A Model for Mental Health Outpatient Care

Raymond N. Tuller
Volunteers of America of Florida

Jeffrey Watts
Florida Department of Children and Families

Abstract

The need to live independently and successfully in the community is challenging for individuals with severe and persistent mental illness. A partnership between a State agency and a faith-based provider created a new momentum in mental health care for persons experiencing mental illness. Services were focused to support specific outcomes. Since 2005, the service model has operated successfully in three Florida cities, and the provider has met all outcomes. Legally compliant behaviors and mental health symptom management have been evidenced consistently among the individuals served affording them more days in the community, and an enhanced life quality.

Introduction

Mental health is used to monitor the health of the nation, and estimates suggest that one in every four Americans will experience mental illness during their lifetime (Kessler, Chiu, Demler & Walters, 2005). Mental illness is a complex, non-linear condition marked by periods of positive growth as well as setbacks. The prevalence of mental illness, particularly for individuals who experience severe, persistent and chronic symptoms, makes it a critical service area for communities across the nation.

Current models for mental health have been less than successful in addressing this social need. Traditional service delivery was challenged and mental health advocates suggested individuals be empowered to make choices and decisions while participating actively in establishing their life goals and service needs (Achieving the Promise, 2003). This paper describes a breakthrough model for outpatient mental health care that places the individual at the center of all services, operates in partnership, and applies payment for performance.

Self-Determination and Recovery

Empowerment or self-determination refers to individuals making choices based on personal preferences concerning their life roles (Fisher, 2008; Cook & Jonikas, 2002; Ryan & Deci, 2000). For persons with severe and persistent mental illness, the opportunity to make choices has not been encouraged by traditional systems of mental health care. The traditional system managed and monitored individuals with a prescriptive, directive approach where individuals were informed and influenced strongly in the choices guiding their care and well-being (Achieving the Promise, 2003). Self-determination reset the role, engagement, and expectations among persons experiencing mental illness. Individuals became involved in their recovery by voicing their goals and the conditions under which a successful recovery would occur.

Supporting individuals in achieving their self-determined goals necessitated a broad framework. In 2006, the Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) offered an outcome framework for individuals striving to attain and sustain recovery. The outcomes offered structure to support individuals striving to live, learn and participate fully in a community (SAMHSA, 2006). The national outcomes were intended to improve services for persons with co-occurring disorders and to improve their ability to attain housing stability, health care, employment, and education. The outcomes also underscored the importance of using evidence-based practices and cost effectiveness to assure quality services to persons experiencing the symptoms of mental illness.

To attain the outcomes, nationally recognized best practices for the treatment of persons with severe and persistent mental illness were reviewed. Three best practices

were identified to support the outcomes: motivational interviewing, individual therapeutic behavioral contracting, and intentional care. The practices were adapted from the American Psychological Association identification of effective approaches for persons with co-occurring disorders (APA, 2007). Each practice has an evidence-based history with demonstrated successful applications in programs supporting individuals with severe and persistent mental illness.

Motivational Interviewing

Motivational interviewing is a clinical process that respects the choices and preferences of the individual while offering alternative choices and their associated favorable consequences. The process allows choices and preferences to be evaluated in relation to goals. It contrasts healthy choices and their consequences with options that are not aligned with the individual's expressed goal. The result of the process is the development of clear goals. Customized and highly individualized, a treatment plan is developed to reach the individual's goals including those relating to stable housing, improved health, employment, as well as other meaningful activity. The result is the development of an individual therapeutic behavioral contract that forms the basis of how the individual will direct attention and efforts during the program.

Therapeutic Contract

The therapeutic contract is a compelling agreement between the case manager and the individual to share responsibility for the attainment of personal objectives. The plan documents goals, the target date for goal completion, and concludes with a signed agreement to work toward the goals. It is a living document and responds to the person's need to review and modify goals. In this way, the person remains involved in a feedback

loop allowing regular, authentic evaluations of progress toward desired outcomes. The plan also recognizes that change occurs slowly, and behaviors modify incrementally. The plan sets the goals which are then broken down into small, attainable behaviors. When sequenced over time, the incremental behavior modifications create successful steps to goal attainment. The contract reflects both the incremental behaviors and the outcomes sought by the individual.

Intentional Care

Intentional care is directed toward explicit outcomes, and progress on these outcomes is regularly assessed by the individual, the provider and the State partner. Intentional care references the tools and standards to support individual recovery. Staff are trained and supported in their use of assessments, and outcome information is used as decision support to modify contracts in relation to individual progress. This practice of using results supports outcome attainment, informs organizational planning, and forms the basis of continuous quality improvement at all levels of operation.

Rehabilitation Support

These practices and the related treatment services are supplemented by rehabilitation services that support individuals in their striving toward meaningful activity, volunteer opportunities, skill and training development, and employment. Work is important not only because it provides an economic basis for self-sufficiency, it also affirms individual dignity, requires regular, responsible behaviors, and offers an opportunity to make a meaningful contribution to society (Tsang, 2001). For persons with severe mental illness, employment is a critical part of their recovery process.

For decades, adults with severe mental illness were unemployed and dependent on public entitlements for both income and health care. Unfortunately, ineffective programs, inadequate education, and a dearth of best-practices on the relationship between clinical services and vocational rehabilitation were among the reasons for limited activity in this area of service. Currently, rehabilitation and workforce support has been improved from entry skills to assist individuals develop social skills with a focus on interpersonal communications, to basic job readiness and survival skills such as personal appearance resume writing, interview preparation, and then to general skills for managing employment responsibilities. This incremental process is based on an assessment of the interests, skills and aptitudes of the individuals striving for recovery.

Program Goals

Programs that develop a clear vision for outcomes and sustainability have distinct advantages. In the outpatient behavioral health care model, performance objectives are negotiated with State representatives to customize the service. In 2007, the faith-based provider accepted two service agreements with objectives primarily targeting improved functioning and economic self-sufficiency among persons with severe and persistent mental illness.

The goals of programs may be adapted to accommodate the needs of diverse special needs populations and the partners providing the service. What is critical is a clear agreement on outcomes, and an information system to provide regular, recurring reports of progress. The alignment of the service goals to the reporting of results, and the service payment are the distinguishing qualities of this flexible model.

A contractual agreement for mental health services was based on the provider achieving clear outcomes. The payment for performance resulted in total payment for achievement of all contracted outcomes. Payment was reduced proportionally for each outcome not attained monthly such that non-performance on the outcomes produced no service payment. The following is a sample set of outcomes: (a) Individuals will demonstrate annualized days worked will be 45 or greater; (b) Individuals will demonstrate annualized days in the community will be 358 or greater; (c) Individuals will achieve stability in housing at ninety percent (90%) housing occupancy on a monthly basis; and (d) Thirty-two percent (32%) of the individuals receiving services will be employed or volunteering or attending a certified school or training program.

Program Implementation

To implement a person-centered approach to mental health, partnerships and new alliances formed to strengthen services for persons with mental illness. States and faith-based providers responded to this national call with strong leadership, and a clear approach to outpatient mental health care. Self-determination underscored the recovery process creating a dynamic, collaborative relationship between individuals receiving services and the professionals supporting their recovery. Grounded in common values and principles, the Florida Department of Children and Families and Volunteers of America of Florida recognized their ability to provide mental health services with an effective, integrated approach to role recovery.

In Florida, the Department of Children and Families protects vulnerable citizens, promotes economically self-sufficient families, and advances mental health recovery and resiliency. This role is part of a broader State mission to transform publicly funded

mental health to a consumer-driven service. The service recognizes individuals as active managers in identifying recovery goals, and targets days spent in the community as a primary outcome for persons with severe, persistent and chronic mental illness. Mental health staff provide treatment and rehabilitation services to support the decisions of each individual. Recovery and resilience are individually defined (Florida Department of Children and Families, 2007).

The faith-based provider is Volunteers of America of Florida, a non-profit, faith-based agency operating affordable housing while providing mental health and employment services. The provider reaches more than 4,500 persons annually through outreach and services. The provider operates from a mission of life-long learning and inspiring individuals to become contributing members of society.

Volunteers of America of Florida incorporates the fundamental components of role recovery in service delivery. As a result, individuals are supported to reach their optimal level of self-sufficiency and integration into the community. Individuals move from receiving service to helping others, and become an example of what role recovery can do. The organization seeks to empower individuals by enabling them to make decisions about their recovery. Role recovery includes the components of self direction, empowerment, peer support, respect, responsibility, and hope. These components are detailed in Appendix A.

The faith-based provider has a multi-disciplinary team approach that blends three specialized areas to better assist persons with mental illness, substance use, and both. The three areas are (a) housing, (b) health care, and (c) training, education and employment. Staff recognizes the importance of collaboration to assist individuals in

their attainment of stable housing, improved mental health, and economic self-sufficiency. The role recovery approach incorporates motivational interviewing, individualized contracts, and intentional care implemented by a professional staff with licensure and credentials in mental health and substance abuse service, and advanced formal study of social work, psychology, vocational rehabilitation and psychiatry. Experienced clinicians supervise staff. Appendix B contains descriptions of these three lines of service.

Since 2005, the outcome-based health care services have been offered in three Florida cities with service to 130 disabled adults. Participating adults are referred through community mental health care centers, local homeless organizations, and public assistance agencies. Services are projected to double with expansion to three additional cities in 2008. Table 1 shows key activities from 2005-2007.

Table 1: Implementation Timeline

Activity	*Year*	2005	2006		2007	
	Dates	7/1-12/31	1/1-6/31	7/1-12/31	1/1-6/31	7/1-present
Identify service outcomes						
Performance contracting						
Contract tracking						
Staff training						
Collect/apply data						

Performance-Based Payment

The outpatient behavioral health care service operates with a set of values that place the individual at the center of all activities and outcomes. The service contract agreement is structured to provide incremental financial rewards to the health care provider based on the number of outcomes achieved. The monthly attainment of all outcomes produces a payment of 100%; however with each reduction in outcome achievement there is a

proportional reduction in service payment. Consequently, there would be no payment for services in a month where outcomes were not accomplished. This is a radical approach to service, and a guarantee of service satisfaction to the State.

Research Objectives

The objective for the mental health care model is to attain the contractual performance objectives. The current operating objectives improve participant (a) independence and stabilization, (b) engagement in training, education and employment, and (c) satisfaction with quality of life. Performance is quantified by six metrics that are assessed monthly to determine participant progress and service payment. The model allows for flexible objectives to address the priority needs of the service recipients. The methods are detailed in Appendix C.

Findings

The findings include qualitative reports from staff and quantitative results to evidence the provider's ability to accomplishment the contractual outcomes. Since the implementation of the model, staff has been challenged to allow participants to offer guidance, become empowered, and take responsibility for their personal recovery. Staff training begins at orientation and is continued through regular meetings. Staff works collaboratively with service recipients to determine the goals of each individual.

During focus groups with staff, they identified clear advantages of the outcome health care model. Specifically, staff noted that the outcomes are clearly communicated, refreshed monthly, posted in common areas, and discussed at weekly staff meetings to target improvement areas. They reported the use of outcome data to improve services, modify individual behavioral contract, and to improve the life quality of persons

participating in the program. Expressed in a clear, timely, and relevant format, the outcomes served to inform staff of their program's progress on the outcomes. Before weekly staff meetings, the team leader reviews the program status on the outcomes with an emphasis on reinforcing areas of success, and strategizing for improvements. According to team leaders, the outcomes model has successfully placed timely results where they may have the most critical influence.

Second, staff and organizational decision-makers reported a clear sense of direction and priorities. Employees are trained in the outcomes as a focal point of their professional role. Staff applies analytical techniques, such as root cause analysis, to probe and examine carefully outcomes that are not performing at the targeted level. Staff values the opportunity to discuss the results of effective therapeutic practices and the favorable impact they had on individuals and on program outcomes. These meetings create a strong backbone for planning and evaluation at the organizational level since positive and negative trends for each program are aggregated to reflect organizational performance.

Finally, organizational decision-makers review performance during quality team meetings and have the opportunity to emphasize the need to maintain high performance while lending oversight to improvement planning. Control charts are used to show average performance and variation expressed in the six sigma approach to operational management. This approach enables variation to be identified and stimulates action planning for results that fall outside the band of standard deviation from the average performance.

The provider has invested recently in an electronic records management system to provide access to real-time information. The system will offer a standardized menu of

input and allow a more efficient capacity to report on critical trends in admissions, assessment, treatment, and outcomes. Within a year, the program and organizational level staff will have improved access and ability to apply information providing more timely decision support.

Performance on the contract outcomes is summarized and presented monthly for all staff. Based on data spanning a 12 month period, the provider has met the State contractual outcomes for 100% of the implementation period. The objectives stipulated that 98% of the participants evidence legally compliant behaviors, and 97.5% manage mental health symptoms such that hospitalization was not necessary. Prior to the program, 97% of the participants were attaining these two objectives consistently. Since the service agreement with the state, both objectives have been met by more than 98% of the participants as shown in Table 2.

Table 2: Target, Pre- and Post Performance for Legal Compliance and Symptom Management

Behavior	Performance target	Pre-Implementation	Post-Implementation
1. Legally compliant	98.0%	97.0%	98.2%
2. Symptoms managed	97.5%	97.2%	98.6%

Monthly trends in participant progress are illustrated in Figures 1 and 2. Figure 1 shows the percent of participants extending days in the community with legally compliant behavior. The figure also shows the stability of performance during the later six months when compared to the earlier six months. This same trend is evident in Figure 2. Figure 2 shows the percent of individuals with extended days in the community and the avoidance of hospitalization. Both outcomes are key indicators for the goal to maximize the number of days individuals spend in the community.

Figure 1: Trends in Days Spent in the Community:
Percent of Individuals Who Did Not Require Incarceration

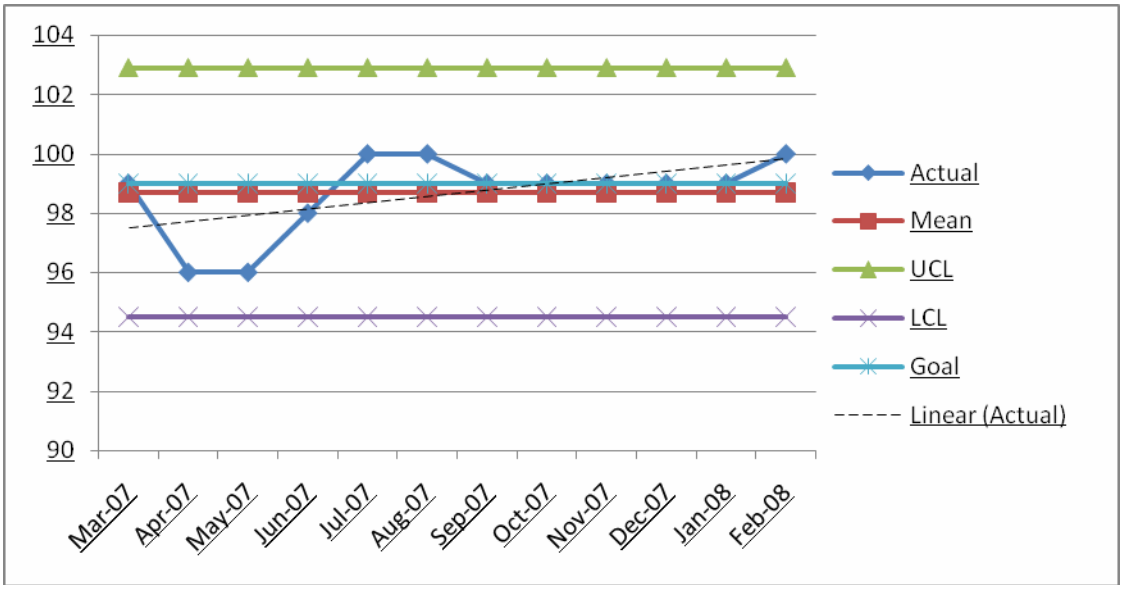
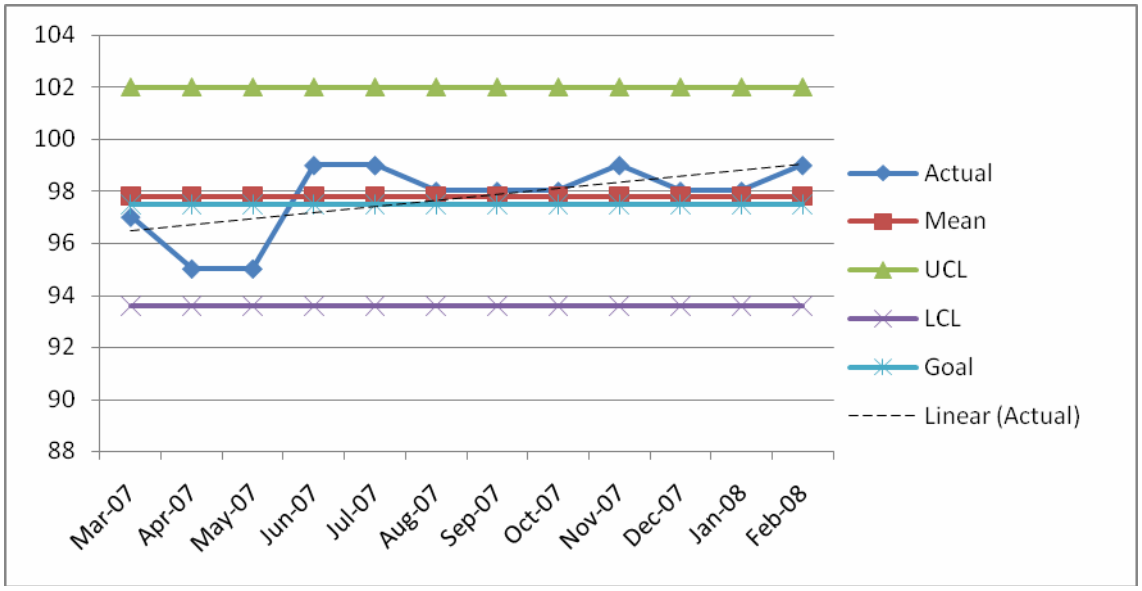


Figure 2: Trends in Days Spent in the Community:
Percent of Individuals Who Did Not Require Hospitalization



In addition to outcomes for stable housing and days spent in the community, progress on indices of work-related and social activities is also assessed. In a comparison of

participant results before and after the program, all measures triangulated to support evidence of progress toward economic self-sufficiency. Table 3 below shows these results.

Table 3: Pre- and Post Measures of Meaningful Activity, Volunteer Activity and Employment

Outcome	Pre	Post	Difference
Engaged in meaningful activity	92.4%	98.5%	6.1%
Engaged in volunteer activity	37.1%	44.0%	6.9%
Employed, full-time	12.7%	15.2%	2.5%
Education program enrollment, full-time	5.9%	6.2%	0.3%

Pre-contract data from 11/06-04/07; post-contract data from 05/07-10/07.

Discussion

The partnership between the State agency and the local provider redefined the quality of services by specifying clear outcomes and using a performance based payment agreement. The agreement provides a universal design for all providers who deliver services to special needs populations and value the use of information to inform decisions. Clear outcomes are essential to guide health service quality. They provide a common set of metrics to inform self-assessment at multiple levels, including the individual service recipient, staff, program personnel, provider organization, and the funding partners. As responsibility to strengthen communities continues to be addressed by faith-based, local providers, the significance of partnerships, agreement on clear outcomes, and payment contingent on performance, and will continue to serve as guideposts for effective services. As service accountability continues to be a hallmark of effective services, providers who contract with clear outcomes and agree to performance-based payment will model effective social services.

Implications

Faith-based organizations will become more instrumental and increasingly accountable as community service providers. As accountable providers, the mental health outpatient model may be applied to address a broad range of social needs including welfare assistance, workforce development, safe and affordable housing, and mental health care. The combination of clear outcomes and performance-based payment provides a useful and successful approach to outpatient care. The model places participant goals at the center of the service and delivers cost-efficient care to meet the needs of disabled Floridians.

References

Achieving the Promise: Transforming mental health care in America. (2003). President's New Freedom Commissions on Mental Health, Michael F. Hogan, Chairman, www.mentalhealthcommission.gov/

APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance. (2007). Catalog of Clinical Training Opportunities: Best practices for recovery and improved outcomes for people with serious mental illness, Version 2.0. www.apa.org/practice/grid.html

Cook, J. A. and Jonikas, J. A. (2002). Self-determination among mental health consumers and survivors: Using lessons from the past to guide the future. *Journal of Disability Policy Studies*. 13 (2), 87-98.

Cook, J. A., Jonikas, J.A. and Solomon, M. L. (1992). Models of vocational rehabilitation for youth and adults with severe mental illness: Implications for AMERICA 2000 and ADA – Americans with Disabilities Act. *American Rehabilitation*, Fall, 1992.

Florida Department of Children and Families. (2007). Role recovery for behavioral health. Suncoast Region, Florida Department of Children and Families, Tallahassee, FL.

Fisher, D. L. (2008). A new vision of recovery. National Empowerment Center, Incorporated. www.power2u.org

Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun; 62(6):617-27.

Ryan, R. M. and Deci. E. L. (2000). Self-determination: Theory and the facilitation of intrinsic motivation, social development and well-being. America Psychologist, 55(10), 68-78.

Substance Abuse and Mental Health Administration [SAMHSA]. (2006). National outcome measures for co-occurring disorders. Health and Human Services, Substance Abuse and Mental Health Administration. www.oas.samhsa.gov/

Tsang, H.W.H. (2001). Rehab Rounds: Social skills training to help mentally ill persons find and keep a job. *Psychiatric Services*, 52, 891-894.

Appendix A
The Components of Recovery

1) Self Direction. Volunteers of America encourages the individual to look at the lost roles in their lives that they may need help regaining. Staff in partnership with the individual creates a life plan to achieve this goal; with the participant writing the goals they wish to work on as well as the steps toward working on that goal. Each individual is unique in experiences, history, and relationships, and as a result the recovery process needs to be self directed, as evidenced by their life plan. The individual is not directed by staff, but guides the staff in identifying areas to look at and work on during role recovery. Participants' surveys allow them to rate how happy they are with the core areas of their life. The data is used as a tool to identify areas the individual may choose to improve. The gathered information helps to format life plans, where the individual writes goals and monthly steps to achieve these goals. This serves to optimize individual autonomy.

2) Individualized and Person Centered. Not all individuals will choose to work on similar areas, nor will each person chose the same process in dealing with problem areas. No two individuals are alike and with this in mind each person will chose the process to recovery they wish to pursue. The focus is on the individual's unique strengths, and resiliencies, taking into account the individual's preferences, experiences, and cultural background. The agency takes into consideration how cultural backgrounds influence the decision making of the individual. This has occurred locally where staff has had to consider the person's culture and beliefs to better understand interactions and responses to various situations. Staff is cautioned not to make conclusions based on their belief system, but consider the individual's background and culture. Some individuals have had a history of trauma where staff has offered a supportive environment where the person can recant and vent, while being treated with respect. Activities of daily living are addressed on an individual basis, because not every one has the same ability to care for self and environment. Some require repeated reinforcement to improve these skills.

3) Empowerment. The individual is empowered to participate in all decisions, and is offered education and support in making these decisions. Individuals are given information on issues so that they can make informed decisions, empowering them to make choices perhaps, for the first time in their life. On occasions, staff role play with individuals to identify better ways to deal with areas of concern, e.g. conflict, dealing with authority figures, and learning assertiveness skills. Those who have problems with their medications are encouraged to speak with the prescriber about concerns. Staff will be available to accompany them to appointments to provide support and encouragement. Options on medical decisions are discussed with individuals to improve their understanding of the choices they may have in dealing with both mental and physical issues. Individuals have been guided to better budget their resources and assisted in

starting savings and checking accounts. This often elicits a sense of pride since many have never been empowered to deal with their own financial resources. Consumers are made aware of and encouraged to complete an advance directive so their wishes are followed if they are unable to express them.

4) Holistic. The entire individual is considered, including mind, body, spirit, and sense of community. Individuals are given staff support to deal with legal issues including probation and court appearances. Employment groups offer assistance to deal with issues surrounding employment including writing resumes, completing applications, role play interviews, and dealing with bosses, co-workers, and stress in the work place. Volunteers offer a Bible study for those wishing to attend. Individuals are encouraged to attend a church of their choice to increase social outlets and a sense of growth as a whole person. Substance abuse groups are provided for those dealing with an addiction history. Individuals are encouraged to increase educational levels, which may include getting their GED, training, or college.

5) Non-Linear. Recovery is not a linear process; rather it often includes setbacks and learning from experience. The staff offers support, understanding, and education to those individuals who face set backs in their recovery. Life plans are reviewed on monthly basis with the participant writing their progress during the month, with the opportunity to change goals and steps. Training is provided in multiple areas where individuals often face set backs, e.g. hygiene, maintaining apartments, and budgeting. Participants are encouraged to progress and to move to affordable housing in the community. However, there are times when individuals may have setbacks and require closer monitoring and support. Participants and staff are reminded that growth is not always smooth. There are set backs, which provide a chance to learn from the situation, rather than be viewed as a defeat.

6) Strength based. The services are based on the resiliencies, talents, coping abilities and self worth of the individual. Staff offers support and understanding to identify strengths the individual may not have considered. This allows what may have viewed as a negative characteristic to be considered a positive one which the individual may use as a tool for recovery.

7) Peer Support. Included in the services are peer support groups which provide an environment of mutual support, where individuals can interact with peers to experience a sense of belonging and community. The agency offers a non judgmental environment which welcomes both the participant and family. The individual is encouraged to work on self acceptance and to advocate for protecting everyone's rights and to help eliminate discrimination and stigma. Multi- common areas are provided where individuals are comfortable to interact with peers. These include the drop in center, community rooms, outside sitting and even chairs in front of the apartments which allow the individuals to have interactions without being constrained. Community meetings offer an environment where peers may share concerns, and organize plans for the community as a whole.

8) Respect. Interactions with staff focus on the individual's goals and dreams and consider the mental illness as a challenge, rather than what defines the person. Individuals are encouraged to routinely speak up for their desires and goals, e.g. daily contacts, and monthly life plan reviews. Respect and consideration for peers is reinforced with behavior guidelines in the drop in center, and rules for the residential settings Staff provides examples of respect by education and modeling, through their own interactions with consumers, both in individuals and group settings.

9) Responsibility. The individual is encouraged to take responsibility for his or her own self care and recovery. This can be a gradual process of owning the outcomes of decisions they have made. The idea that rights also come with responsibilities is reinforced with participants. Staff help participants identify options and the responsibilities that come with each choice. Participants learn that to be independent means being responsible for things such as paying rent, shopping, and cooking. These are areas they may have neglected in the past.

10) Hope. Hope is offered in the message of a better future, where the individual can overcome barriers and obstacles. The staff bolsters the individual to focus on this ability to live, work, learn, and fully participate in our society. The participants are encouraged to look at the process of admission not as an end but a beginning to regain a positive life experience. The empowerments of the individual offer hope and vision to build and participate in life's decisions. Staff often reframes overwhelming situations to allow the participant to see and feel there is hope. Due to the number of set backs the individual may have faced over the years, it is imperative that a continued sense of hope is provided.

Appendix B
Housing, Health and Employment Services

A brief explanation of the housing, health and employment services offered to participants follows.

Housing services concentrate on the provision of safe and affordable housing in Florida communities where the need is pressing and community partners invite the faith-based provider to create permanent or transitional living arrangements. This service is staffed with resident managers who oversee rental payment, and offer a safe, non-threatening living environment. Housing staff work closely with the health services personnel to create therapeutic housing communities, maximize occupancy, and intake individuals motivated to advance their self-sufficiency skills.

Health services include motivational case management, housing retention, support for independent living skill attainment, crisis intervention and care, assistance with entitlements, mental health care and treatment, substance abuse treatment, and management of prescription medications. Mental health professionals, with specialized licensure and credentials, work consistently to enable individuals with mental illness to meet their goals. The health services staff manages the intake process in collaboration with the housing staff. The intake process is comprehensive, multi-faceted, and engages all stakeholders in the housing placement decision.

Employment is the third service area. This area of service is critical to the attainment of self-sufficiency. With poverty underlying the condition of the homeless, and further challenging the resources for persons with mentally illness and substance abuse, employment, education and training are essential to role recovery. This rehabilitative service advances employment, training and education through an array of learning opportunities from voluntary meaningful activity to employment and earned income. Additional venues to advance recipients' skills include 24/7 on-line, self-paced learning modules, employment readiness courses, and apprenticeship programs in entry level trade positions. Individuals are assessed to determine their interests, strengths, work history, skills and aptitude. The goal is to support the individual in his/her management of mental health symptoms and capacity to learn and live within the context of community.

Appendix C
Methodology Notes

Methodology. Participants are aged 18 or older, and qualify for affordable housing based on low income. The majority of participants (71 percent) are females. Participants have an ethnic background comparable to all Floridians with 16 percent African-American, 21 percent Hispanic, and 63 percent Caucasian. The table below shows the average number of consumers in three program sites in Florida.

Number of Individuals by Program Location

Location	Quarterly Participation, 2007			
	Winter	Spring	Summer	Fall
Hillsborough	79	80	83	80
Manatee	41	40	40	43
Sebring	NA	NA	NA	28
Total	120	120	123	151

Participant data were sourced in a written life plan with clear behavioral objectives. These data are collected by direct care staff that update participant records monthly and upload to a quality management system. The system manager tracks progress and outputs statistical control charts to guide housing, health and employment coordination among team leaders.

Outcomes were based in three categories: (1) increased functioning (decrease in incarcerations, decrease in psychiatric hospitalizations); (2) increased self-sufficiency (training, education and/or employment activity); and (3) increased participant satisfaction.