have a primary diagnosis, based on the *International Classification of Diseases, Ninth Edition (ICD-9)*, of schizophrenia, bipolar or depressive mood disorder, delusional disorder, psychotic disorder, or autism, or have any other ICD-9-CM primary diagnosis that meets one of the following conditions: (a) received services for current mental health problem for at least 12 months or current mental health problem is expected to endure 12 months, (b) currently receives disability income for a psychiatric condition, or (c) is unable to perform independently in day-to-day living activities.

⁴ Participants must be receiving, or have received within the past five years, government assistance related to their psychiatric or other disability.

⁵ Single includes participants who were widowed, divorced, or separated.

approximately two-thirds of the participants were between the ages of 40 and 59 and approximately three-quarters had at least a high school diploma and many had attended college.

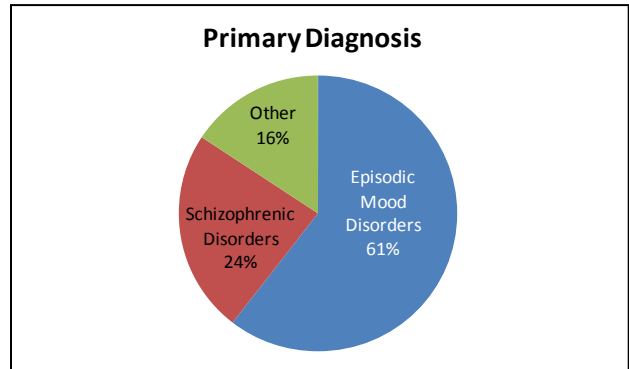
**Exhibit 2
In Fiscal Year 2008-09, Most Participants Were Between 40 and 59 Years of Age and Had Completed High School**



Source: OPPAGA analysis of Department of Children and Families' data.

The majority of participants had a diagnosis of episodic mood disorder or schizophrenia. (See Exhibit 3.) A mood disorder is characterized by a disturbance in a person's mood. The two most common mood disorders are depression and bipolar disorder. Schizophrenia is a severe, chronic brain disorder that alters the way a person acts, thinks, perceives reality, expresses emotions and relates to other people.

**Exhibit 3
In Fiscal Year 2008-09, Most Participants Had a Diagnosis of Episodic Mood Disorder or Schizophrenia**



Source: OPPAGA analysis of Department of Children and Families' data.

What services are available to participants and what do they purchase?

Program participants can use their budgets to purchase traditional mental health services as well as other services and supports that are not typically provided by the department's community mental health system. Traditional clinical recovery services include mental health counseling, medications, and medication management. Depending on participants' life action plans, they may also purchase recovery support services to help them meet their recovery goals. For example participants who are depressed and overweight may allocate a portion of their budgets to pay fees to attend a weight loss program; other participants may pay fees for art classes or massage therapy. In addition, participants may purchase recovery enhancements, which are generally consumable items that can help them become more independent and active in the community. For example, participants may use funds to pay rent and utilities for a limited period of time, or may purchase clothing, furniture, food, and entertainment services. (See Exhibit 4.)

⁶ The department defines living independently as paying all of their own housing costs or their equal share of costs if they are living with others.

Exhibit 4

The Self-Directed Care Program Allows Participants to Purchase Traditional and Non-Traditional Mental Health and Support Services

Service Category	Type of Service	Description	Examples
Clinical Recovery Services	Traditional	Traditional mental health services	Mental health counseling, psychotropic medication, medication management
Recovery Support Services	Non-Traditional	Non-traditional services that are expected to produce the same outcomes as traditional services	Massage therapy, weight loss programs, smoking cessation programs, art classes
Recovery Enhancements	Non-Traditional	Tangible items and other non-mental health supports that are expected to enhance a person’s integration into the community or relate to employment, volunteering, or socialization; some of these services are time-limited, require a maintenance plan, or are recommended by a licensed mental health professional as part of the participant’s treatment	Housing and utility assistance, transportation, furniture, dental and vision services, clothing, entertainment, craft supplies and cameras, food, computers, haircuts

Source: Department of Children and Families’ Self-Directed Care Purchasing Guidelines.

Our analysis of participants’ expenditures for the July – December 2009 period showed that most (81%) purchases were for non-traditional services, which included both recovery supports and recovery enhancements.⁷ However, the types of services purchased by participants varied between the two circuits. In Circuit 4, participants directed a little more than half (54%) of their budgets to pay for living expenses (food, housing, and utilities) and transportation. In contrast, a much smaller proportion (25%) of Circuit 20 participants’ expenditures was spent on these types of services. In addition, Circuit 20 directed a higher proportion of their budgets to traditional mental health services than did Circuit 4 participants (24% compared to 16%) and participants in both circuits used their budgets to purchase computers and computer accessories. See Appendix A for a detailed listing of participants’ purchases for each circuit.

There is limited data available to explain the differences between the two circuits or to determine whether the percentage of non-traditional purchases is reasonable. Participants who do not qualify for other publicly funded mental health benefits must spend 48% of their budgets on traditional mental health services,

but participants with publicly funded insurance may spend up to 100% of their budgets on non-traditional recovery support services and enhancements. However, the available data on purchases only identified expenditures by type of service and did not include specific information on whether or not participants received Medicaid or other publicly funded mental health benefits. In addition, available data was limited to only six months which may not represent participants’ annual purchases.⁸ Further, differences in purchases could reflect variations in how the fiscal intermediaries and life coaches interpret participants’ needs.

How much does it cost to serve participants in the program and is it cost-neutral?

In Fiscal Year 2008-09, it cost, on average, \$4,313 to serve each participant in the Self-Directed Care program. The program is not cost-neutral as it costs the state more to serve these participants than it would have cost to serve them in the traditional community mental health system.

As shown in Exhibit 5, in Fiscal Year 2008-09, it cost, on average, \$4,313 to serve each participant in the Self-Directed Care program. A portion of

⁷ The analysis is limited to six months of expenditure data because Circuit 4 provided data only for this period.

⁸ The program allows participants to carry forward some or all of their quarterly or semi-annual budgets to save for more expensive items.

these costs reflect actual expenditures for participants' purchases; the rest reflects operational costs associated with assisting participants to spend their budgets in accordance with their life plans. These additional costs include fiscal intermediary expenses and compensation for life coaches. Overall, for each \$1 that a participant spent in Fiscal Year 2008-09, it cost the state \$1.83 to operate the program. This varied between circuits, from \$1.75 for Circuit 4 to \$2 for Circuit 20.

Exhibit 5
Average Cost Per Self-Directed Care Program Participant Totaled \$4,313 in Fiscal Year 2008-09

Self-Directed Care Program	Average Cost Per Participant Fiscal Year 2008-09 ¹		
	Total	Participant Purchases	Program Operations
Circuit 4	\$4,092	\$1,488	\$2,604
Circuit 20	4,846	1,618	3,228
Total Program	4,313	1,526	2,787

¹ The average cost was calculated by dividing total expenditures by the number of individuals served.

Source: OPPAGA analysis of Department of Children and Families' expenditure data.

A question that has been raised by stakeholders is whether the program is cost-neutral or requires higher levels of funding than that provided for other individuals who receive services in the traditional community mental health system. Our analysis indicates that the program is not cost-neutral as it costs the state more to provide services to participants than it would have cost to serve them in the traditional community mental health system.

The state does not provide additional funding for the Self-Directed Care program. However, the two circuits that operate the program allocate funds to the program from their overall community mental health budgets, and the overall level of spending per participant is higher than that for other adults receiving community mental health services. Some stakeholders have noted that participants receive a budget that represents the average amount spent on adults in the traditional

community mental health program.⁹ However, these individual budgets do not include the operational costs associated with the program, which are substantially higher than the average amount spent by participants from their individual budgets.

As shown in Exhibit 6, it cost, on average, nearly three times as much to serve adults with serious and persistent mental illness in the Self-Directed Care program than through the traditional community mental health system (\$4,313 and \$1,484, respectively). It should be noted that this comparison does not adjust for factors such as differences in mental health diagnoses, level of functioning, educational levels, individual needs, and other characteristics as well as differences in access to, types of, and utilization of services that could contribute to cost differences.

Exhibit 6
Average Cost of Self-Directed Care Program was Nearly Three Times that of Traditional Community Mental Health Services in Fiscal Year 2008-09

Mental Health Services	Average Cost Per Participant Fiscal Year 2008-09 ¹		
	Circuit 4	Circuit 20	Total
Self-Directed Care Program	\$4,092	\$4,846	\$4,313
Traditional Community Services for Adults	\$1,402	\$1,538	\$1,484

¹ The average cost was calculated by dividing total expenditures by the number of individuals served in each category and does not include expenditures for adults served in the Florida Assertive Community Treatment program and crisis intervention and emergency services.

Source: OPPAGA analysis of Department of Children and Families' expenditure data.

Does the program have an adequate accountability system for determining if it meets its goals?

The premise of the Self-Directed Care program is to assist participants to move toward recovery and independence. However, the department has not established an accountability system to

⁹ Since program implementation, some stakeholders also have asserted that the program is cost-neutral because participants do not always spend all of their budgets.

monitor and assess the program's overall progress and the extent to which it is helping participants achieve their personal goals. Without better accountability information, policymakers and other stakeholders cannot readily determine whether the program is a good use of state funds and is helping participants reach their recovery goals.

The department has not established specific objectives and standards for the program, and it does not require the fiscal intermediaries to routinely collect and report data that enables the department and policymakers to monitor program outcomes. For example, the department has not established criteria or mechanisms to assess whether participants are making adequate progress towards their individual goals as well as the program's overall objective of achieving recovery and independence.

At present, participants' life action plans frequently do not contain specific objectives, targets, or timeframes for measuring progress. Our review of 56 participants' life plans determined that individual goals were often vaguely stated (e.g., "improving my ability to mentally handle the many stressful issues in my life", "increase my quality of life", or "have better control and mental health"). Of the plans we reviewed, 40 lacked measurable objectives, targets, or timeframes for measuring progress. The remaining 16 plans included objectives such as "further my education," "become self-supported", "lose 20 pounds", "earn a degree", or "stay sober", but only 5 included specific time deadlines for completing objectives.

The department also has not developed a data system to track information on program participants and their outcomes. While some information is available that can be used to assess program success, this information is maintained in individual paper files and separate data bases and is not routinely compiled or reported. As a result, the department lacks summary data on the participants' life action plan goals, the types of

purchases they make and how these purchases relate to their goals, whether participants are achieving their goals, and how long they stay in the program.¹⁰

Our interviews with 64 program participants found that they generally expressed satisfaction with the program and believed that it was helping them to maintain their ability to live independently or move toward recovery. These participants also reported satisfaction with the help they receive from their life coaches and their budgets. The participants commonly reported that the program and life coaches provided an emotional safety net, and helped them set recovery goals and be accountable for meeting these goals. Some participants indicated that their budgets enabled them to return to school, work, meet their living expenses and/or start their own businesses. Many participants reported buying computers which helped them connect electronically with family and friends who provided social support systems. Other participants reported that their budgets helped them afford medications and medical treatment and that using some of their budgets for items such as hair care, restaurant meals, cameras, and household goods helped their self-esteem.

What options could the Legislature consider for the program?

The Legislature may wish to consider the following three options for the Self-Directed Care program: 1) modify the program to improve accountability, 2) expand the program, or 3) eliminate the program.

Option 1. Modify the program to improve accountability. As the Self-Directed Care program is small and provides additional options for individuals with mental illness, the Legislature may wish to continue the program in Circuits 4 and 20 and direct the department to improve its accountability system for the

¹⁰ While several evaluations of the program have been conducted, these evaluations did not address the extent to which the program helped participants reach their recovery and independence goals.

program. At a minimum, the department should develop program goals and standards and monitor participants' progress in meeting their individual life action plan goals. This would require the department to establish additional policy guidance for the program and require the fiscal intermediaries to maintain electronic data related to participants' life action plan objectives and purchases. This would enable the Legislature to better assess critical program elements such as how participants use their budgets, whether participants' purchases are linked to their recovery goals, and whether participants are making adequate progress towards their life goals. In doing so, the department could consider design components of similar programs operated by other states. Six states have or are currently operating similar programs – Iowa, Maryland, Michigan, Oregon, Pennsylvania, and Texas. (See Appendix B for descriptions of these programs.)

Option 2. Expand the program. As allowed in current law, the Legislature may wish to direct the department to expand the program to one or more additional circuits. However, based on our cost analyses, it costs approximately \$2,800 more to provide services to adults with serious and persistent mental illnesses through this program than through the department's traditional community mental health system. As such, expanding the program would require additional funding or a reallocation of current community mental health funding.¹¹ Alternatively, the Legislature could direct the department to limit Self-Directed Care program funding to the average cost to serve clients in the traditional community mental health system. However, this would likely result in a significant reduction in the individual budget allocations for current participants.

If the program is expanded, the department should establish a stronger accountability system as discussed in Option 1 above. This

would provide the department an opportunity to strengthen the program's design and implementation as well as to establish a monitoring system to assess the program's outcomes.

Option 3. Eliminate the program. Given the state's current fiscal condition, the Legislature may wish to eliminate the program. This option would increase the funding available to serve other clients through the traditional community mental health system in Circuits 4 and 20. However, this option would reduce participants' flexibility in obtaining services that they believe will best assist them achieve their recovery goals.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Department of Children and Families to review and respond. The Secretary's written response has been reproduced in Appendix C.

¹¹ The department has estimated that it would cost approximately \$6.4 million annually to expand the program to all circuits. This would allow 60 participants to be served in each expansion circuit.

Appendix A

Self-Directed Care Participants' Expenditures Varied by Circuit

Participants in the self-directed care program can use their budgets to purchase traditional mental health services as well as other services and supports that are not typically provided by the department's community mental health programs. Traditional clinical services include mental health counseling, medications, and medication management. Participants can also purchase recovery support services to help them meet their recovery goals as well as recovery enhancements, which are generally consumable items that can help them become more active in the community.

Participant purchases for the first six months of Fiscal Year 2009-10 varied by circuit.¹² As shown in Table A-1, in Circuit 4 (the Jacksonville area), participants directed a little more than half (54%) of their budgets to pay for living expenses (food 16%, housing 14%, and utilities 12%) and transportation (12%).¹³ Expenditures for traditional mental health services represented 16% of the total and furniture, clothing, dental services, and computer purchases each represented between 4% and 7% of total expenditures.

Table A-1
During the First Six Months of Fiscal Year 2009-10, Participants in Circuit 4 Spent 54% of Their Budgets on Living Expenses and Transportation¹

Type of Purchase	Amount	Percentage of Total
Food	\$25,304	16%
Housing	21,117	14%
Transportation	18,810	12%
Utilities	17,977	12%
Computers and accessories	11,450	7%
Psychotropic medications	9,100	6%
Mental health counseling	8,884	6%
Dental services	8,078	5%
Clothing	7,067	5%
Furniture	6,600	4%
Medication management services	5,902	4%
Massage, weight control, smoking cessation	3,684	2%
Education, training, and materials	3,288	2%
Vision services	2,332	1%
Supplies and storage	1,685	1%
Equipment	1,225	1%
Crafts	1,133	1%
Cameras and supplies	1,053	1%
Travel	529	<1%
Licenses/Certification	337	<1%
Entertainment (movies, eating out, etc.)	260	<1%

¹² The analysis is limited to six months of expenditure data because Circuit 4 provided data only for this period.

¹³ Transportation included bus passes, gasoline, and auto repairs and maintenance; housing included rent, mortgage, and maintenance; utilities included electricity, water, and phone and internet service; and food included groceries and any non-food items purchased at the same time, such as household and hygiene items.

Type of Purchase	Amount	Percentage of Total
Pet ownership	214	<1%
Hair cut, manicure, make up lessons	80	<1%
Non-mental health medical	0	0%
Other	0	0%
Total	\$156,109	100%

¹ Bolded purchases are traditional mental health services.

Source: OPPAGA analysis of self-directed care purchases for the first six months of Fiscal Year 2009-10.

In contrast, as shown in Table A-2, participants in Circuit 20 (the Ft. Myers area) directed a higher proportion (24%) of their budgets to traditional mental health services and a smaller proportion (25%) living expenses (food 2%, housing 7%, and utilities 3%) and transportation (13%) than did Circuit 4 participants. Participants in this circuit spent 12% and 11% of their budgets, respectively to pay for computers and dental services. In addition, participants used 5% of their budgets to purchase recovery support services such as massages, weight control, and smoking cessation.

Table A-2
During the First Six Months of Fiscal Year 2009-10, Participants in Circuit 20 Spent 24% of Their Budgets on Traditional Mental Health Services¹

Type of Purchase	Amount	Percentage of Total
Transportation	\$10,940	13%
Computers and accessories	10,029	12%
Dental services	9,684	11%
Medication management services	7,119	8%
Psychotropic medications	7,107	8%
Mental health counseling	7,069	8%
Housing	6,009	7%
Massage, weight control, smoking cessation	4,386	5%
Utilities	2,862	3%
Travel	2,502	3%
Equipment	2,349	3%
Clothing	2,069	2%
Food	2,021	2%
Crafts	1,979	2%
Licenses/Certification	1,822	2%
Entertainment (movies, eating out, etc.)	1,768	2%
Vision services	1,639	2%
Furniture	931	1%
Non-mental health medical	749	1%
Camera and supplies	694	1%
Education, training, and materials	573	1%
Hair cut, manicure, make up lessons	489	1%
Pet ownership	481	1%
Supplies and storage	410	<1%
Other	12	<1%
Total	\$85,693	100%

¹ Bolded purchases are traditional mental health services.

Source: OPPAGA analysis of self-directed care purchases for the first six months of Fiscal Year 2009-10.

Appendix B

Other States Have Implemented Self-Directed Care Programs for Adults with Mental Illness

We contacted six often cited states that have implemented self-directed care programs for individuals with mental illnesses. These states are Iowa, Maryland, Michigan, Oregon, Pennsylvania, and Texas. Of these states, Michigan and Oregon have on-going programs. Michigan’s program has operated since 2003; Oregon’s program has operated since 2004 and serves 25 participants in one area of the state. The Iowa program was a two-year pilot that ended in 2008 and has not been extended. The remaining three states’ programs are time-limited grant-funded pilot programs that will end in either 2010 (Maryland) or 2011 (Pennsylvania and Texas). See Table B-1 for descriptive information about these six programs.

Table B-1
Six Other States Have Implemented Self-Directed Care Programs for Individuals with Mental Illnesses

Iowa

Start and end dates:

Enrollment began in May 2006 as a two-year pilot program and ended in 2008.

Number of participants and money received:

There were 36 participants who received up to \$2,000 over two years, with the average amount being \$1,299 per participant.

Funding source:

The state’s managed care contractor used funds available from its Medicaid contract for community reinvestment.

Administrative structure:

The state contracted with a managed care entity to be the fiscal intermediary and a local rehabilitation provider operated the program.

Program description:

Self-directed care was provided as a budget enhancement of an existing two-year, self directed Intensive Psychiatric Rehabilitation (IPR) program from which participants were selected. Participants could purchase goods and services not covered by Medicaid or available through existing community resources.

Program effectiveness:

A 2008 evaluation compared the self-directed care participants with the IPR groups and reported that

- self-directed participants showed more improvement in residential status, employment, and monthly earned income, suggesting that when participants are given a budget to direct their own care, they show enhanced improvements; and
- the groups were similar in their success in attaining other life goals and discharge from the program.

Maryland

Start and end dates:

The three-year pilot program began in 2007 and is expected to end in September 2010.

Number of participants and money received:

There are 50 participants who receive approximately \$3,000 while in the program.

Funding source:

Federal Mental Health Transformation Incentive Grant and state general revenue

Administrative structure:

A consumer-run organization is responsible for day-to-day program operations. The local mental health authority approves participants’ plans and acts as the financial manager (fiscal intermediary).

Program description:

The program, which operates in one county in the state, is an enhancement of the existing traditional mental health system for referred residents receiving services through the public mental health system. There is no time limit for participation; however, participants are generally in the program for 6 to 12 months. Participants use funds to pay for items and services not available through existing community resources. The program is considered a payer of last resort and does not pay for on-going living expenses. Participants’ budget amounts vary based on items identified in their plans as necessary to support ongoing progress in recovery. Some participants have reached their goals without using any self-directed care funds.

Program effectiveness:

The University of Maryland is currently evaluating the program to assess if participant satisfaction increases and costs are reduced.

Michigan

Start and end dates:

The program began in 2003 and remains on-going.

Number of participants and money received:

Because there is no set participant cap, the number of participants varies based on participant interest. Participant funding levels are based on the participant's previous year's public mental health expenditures.

Funding source:

Medicaid

Administrative structure:

Any community mental health program can offer mentally ill clients treatment through self-directed care. The state Medicaid manual establishes the policies for all mental health service programs including the option of self-directed care. Managed care entities serve as the fiscal intermediaries.

Program description:

Self-directed care currently is operating in two counties, but there is potential for statewide operation. The county mental health programs provide self-directed care as one of the services available to clients. Participants work with certified peer support counselors to develop plans and budgets to purchase services. All services purchased must meet the medically necessary criteria as outlined in the state's Medicaid policy.

Program effectiveness:

The state has not conducted a formal evaluation to assess the effectiveness of the program.

Oregon

Start and end dates:

The program began in 2004 and remains ongoing.

Number of participants and money received:

There are 25 participants who receive up to \$3,000 for one year.

Funding source:

State general revenue funds

Administrative structure:

The county contracts with a local non-profit organization to run the program.

Program description:

The program, which operates in one area of the state, uses 'brokers' to assist participants to develop plans, coordinate with community resources, and purchase non-traditional services and products to help towards their recovery and independence. After participants have received funding for one year, they may continue to work with brokers in planning their rehabilitation, but they are provided no further funds.

Program effectiveness:

There has been no formal evaluation of the program. However, data relating to employment, housing/residency, and incarcerations is collected at enrollment, midway through the program (6 months), and at the end (12 months).

Pennsylvania

Start and end dates:

The program began in February 2009 as a two-year pilot which is scheduled to end in 2011.

Number of participants and money received:

It is anticipated that 75 participants will receive up to \$7,500 for all traditional and non-traditional services over a two-year period. The budget is calculated on how much participants spent on traditional mental health services prior to program entry.

Funding source:

Traditional services are paid with Medicaid funding. Non-traditional services are paid from local community reinvestment funds.

Administrative structure:

The state managed care contractor for Medicaid behavioral health services acts as the fiscal intermediary and approves non-traditional expenditures. A non-profit citizen's organization is responsible for service delivery and program administration.

Program description:

The program is a component of the existing public mental health system for adults who use community mental health services on a regular basis, have not been recently hospitalized or considered a high-end user, and are legally competent to manage affairs. Actual participant budgets are based on historical costs for the participant from the previous two years. Recovery coaches are certified peer specialists covered by Medicaid.

Program effectiveness:

The University of Pennsylvania is conducting a two- year evaluation of 75 program participants and 75 individuals in a control group. Outcome measures will be assessed before, during, and after involvement in the program.

Texas**Start and end dates:**

The program began in spring 2009 as a two-year pilot program which is scheduled to end in 2011.

Number of participants and money received:

It is expected that 150 participants will receive \$4,000 per year for traditional and non-traditional services; however, the program has the discretion to allow up to \$7,000 for a participant per year on an exception basis.

Funding source:

A federal grant pays evaluation and administrative costs. Medicaid funding is used to pay for participants' traditional services, and non-traditional services are paid from a combination of a federal block grant, local funds, and state general revenue that has been reallocated from the existing mental health services budget.

Administrative structure:

The state contracts with a local behavioral authority to provide services. The managed care company for the service area is the fiscal intermediary for the program and manages the provider network.

Program description:

The program operates in a seven-county region of the state. Eligibility criteria include adults residing in the service area who are able to handle personal finances and are willing to be part of a research study.

Program effectiveness:

The University of Illinois at Chicago is conducting a study of 150 program participants and 150 individuals in a control group. Participant assessments will be done at intake, 12 months, and 24 months. Study outcomes are expected to include use of services, rehabilitation, improvement in functional impairment level, and quality of life.

Source: OPPAGA analysis of interviews with other states and other states' program materials.

Appendix C



State of Florida
Department of Children and Families

Charlie Crist
Governor

George H. Sheldon
Secretary

April 21, 2010

Gary R. VanLandingham, Ph.D., Director
Office of Program Policy Analysis and Government Accountability
111 West Madison Street
Room 312, Claude Pepper Building
Tallahassee, FL 32399-1475

Dear Dr. VanLandingham:

Thank you for sharing the Office of Program Policy Analysis and Government Accountability's (OPPAGA) preliminary findings and recommendations of its review of the Self-Directed Care (SDC) Program. It is clear that staff dedicated considerable time and expertise into understanding the needs and issues of individuals with mental illnesses and the principles of self-directed care.

The Department's Mental Health staff reviewed the draft findings and provided their comments to your staff directly. Those comments included the following:

- The discussion of the percentage of participant purchases for non-traditional services on pages 1 and 4 should be expanded to ensure that the reader is aware that, for participants who are Medicaid-eligible, 100% of their purchases may be used for non-traditional services.
- Services available outside of SDC for program recipients and those receiving traditional community services for adults were not included in the costs identified in Exhibit 6. Consequently, the footnote should not include the reference to residential services. The number of individuals in Self-Directed Care that also receive residential services is extremely limited.
- For comparison, it is recommended that the cost of Program Operations included in Exhibit 5 also be displayed separately for "*Traditional Community Services for Adults.*"

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

Dr. Gary VanLandingham
April 21, 2010
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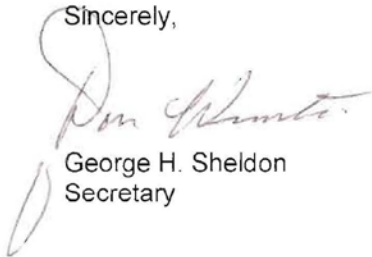
The Department agrees with OPPAGA's findings and recommendations concerning the need to improve accountability for the SDC Program. The Department has not yet been successful in our attempt to secure funding to create a data and payment system for the SDC Program. However, we have recently taken steps to address some of these identified concerns using other methods. The revised Self-Directed Care Purchasing Policies will improve program understanding and clarify purchasing requirements. Circuit 4 has also taken steps to improved data collection through their new 2009 SDC contract. In addition to data collection, the provider is focusing on retraining of Life Coaches to improve goal setting and evaluation.

The Department recognizes that additional controls will be needed to ensure there are clear contract expectations for measuring progress and reporting outcomes for program participants.

Finally, the report references similar programs from six states. Several of these programs modeled their program on Florida's SDC Program. However, if there are specific components that you believe should be incorporated into Florida's Program, it would be very helpful to have them identified in detail.

Again, thank you for the commitment and dedication that you and your staff have invested in the review of the Self-Directed Care Program. The Department looks forward to your final report.

Sincerely,

A handwritten signature in cursive script, appearing to read "George H. Sheldon".

George H. Sheldon
Secretary

The Florida Legislature

Office of Program Policy Analysis and Government Accountability



OPPAGA provides performance and accountability information about Florida government in several ways.

- Reports deliver program evaluation, policy analysis, and Sunset reviews of state programs to assist the Legislature in overseeing government operations, developing policy choices, and making Florida government better, faster, and cheaper.
- PolicyCasts, short narrated slide presentations, provide bottom-line briefings of findings and recommendations for select reports.
- Government Program Summaries (GPS), an online encyclopedia, www.oppaga.state.fl.us/government, provides descriptive, evaluative, and performance information on more than 200 Florida state government programs.
- The [Florida Monitor Weekly](#), an electronic newsletter, delivers brief announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.
- Visit OPPAGA's website at www.oppaga.state.fl.us

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