Brief Critical Time Intervention (B-CTI)

Program Manual

OPAL

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Introduction

CTI is an innovative case management model that was originally developed to prevent homelessness and other adverse outcomes among vulnerable people during periods of significant life transition. During such periods, which may include the transition from shelters, hospitals, jails and prisons into the community, vulnerable people often have difficulty re-establishing themselves with access to needed supports. This, in turn, places them at risk of ongoing instability and return to homelessness, re-institutionalization and other adverse outcomes. CTI provides direct emotional and practical assistance during the critical time of transition and strengthens individuals' ties to services and ongoing social supports. Despite its time-limited approach, CTI exerts a long-term impact by effectively building enduring connections to sources of support that remain in place after the intervention ends.

Originally tested with chronically homeless mentally ill shelter residents using a nine-month model, it has since been adapted for use with various populations in a wide variety of settings employing varying durations of service. A brief three-month model (B-CTI) was developed and tested to enhance continuity of care among high-need behavioral health consumers following discharge from acute psychiatric care.
For the current effort, we further modified B-CTI to assist patients with schizophrenia and co-morbid health conditions in making the transition from hospital inpatient units to outpatient services and community supports. This manual describes the adapted B-CTI model.

B-CTI Model

The B-CTI care manager's mission is to help the patient effectively navigate the post-hospitalization period so that he or she successfully engages in needed services and supports intended to prevent re-hospitalization and other adverse outcomes. The care manager does this through identifying patients' needs and building on their strengths and capacities to successfully link them to services and supports that will persist after the care manager withdraws. Since the intervention is brief, it is important the care manager and patient together decide on a relatively small number of needs on which to focus the work; these should be those that are seen as most important to ensuring continuity of access to needed medical and psychiatric care. B-CTI is delivered in three phases: **1) Engagement; 2) Transition and Linkage; and 3) Transfer of Care**. A hallmark of CTI is that the level of intensity of contact between the care manager and the consumer diminishes over time as the patient's connection to ongoing sources of support grows.

Phase 1: Engagement

The care manager meets with the patient prior to discharge from the hospital, in order to begin building rapport and appraising needs. This face-to-face meeting should ideally take place within 24 hours (one business day) of admission or referral to the CTI team and should be coordinated with the inpatient clinical team to ensure that the timing of the meeting is appropriate. The purpose of this meeting is to begin to form a personal relationship between the care manager and the patient and to help the patient begin to identify priorities for the post-discharge period. This should

include reviewing with the patient potential barriers to successfully engaging in follow-up care including unmet social needs such as housing instability, benefit disruptions, transportation needs, etc.

The care manager should obtain the hospital discharge plan, medication plan and aftercare appointment plan before the client is discharged. This may involve communication with the inpatient treatment team, hospital care managers or the psychiatric consultation liaison team.

Phase 2: Transition and Linkage

Phase two represents the most active phase in the intervention and requires significant face-to-face contact in the community with the patient and members of his or her support system. The goals are to both provide direct emotional and practical support while at the same time ensuring that the patient is effectively connected with services and supports that will be sustained after CTI ends.

During this phase, the CTI care manager will also refine his/her understanding of the patient's needs and capacities by directly observing his/her interactions in the community. The care manager simultaneously observes the capacity of key services and supports to effectively meet the patient's evolving needs.

The care manager should meet the patient at the hospital on the day of discharge in order to assist with transfer home, as appropriate.

After discharge the care manager maintains regular in-person and telephone contact with the patient, visits him/her in his/her residence, continues assessment and care plan development, coordinates care with identified providers, and meets with people who support the patients' treatment and wellbeing. These other providers may include housing care managers, health home care coordinators, ACT teams, etc.

Medical Appointments

If needed, the care manager will directly assist in helping to schedule initial treatment appointments and, with the patient's permission, attend appointments in order to help the patient make solid initial connections with outpatient healthcare treatment providers. **Initial medical and psychiatric follow-up appointments typically should occur within seven days of discharge.** The care manager should learn the outcome of these visits in order to ensure that they are aware of any needed follow-up (including bloodwork) and can help to facilitate as needed.

Transportation

Identifying transportation barriers, developing transportation plans, assisting with transportation to aftercare appointments and community resources is an important priority for many patients.

Housing

Identifying housing barriers and supporting participants with seeking housing assistance may be critical to ensuring that patients are able to effectively make use of needed psychiatric and health services. If the patient is being discharged to an existing housing arrangement, it is important for the care manager to carefully assess whether this setting will continue to meet the patient's needs. Additional supports may need to be put in place (homemaker services for example) or housing alternatives may need to be sought. For patients who are residentially unstable or homeless, the care manager may have to help the patient obtain temporary housing while longer-term options are identified.

Family
With the patient's permission, the care manager should engage with the patient's family so that, where appropriate, the family members can be mobilized in order to assist the patient in making use of needed services and supports. They may also benefit from education about the patient's condition in order to maximize their understanding of the patient's needs and ways that they may be helpful.

Social Integration
In order to maximize patient's quality of life, involvement in activities beyond simply receiving needed medical care is paramount. Depending on the patient's preferences and capacities, the care manager should assist the patient in pursuing involvement in employment, volunteering, recreation, and other activities that combat isolation and enhance social integration.

Phase 3: Transfer of Care
In the final phase, the care manager continues *in vivo* assessment of the patient's treatment and service needs and ongoing collaboration with the patient and key caregivers (family, friends, professionals) to fine tune the various supports and treatments identified and implemented during phase two. Assuming that effective linkages and supports are in place, this permits the care manager to reduce the number of face-to-face contacts required. Priority is placed on strengthening the patient's skills and sense of autonomy in managing service engagement and use. However, the care manager must continue to be available as needed when additional assistance is needed or when existing linkages and plans are not operating as expected and require modification.

Given B-CTI's time-limited design it is important to adhere to timelines for transferring care, even for challenging transitions or when participants have developed strong alliances with the B-CTI providers.

As this phase nears its end, for patients who have Medicaid, the care manager should **organize a final treatment planning meeting between the patient and the MCO care manager** who will be involved in supporting his/her future care. At this time, the care manager should be prepared to communicate (particularly for highest-need participants) whether participants can transfer to Health Home, Health Home Plus, or

ACT team, and to coordinate with the MCO care manager to identify which provider/agency will provide on-going care.

Planning for this meeting should begin early enough in order to ensure that it can be carried out within the required timeframe. During this meeting, the care manager should provide a summary of progress to date as well as identify ongoing patient needs, key support resources, and expected challenges. This should include providing treatment plan forms and documentation that will be important for ensuring ongoing continuity of care (e.g., medication lists) including contact information for the participant's treatment providers and other key individuals supporting the participant (e.g., family).
Ideally, the care manager should also conduct an ending conversation with other key members of the patient's support system including therapists, family members, housing counselors, etc. Given the logistical challenges involved in organizing face-to-face meetings, these may be accomplished via telephone.

NOTE: Sharing of Information with other providers
In order to facilitate care managers' ability to obtain and share information with other providers, they should seek clients' permission to share the study consent from with other providers. In some cases, providers will have their own consent for release of information forms; in these cases, the care manager can facilitate clients' sign-off on these. It is also important for workers to understand that, regardless of frequent misconceptions about HIPAA requirements, a signed release of information form is not technically needed for any member of the treatment/care team to share information with other treatment/care team members regardless of whether members work at different facilities (i.e., mental health providers, medical providers, hospital staff). In fact, HIPAA expressly permits this sharing of information (the sole exception is to share information related to substance use treatment for which written patient consent is required). If disagreements with other providers emerge about the permissibility of information sharing, care managers should discuss these cases with the team supervisor.

Focus Areas
Care managers and patients should jointly identify a limited number of target areas on which to focus the work during phases two and three. While these areas may remain the same between phases, they may also shift somewhat. It is essential that the worker's efforts are not spread too thin and the emphasis remains on meeting the primary outcomes of the program ensuring effective connections to community-based medical and behavioral health care and reducing the risk of readmission to the hospital within the first week and month following discharge.

For most patients, these will be drawn from the following "menu" of focus areas: (a) Continuity of Integrated Medical and Psychiatric Care; (b) Sustaining Motivation in Substance Abuse Treatment; (c) Medication Adherence; (d) Family Involvement/Social Network Support; (e) Housing and Income; and (g) Practical Needs Assistance. Ongoing assessment of need in each area is conducted to inform the initial CTI service plan and one subsequent updated treatment plan as the client moves from phase 2 to phase 3. In addition to prioritizing Continuity of Medical Care, an additional two or three

foci are generally selected for targeted assistance, depending on patient needs and priorities. The typical target areas are detailed below.

Continuity of Integrated Medical & Psychiatric Care
Clients with both schizophrenia and a chronic medical condition are especially vulnerable to gaps in care due to wide range of causes including complicated medication regimens, confusing and sometimes conflicting information from providers, difficulties with transportation to multiple appointments, and cognitive difficulties that make it harder to problem solve and follow directions. Care managers will prioritize activities that:

- Coordinate care for medical issues, including providing referrals to community medical providers, scheduling appointments, and liaising with medical providers to obtain patients' records;
- Facilitate communication between the client, medical, and mental health providers
- Ensure medication adherence;
- Ensure attendance at community-based appointments;

<u>Specific activities care managers will pursue could include:</u>

- Meet with the client in the hospital prior to discharge to home to facilitate and support the discharge process
- Communicate with the hospital inpatient staff to coordinate discharge planning and aftercare follow-up
- Regular meetings in the community, including at the client's place of residence, to accomplish the planning and coordination to accomplish these goals
- Helping the client prepare a Health Record (see appendix) outlining his/her current problem list, medications, and concerns to present to providers at each appointment;
- Accompanying client to appointments if necessary to ensure attendance
- Following up before and after appointments with the client to ensure compliance
- Contacting medical providers to offer support in coordinating integrated care;
- Helping the client adhere to prescribed medical regimens and maintain related health behaviors;
- Helping the member play a more active role in the self-management of his health;
- Encouraging member to adapt a healthier diet and activity level; and
- Facilitating a "warm hand-off" to a Health Home or other community-based care manager upon the completion of the 3-month period of care management.

The care manager will document all service planning, collaborative goal setting, linkage, advocacy and mediation activities carried out with and on behalf of the client and will participate in training and supervision activities with other care manager and supervisors.

Sustaining Motivation in Substance Abuse Treatment and other Behavioral Change

- Helping the patient address any substance-related treatment needs, emphasizing engagement in ongoing treatment.
- Assisting and supporting the patient in changing other problematic behaviors.

Specific activities care managers will pursue could include:

- Acknowledging stages of change
- Conducting motivational interviews to help the patient identify and enhance his/her readiness to change harmful addictive behaviors
- Providing basic psychoeducation regarding substance use, its effects on psychiatric symptoms, and its interactions with psychiatric medications
- Facilitating patients' longer-term engagement in substance abuse related services; and employing a harm reduction viewpoint

Please see Appendix A for further information and instructions on stages of change, motivational interviewing, and other clinical strategies as they relate to this focal area and others in the B-CTI model.

Medication Adherence

- Working with the patient, providers and caregivers to support medication adherence.
- Assisting the patient in developing medication self-management strategies.

Specific activities care managers could pursue include:

- Providing basic education about medication use, benefits, and side effects to the patient and his/her involved family
- Fostering medication self-monitoring and management skills
- Helping patients and providers communicate more effectively about medication issues
- Conducting adherence risk assessments to identify and address obstacles to optimal medication use; assisting the patient with adherence strategies (e.g. use of pill boxes, visible schedules, etc.)
- Role-playing with patient to improve skills in talking to his/her psychiatrist about medication issues
- Facilitating referrals to programs/services providing additional supports (e.g. medication management group, depot clinic etc.)
- Working to establish linkages so that the patient can easily and reliably obtain needed medications.

Family Involvement /Social Network Support

- Collaborating with the patient to engage family members and other members of patient's social network to support the patient's care and well-being.
- Assist the patient in developing natural social supports of his/her choosing.

Specific activities care managers could pursue include:

- Talking over family relationships and how the patient may want to improve them
- Providing basic education to involved family/network patients about mental illness and its treatment
- Talking with family/network patients about concerns and questions
- Distributing resource and referral information to providers, patients, and family patients
- Conducting social network assessment to help identify potentially helpful network members and accessible sources of support
- Encouraging (and/or making) referrals to family self-support interventions
- Helping the patient mediate conflicts with family and/or providers regarding family issues
- Increase positive social support contacts.

Please see Appendix B for details of explaining the B-CTI to family and other social support network patients.

Housing and Income

- Assessing and responding to threats to housing stability to prevent homelessness and linking to housing resources for those currently unhoused
- Assessing access to income and entitlements and coordinating oversight of financial resources.

Specific activities care managers could pursue include:

- Assessing potential for large and small crises in housing and helping the patient develop and use coping strategies to avoid (and deal with) them
- Reviewing personal history relating to housing including credit and legal history, previous living arrangements etc. all to help support efforts to secure and maintain stable housing
- Reviewing income and entitlement status
- Providing assistance in securing and maintaining resources
- Providing assistance in managing finances
- Linking patients to other providers and agencies offering housing assistance

Practical Needs Assistance

- Assisting the patient with meeting his/her everyday needs.
- Providing practical assistance as needed.
- Facilitating access to any needed additional vocational, educational or other rehabilitation related services.

Specific activities care managers could pursue include

- Assessing transportation needs and helping the patient identify available transportation options and use them

- Helping the patient access services and supports related to meeting child care needs, legal issues and other concerns
- Assisting with linkages to access additional vocational, educational or other rehabilitation related services.

Summary Table: Targets Areas of B-CTI

TARGET AREA	RELATED PROBLEMS	Phase 1-2: Bridging The Transition (EXAMPLE ACTIVITIES)	Phase 3: Facilitating Ongoing Engagement (EXAMPLE ACTIVITIES)
A. Continuity of Integrated Medical & Psychiatric Care	➢ Challenges coordinating referrals ➢ Communication challenges between/among providers ➢ Gaps in responsibility for following up with patient	➢ **Attend IP discharge and/or disposition meeting and review aftercare and crisis plan with the patient and IP treatment team.** ➢ **Ensure that inpatient records and treatment summary are passed on to outpatient provider.** ➢ Meet with patient on the day of discharge (preferred) or within the first three days post discharge in home/community. ➢ Continue frequent home/community (2- 3x weekly) visits for 1 month, then taper frequency as indicated. ➢ Carry out Needs Assessment ➢ Complete Crisis Plan and My Health Record ➢ Contact all providers on referral list within one week of initial contact with patient to introduce yourself and specify how and when you can be contacted and what types of assistance you will be able to provide. ➢ Accompany patient to first aftercare appointment. ➢ Assess patient's comfort level with aftercare provider and try to make other arrangements if match seems poor. ➢ Meet with supervisor weekly to review progress and refine target intervention foci. ➢ Contact medical and behavioral health providers to introduce yourself and specify how and when you can be contacted and what types of assistance you will be able to provide. ➢ Accompany patient to first medical appointment with primary care physician/health clinic. ➢ Assist patient with referral to and attendance at any recommended follow-up or specialist appointments. ➢ Assist patient is communicating more fully and effectively with medical & behavioral health providers.	➢ **Help patient develop system for keeping track of appointments.** ➢ Meet with patient and provider to discuss treatment plan. ➢ Review and update target intervention foci. ➢ Continue to taper home and office visits with patient. ➢ Maintain regular phone contact with patient; taper as indicated. ➢ Conduct transition planning meeting with patient and all providers with whom patient is engaged in treatment to go over long-term treatment goals. ➢ Conduct transition planning meeting with supervisor to review progress and plan for post-intervention coordination of care. ➢ Help patient adhere to treatment regimens and maintain related behaviors associated with medical need. ➢ Help the patient develop a healthier lifestyle. Review benefits of healthy diet, being physically active and not using tobacco; support and encourage daily wellness management as specified in Recovery Plan. Review and update as indicated
B .Sustained Motivation and Engagement in Substance Abuse Treatment	➢ Alcohol and substance abuse are disorganizing factors impeding patient's' ability to keep appointments ➢ Patients are concerned regarding stigmatizing responses from mental health providers because of their substance use/histories	➢ Conduct motivational interviewing to identify patient's level and readiness to change harmful addictive behaviors. ➢ Use assessment to help target appropriate referrals and to inform coordination of indicated follow-up care. ➢ Provide basic psycho-education regarding substance use, its effects on psychiatric symptoms, and ways in which substances interact with medications. ➢ Attend first appointment with patient at substance	➢ Periodic monitoring of patient's stage of change readiness to help target referrals and coordination of indicated follow-up. ➢ Facilitate engagement in longer-term services designed to address substance abuse issues.

TARGET AREA	RELATED PROBLEMS	Phase 1-2: Bridging The Transition (EXAMPLE ACTIVITIES)	Phase 3: Facilitating Ongoing Engagement (EXAMPLE ACTIVITIES)
		abuse treatment provider ➢ Assess patient's comfort level with aftercare provider and try to make other arrangements if match seems poor in relation to substance abuse related needs ➢ Refer patient as indicated for additional supports (e.g. AA/NA groups, recovery support)	
C. Medication Adherence	➢ Lack of knowledge regarding medication side-effects ➢ Ambivalence regarding need for medication	➢ Conduct adherence risk interview to identify obstacles and barriers related to medication use. ➢ Talk to patient about side effects and use role plays to help patient improve communication with psychiatrists about medications. ➢ Help patient develop medication management self-monitoring skills. ➢ Assist patient in establishing strategies for adhering to medication regimens (e.g. use of pill boxes). ➢ Review rationale for taking medication in joint meeting with patient and outpatient provider. ➢ Refer patient as indicated for additional supports (e.g. Medication Management group, peer support). ➢	➢ Conduct periodic assessment of patient's medication adherence. ➢ Promote, encourage and reinforce patient empowerment and support efforts to maintain commitment to addressing substance abuse related problems and challenges.
D. Family Involvement/ Social Network Support	➢ Difficulty contacting and engaging family in care and treatment planning ➢ Family attitudes and misconceptions about mental illness and treatment ➢ Family concerns regarding available resources and support	➢ Provide basic psycho-education to address family/significant others attitudes and misconceptions. ➢ Distribute resource and referral sources to family patients/significant others. ➢ Assess patient's social network and available sources of instrumental and emotional support.	➢ Encourage referrals to family self-support and psycho-educational interventions. ➢ Help patient mediate conflicts with family regarding treatment. ➢ Support and encourage participation in community activities. ➢ Work with family and providers to ensure ongoing communication among all invested in patient's well-being.
E. Housing and Income	❖ Difficulty maintaining stable housing ❖ Difficulty accessing subsidized housing programs ❖ Unstable housing often an antecedent for inpatient admission/readmission and subsequent poor engagement in aftercare treatment services and community tenure ❖ Gaps/lapses/loss of entitlements ❖ Unstable income	➢ Assess potential for large and small crises in housing and help patient develop and use coping strategies to avoid (and deal with) them. ➢ Review personal history relating to housing including credit and legal history, previous living arrangements etc. ➢ Accompany patient to housing related appointments and interviews; assist with completion of applications and related paperwork ➢ Assist with entitlements and coordination/management of finances.	➢ Visit and support patient to help support tenure/continued residence in stable housing situation. ➢ Work with patient to develop longer term plans to manage finances and benefit from stable housing. ➢ Help shore up financial management skills.
F. Integration of	➢ Chronic and acute illness	➢ Contact medical providers to introduce yourself and	➢ Help patient adhere to related medical regimens and maintain

TARGET AREA	RELATED PROBLEMS	**Phase 1-2: Bridging The Transition** **(EXAMPLE ACTIVITIES)**	**Phase 3: Facilitating Ongoing Engagement** **(EXAMPLE ACTIVITIES)**
Medical Care	management make it difficult for patient to prioritize psychiatric needs	specify how and when you can be contacted and what types of assistance you will be able to provide. ➢ Accompany patient to first medical appointment with primary care physician/health clinic. ➢ Assist patient with referral to and attendance at any recommended follow-up or specialist appointments. ➢ Assist patient is communicating more fully and effectively with medical providers.	related behaviors associated with medical need. ➢ Help the patient develop a healthier lifestyle. Review benefits of healthy diet, being physically active and not using tobacco; support and encourage daily wellness management as specified in Recovery Plan. Review and update as indicated.
G. Meeting Practical Needs	➢ Lack of transportation ➢ Limited information about how to access available transportation options ➢ Legal issues ➢ Child care needs ➢ Difficulty accessing additional vocational, educational or other rehabilitation related services	➢ Assess patient's transportation needs and help identify available transportation options. ➢ Help patient access services and supports related to meeting childcare needs. ➢ Review/consider and utilize strategies/resources to help patients address legal issues.	➢ Monitor patient's ongoing and anticipated needs regarding legal issues, transportation, child care, and intervene accordingly. ➢ Include consideration of ongoing and anticipated connection to additional/needed vocational, educational or other rehabilitation related services as part of termination planning.

III. CLINICAL PRINCIPLES OF B-CTI

Work in B-CTI's target areas should be carried out in ways that embody principles of good clinical and human services practice, and that strike a balance between direct support and facilitating services and patient autonomy. These are described below, and each applies to all facets of the work.

Continuity of Care

Continuity of care is the orderly, uninterrupted movement of individuals among diverse elements of the service delivery system in ways that appropriately address each patient's needs and is a hallmark goal of the B-CTI model. Good care is ***longitudinal***, meaning that it is responsive to changes in the patient's needs over time even though individual caregivers, treatment modalities, or sites may change. It is ***individualized***, meaning that care is planned with the patient, addressing his/her particular needs, goals, preferences, and strengths. It is ***comprehensive***, meaning that patients can receive a variety of services as needed in a well-coordinated fashion. It is ***flexible***, meaning that patients progress at their own pace, are not measured by one generic definition of "progress," and that service delivery is not unnecessarily regimented. It is ***organized*** around relationships, meaning that patient's contacts with the service system are characterized by familiarity, personalization, and warmth. It is ***accessible***, meaning that patients are able to reach the services they need when they need them, and in ways that are psychologically, culturally, financially, and physically suitable. Finally, it is characterized by ***two-way communication***, both between patient and service providers, and among the various service providers involved with a specific patient's care.

In sum, continuity of care stresses the importance of patients having positive, reliable connections to quality service providers and caregivers in an orderly and responsive system that persists over time. These elements strongly imply the need for someone to coordinate and ensure this continuity of care: in this case the care manager.

Case Management Model

Case management (service coordination) makes continuity of care possible. Service coordination roles vary widely, combining linking (connecting patients to available resources) and direct clinical care – assisting the patient both practically and emotionally. It focuses on treating the individual and his or her environment, both through the care manager's direct therapeutic relationship with the patient, and through the care manager's working to help make the patient's surrounding environment more supportive and more responsive to the patient's needs. The overarching goal is to help improve the patient's quality of life through reducing stresses and symptoms, focusing on rehabilitative goals, and identifying and providing reasonable interventions.

Ongoing Assessment

The B-CTI model emphasizes ongoing assessment of the patient's needs throughout the duration of the intervention. Such assessments should be used to explore and document the patient's concrete needs, psychological needs, individual strengths and

capacities, and goals. Completed in the community where patients live, such assessments also allow the care manager to both ask and observe where there are holes in the patient's treatment plan and where the patient needs more or less support or services. These methods should inform the completion of the required phase-specific plans. Please See Appendix D for the B-CTI Phase Plan.

Recognizing the Strength in Ambivalence

Most people struggle with a combination of conflicting wishes when they seek any kind of help. On one hand, they may wish to be taken care of, relieved of responsibility, and supported. On the other, they may at the same time wish to maintain personal autonomy, independence, and dignity. This combination often manifests as ambivalence and inconsistency in asking for and accepting help. Such struggles may be particularly intense among mentally ill patients. Their psychiatric problems and concrete needs may at times force them to rely on others for many things they wish to provide for themselves, while also isolating them, perhaps even to the point of being out on the streets alone. Mental illness and its many sequelae, often including joblessness, homelessness, and other related problems, can erode self-esteem, so that maintaining personal pride and self-determination becomes extremely important. It is also important to recognize that many patients may have had negative past experiences in the mental health system and are wary to open themselves to further contact. Thus treatment ambivalence can be seen as a personal protection strategy and a sign of self-agency, even if sometimes misdirected.

When the care manager is sensitive to this dimension of the patient's experience, s/he is better able to be empathic and to balance being supportive with encouraging autonomy. Over time, the care manager will try to find the right balance between providing structure and waiting on the sidelines for the patient to find his/her own way. In general, B-CTI advocates the least coercive and most collaborative approaches, so as to increase patient autonomy and informed choices.

Focusing on Patient's Strengths

A key assumption underlying the B-CTI model is that despite struggling with health and mental health challenges, all patients have strengths and capacities that can be identified and encouraged. These may include job skills, social skills, educational strengths, determination, creative talents and special interests and aptitudes. These capacities, however, are often under- or un-recognized by the patients themselves and/or those around them. For example, a patient who has spent a long time in mental health facilities, especially inpatient, or shelters, may show little initiative, seem emotionally unresponsive, and/or act excessively dependent on others. These behaviors, however, may not be intrinsic to the patient and his/her illness--they may instead (or also) reflect adaptations to previous experiences and limited opportunities.

Therefore, the B-CTI model operates on the belief that patients can be most effectively engaged and helped when each person's individuality and strengths are recognized and nurtured. Patients participating in CTI are assumed to have the internal resources needed to make positive changes in their lives, but it is also recognized that these

internal resources may have atrophied from disuse, may need further development, or may need to be adjusted for use in new settings. The care manager's role is to help discover and foster these strengths. In addition, care managers may reframe elements of the patient's personality usually seen as bothersome as strengths (e.g., viewing loudness or constant talking as behaviors that help the patient persevere in getting the attention and services s/he needs), and thereby help the patient use them more adaptively.

The Therapeutic Stance

The therapeutic relationship and alliance between the care manager and patient is a key element in fostering successful treatment outcomes. Although the care manager is not a therapist in the strict sense of the word, many of the same ingredients and considerations are important. In her/his therapeutic interactions with the patient, the care manager should strive to be active and focused, supportive and empathic, consistent but flexible, and fostering of autonomy while remaining available for support.

An active and focused stance is necessary given the short duration of the intervention. It will be important to work quickly to carry out assessments, and then formulate and implement realistic service plans. While the care manager may need to provide the initial "energy" to begin these activities, s/he should also obtain a commitment from the patient for active follow through, and help the patient also take an active and focused role in his/her care.

Support and empathy are crucial to the formation and maintenance of the therapeutic alliance between the care manager and patient. The patient must feel that the care manager hears and respects his/her views, feelings, needs, even if the care manager disagrees with them. Care managers should be particularly sensitive to supporting the patient's self-esteem and sense of personal agency. When these are injured, s/he may retreat defensively or act out towards him/herself or others, also damaging the working relationship. Patients may be very sensitive to criticism and judgmental attitudes, and feeling criticized may inhibit their expression of concerns, needs, and conflicts important to their clinical outcomes and well-being.

Being flexible but consistent is a dynamic therapeutic balance that the care manager should strive for. Flexibility allows care managers to respond sensitively and practically to the varied situations they will encounter. Service plans may need to change mid-stream; unexpected problems and opportunities will crop up. Flexibility also allows more true collaboration between the care manager and patient than is typically offered in health and mental health systems and allows the care manager to respond to the patient on a realistic, as-needed basis as situations, needs, and preferences change. Research indicates that people with serious mental illnesses prefer and benefit from this type of helping relationship over a more rigid structure. Of course, this can be challenging given the many bureaucratic and organizational constraints that care managers and other service providers operate within. At the same time, consistency complements flexibility. Patients need to see the care manager as a reliable person with predictable, coherent patterns of interaction and work, and that their involvement in the

service relationship is also stable with service goals and other agreements followed and respected. While they are open to renegotiation, this is done in a purposeful, open way, rather than haphazardly. At times, the care manager may feel caught between flexibility and consistency. In such cases s/he should consult with the supervisor, weigh the pros and cons of different options, and talk openly with the patient about this process.

Fostering autonomy while remaining available for support is a similarly active balance for care managers. The patients participating in CTI are identified as needing support regarding the inpatient-outpatient transition, treatment retention, and community living. At the same time, their growth in self-care skills, self-confidence, and autonomy are major goals. Therefore, care managers will want to respond differently at different times, staying aware of fluctuating needs for support (such as to maintain psychological or material stability) and for autonomy, such as encouraging patients to try new things and even to fail… with the safety net of the care manager's involvement.

Appendix A: Motivational Interviewing and Other Principles of Enhancing and Sustaining Motivation Regarding Mental Health Services and Substance Abuse Treatment & Recovery.

The B-CTI model uses many principles from the substance abuse literature, including variable treatment intensity, stages of change, motivational interventions, and harm reduction. These principles can be adapted to the unique situations of people who have a mental illness and have been homeless. These principles and skills will also be useful to CTI work in other target areas as well.

1. Variable Treatment Intensity

Since drug and alcohol problems vary in magnitude, the intensity of treatment should match the severity of the disorder (Institute of Medicine, 1990). Following from this, the least restrictive options should be explored first, while more intensive ones should be employed only when necessary. For example, someone who has been drinking every day for years will likely need a detoxification, followed by inpatient rehabilitation, whereas someone who uses marijuana only occasionally might be able to do well with outpatient substance abuse counseling.

2. Stages of Change

Prochaska and DiClemente's Stage Model of the Process of Change (1992) is a model of how people change addictive or habitual behaviors, with or without formal treatment. It is vital for the Care manager to identify which stage the patient is in because each stage implies a different level of awareness and readiness for change, and therefore calls for different intervention techniques. If techniques are used that do not match the patient's level of awareness and commitment, they will be ineffective. However, if stage appropriate intervention techniques are used, they often spur the patient on to the next stage in the change process.

Prochaska and DiClemente's (1992) Stages of Change model is made of the following stages: *Precontemplators* are individuals who do not consider their substance abuse to be a problem and are not considering any change in their behavior. *Contemplators* realize that they do have a problem and are weighing the feasibility and costs/benefits of changing their behavior. In the *Preparation* stage, individuals are making a decision to take action and change their behavior, and therefore make preparations to facilitate this. When they begin to actually modify their problem behavior, they are in the *Action* stage, which lasts about 3-6 months. If/when the acute period of initial behavior change (such as quitting cigarettes) has stabilized into ongoing new behavior (e.g., abstinence) they enter the *Maintenance* stage. *Relapse* is also recognized as a stage in this cycle. It is worth emphasizing that relapse is not seen as

a treatment failure, but as a common part of the recovery process and an opportunity to assess what went wrong and try again.

3. Motivational Interviewing

A patient's movement among the Stages of Change, toward healthier behavior, can be facilitated by the Care manager's practice of Motivational Interviewing (Miller & Rollnick, 1991). Motivational Interviewing is designed to mobilize the individual's own desire to change. Its techniques are non-confrontational and geared to minimize the defensiveness often created by traditional confrontational models. It can help individuals move through the stages of change more quickly and effectively than they would without intervention, while assuming that the responsibility and capability for change lie within the individual.

The specific Motivational Interviewing techniques an Care manager uses depend on the patient's Stage of Change regarding the targeted problem behavior. Miller and Rollnick (1991) recommend the following techniques: For a patient in *precontemplation*, an Care manager would seek to gently raise doubt and increase the patient's perception of risks and problems with current behavior. For someone in *contemplation*, the Care manager would seek to evoke reasons for change that could tip the balance for that individual, draw out the risks associated with not changing the behavior, and strengthen the individual's self-efficacy for changing the behavior. For a patient in *preparation,* the ASC would want to help the individual plan the best course of action toward concrete change, anticipate and plan for obstacles, and help increase natural supports. For a patient in the *action* stage, the ASC would actively help the individual take the concrete change steps needed and work to sustain abstinence in the acute term. In *maintenance,* the ASC would help the patient identify and use strategies to prevent relapse. For someone in *relapse*, the ASC would help the patient renew the processes of contemplation, determination, and action, and see relapse as a predictable and surmountable phase from which improved change strategies can be learned.

To use Motivational Interviewing for B-CTI, especially regarding substance abuse, the Care manager should take the patient's history of substance use, with a particular focus on: frequency, severity, and choice of substances used; how the patient views the costs and benefits of continued use; and strategies the patient has used in the past, if any, to curb use. Triggers for substance use should also be explored. If the patient is not aware of any, the Care manager might ask for several stories about past use episodes. Care managers should also rely on their clinical skills to monitor what the patient is not willing to reveal about their substance use. For example, Care managers might be on the lookout for money-seeking behaviors, the selling of possessions, physical signs of substance use, curfew violations, irritability, or any other significant changes in the patient's mental status. Together, the patient and Care manager might be able to identify what feelings or circumstances lead to substance use. This inquiry will help inform the Care manager about the intensity of treatment needed, the stage of change the patient is in, "trigger" situations, and strategies that may help the patient curb his use.

Motivational Interviewing also can and should be used as needed across both phases of the B-CTI intervention and all target areas…not only for substance abuse. It can help build rapport, set treatment priorities, and help the individual recognize and develop personal strengths, including mobilizing his/her own values and motivations to meet his/her own goals.

Motivational interviewing uses five basic clinical strategies: expressing empathy, developing discrepancies, avoiding argument, rolling with resistance, and supporting self-efficacy:

Expressing empathy communicates respect for the individual and avoids implications of inferiority/superiority. It conveys an acceptance of the patients as they are, while also supporting them in the process of change. Freedom of choice and self-direction are respected and emphasized.

Developing discrepancy is a process through which the Care manager helps the patient become aware of discrepancies between where s/he is and where s/he wants to be. In the early stages of change, this involves raising the patient's awareness of the personal costs of his/her substance use or other problematic behavior, to move the patient towards the contemplation stage. In later stages it continues in the reminder of these costs as a way of maintaining motivation.

Avoiding argument must be practiced even as the Care manager tries to make the patient aware of discrepancy. Strong confrontations about a patient's substance abuse usually evoke defensiveness and opposition rather than self-reflection, and make the patient feel that the Care manager does not really understand. Care managers may certainly need to bring up some of the possible negative consequences of continuing substance use, but sensitively… in an empathic and non-punitive way.

Rolling with resistance means that the patient is encouraged to think about problems in new ways, but the Care manager's viewpoint is not imposed on the patient. Ambivalence and resistance to change are viewed as natural and expected, and should be explored openly. Patients need to be able to talk about what substances do for them, and their fears of what might happen if they were not to rely on them (e.g., the costs of quitting).

Support patient self-efficacy is the final strategy. Self-efficacy (Bandura, 1982) is the belief that one can perform a particular behavior or accomplish a particular task. In the case of substance abuse or other problematic behavior, individuals must believe that they can change before they will try. Therefore, the Care manager needs to notice and support the patient's expressions of self-efficacy, even if minor or fleeting, and help the patient nurture his/her strengths and feelings of agency.

4. Harm Reduction

B-CTI approaches to substance abuse also employ the principle of harm reduction (Marlatt & Tapert, 1993), which is based on the idea that substance use exists on a continuum of abstinence to abuse. If a person reduces the quantity or frequency of substance use, its harm will be reduced. Although abstinence is usually the optimal goal, any reduction in use is encouraged and supported. This stance is in contrast to traditional all-or-nothing approaches to substance abuse treatment, where clinicians refuse to treat anyone who has not made a commitment to 100% abstinence. A relevant B-CTI example of this might involve a patient who is still using substances when he moves into housing in the community. Given that substance abuse is likely to jeopardize his housing, the patient and Care manager work to find ways to minimize this risk even if the patient is not contemplating abstinence. For example, he might agree not to get high or drink in the residence. Although this is not ideal, it is a realistic first step in helping the patient preserve his housing and move towards sobriety.

By using all these techniques in combination, the Care manager improves the chances that the individual will commit himself to change. If the patient has made this commitment, he will be much more likely to use long-term supports after the three-month B-CTI period.

Appendix B: Working with Family Patients and Important Others

When appropriate, Care managers work with patients' families and important others in order to address concerns, improve understanding between the patient and family, and thereby increase the natural supports and positive interactions for the patient. This commonly includes providing information to the family or important others on the nature and treatment of mental illness; correction of misperceptions; answering questions; and suggesting support resources for family patients. Such education will facilitate families' ability to respond to crises that might arise and can greatly improve the family's relationships and ability to appropriately assist the patient. Therefore, during the three months of B-CTI, the Care manager should cover the following areas:

1. The Family's Perspective

The Care manager needs to be open to meeting and talking with important people in the patient's life, in a spirit of mutual concern and collaboration. The clinician will want to listen to the family's perspective of the patient's strengths, needs, history, living situation, and illness as one important source of information, and to do so with the patient present, since the Care manager's primary therapeutic alliance and focus lies with the patient. Family patients and others also can be important sources of information about what has helped the patient, and what has not, in the past.

2. The Nature of B-CTI

The Care manager explains the intervention model and the role of the family in adding to its success. This should include explanation of the Care manager's role, the patient's need for support at the time of transition, the type of services that ASC offers, the different types of residential facilities available, and the Care manager's and family patients' roles in supporting the patient.

3. The Nature of the Mental Illness

The Care manager educates family patients about typical symptoms of the patient's mental illness, and psychiatric and psychosocial approaches to treatment – both in abstract and specific to the patient's current treatment. This should also include education about the patient's medications, such as explaining what symptoms the medication treats and common side effects. Care managers should try, through information and clarifications of misconceptions, to alleviate the guilt and stigma many families feel when a relative has a mental illness.

4. Positive and Negative Support

The Care manager works with the patient's family or important others on how to most effectively and sensitively address issues in order to support the patient's health, growth, and independence. In many ways the nature of the Care manager can be a model for family support of the individual: being supportive, empathic, flexible, consistent, and encouraging of autonomy but available in times of crisis. The Care manager may also, as needed, educate the family about negative, unhelpful patterns of interaction or attempted support, such as being punitive or blaming in an effort to "motivate" the patient.

Special attention should also be paid to how the family deals with stress. People with serious mental illnesses and people undergoing life transitions may be particularly sensitive to stress and conflict. Therefore, both the patient and the family patients may function better if patients learn how to communicate clearly; use constructive problem-solving skills (Grunebaum & Friedman, 1988); pay attention to their own well-being; make comments in a calm, supportive tone; and state requests simply and directly (McFarlane & Cunningham, 1996).

5. Ongoing Active Support

Throughout the 3-month B-CTI intervention, the care manager is available to assist and mediate between patients and their families as needed. Common situations where the B-CTI intervention can be beneficial are: mediating substance abuse related conflicts; facilitating communication between family and staff at community residences; and talking with families about their feelings about the patient and his/her situation, health, and other factors. Through modeling during such situations, as well as overt education and discussions about communication, care managers can also help family patients and patients learn to set clear boundaries and limits, and educate them about the importance of having clear, compassionate, and consistent ways of interacting with each other.

Appendix C: Needs Assessment

B-CTI includes an "ongoing assessment" model, meaning that the patient's needs/resources and strengths/weaknesses are evaluated frequently, with previous knowledge informing subsequent assessment and under the assumption that that the nature of the assessment will change over the course of the intervention.

For example, at the beginning of the care manager's relationship with a specific patient, there are "baseline" issues that must be assessed such as: How much support does the patient want? In what areas? Is the offer of B-CTI help experienced as helpful, or intrusive? What is the patient's cultural background? How does it affect how the patient seeks or receives help? Is there a cultural or racial difference between the patient and care manager? If so, how will that affect the work they do together? How does the patient typically deal with stress? What "natural" support systems are available to the patient, such as family or friends? Does the patient typically make use of them in times of trouble? Or, when crisis hits, does he isolate himself? What are typical scenarios that have led to successful or troubling outcomes for this patient in the past?

The care manager's initial efforts are aimed at joining with the patient in the pursuit of need satisfaction, from the patient's perspective. This means the care manager must balance collecting factual information across the various need areas with engaging with the patient in a recovery-oriented discussion in which the patient is heard and helps establish priorities. This is best done by creating an atmosphere of support and safety in which patients can express their feelings, feel understood, and perceive the care manager as an ally and advocate. To help create such an atmosphere it is recommended that the care manager begin all assessments by actively engaging patients in a discussion of the things that are important to him/her, the strategies or supports that they find helpful, and the patients' thoughts/ideas about how the care manager can be helpful to them. These open-ended questions are critical to building a relationship, communicating support and understanding, and supporting the development of a therapeutic collaboration.

In addition to this approach, the care manager is strongly encouraged to collect needed information about needs, priorities etc. across the B-CTI specified target areas. This can be done by combing information from existing documents, completing more formal intake assessments, observations of patients' behaviors, consideration of life and treatment history, and conversations with others involved in the client's life, such as family, friends, or treatment providers. Below are some of the observational aspects of assessment that care managers should attend to:

-- The patient's non-verbal behavior, such as facial expressions, body movement, posture, physical distance, eye contact, and general appearance can yield

information both about the person's level of psychological distress, receptiveness to the Care manager and the ideas being expressed, and unspoken needs.

-- The patient's verbal statements: word choice, recurring themes, voice volume and tone, amount and speed of talking, focus and tangents, can give further information.

--It is often useful to observe whether a person's non-verbal and verbal expressions are discrepant. Does the patient say he agrees with the plan, but in a brusque, clipped tone with eyes averted?

Cultural awareness is also a vital component in providing support and empathy. When the care manager and patient come from different racial, ethnic, or social backgrounds, the care manager must be aware of how these differences may be contributing to misunderstandings between the dyad. The care manager might be sensitive to these issues by asking the patient how certain issues are looked at within the patient's culture. For example, a patient who abuses alcohol might be asked about what social or cultural role it plays for him. The care manager can still work with the patient's substance abuse as a problem, while maintaining empathy towards these factors and the challenges they may present. In other areas, care managers might deviate from their standard practice to be sensitive to the patient's culture. For example, a care manager might accept a gift, knowing that gift-giving is an important way of expressing gratitude in that patient's culture.

MEDICAL CASE MANAGEMENT INITIAL INTERVIEW &ASSESSMENT

CARE MANAGER _____

DATE _____

BIOGRAPHICAL DATA

Client Name _____
Participant Number _____
Age _____
Date of Birth _____
Gender _____
Ethnicity _____
Address _____
_____
Phone number(s) _____
_____

FAMILY / EMERGENCY CONTACT(S)

Name _____
Relationship _____
Phone Number _____

Do we have your permission to contact this person in case of an emergency? _____yes _____no

CURRENT MEDICAL PROVIDERS

Do you currently have a place to go for medical care? _____yes _____no
If NO: Where would you ever go if you needed medical care? _____
_____

If YES: Who is that provider? _____
Where do you see him/her? _____

Do you see any specialists regularly? _____yes _____no
If YES: Who is that provider? _____
Where do you see him/her? _____

PERSONAL AND SOCIAL HISTORY

Where were you born? _____
If born in the U.S.: Where is your family from? _____
If immigrated: How long have you lived in the U.S.? _____

What is your preferred language? _____

What is the highest level of education that you achieved? _____
(The number that represents the highest grade.)

GED = 12
College Undergraduate Degree = 16
University Graduate Degree = 20
University or Professional Doctorate Degree = 25

Where you ever in the armed forces? _____yes _____no

What religion are you? _____ (CODE)

01 = Christian
02 = Jewish
03 = Muslim
04 = Buddhist
05 = Atheist
06 = No formal religion
07 = Don't know
08 = Other Specify: _____

Who do you turn to for support? _____

What is your current housing situation? _____ (CODE)

01 = Own a house or an apartment
02 = Rent a house or an apartment
03 = Government subsidized housing
04 = Live with friends or relatives without payment
05 = Live with friends or relatives with payment
06 = Half-way house / residential program
07 = Homeless shelter
08 = On the street
00 = None of the above codes apply (see instruction below)

What is your current employment situation? _____ (CODE)

01 = Regular full-time (35 hours/week or more for most of the year)
02 = Regular part-time (regular but < 35 hrs/wk)
03 = Irregular but full-time when working (full-time but for < 6 mo. of yr.)
04 = Student
06 = Military Service
07 = Retired
08 = Disability
09 = Unemployment
10 = In controlled environment
11 = Homemaker (chose to stay at home)
12 = Volunteer (not vocational rehab)
00 = None of the above codes apply (see instruction below)

CURRENT MEDICATIONS (Health and Psychiatric)

What medications are you currently taking (prescription, over-the-counter, herbal)?

MEDICATION	DOSAGE	INDICATION	SIDE EFFECTS	COMPLAINT

Are there any medications that are currently prescribed to you, but you are not taking?

_____ yes _____ no _____ don't know

If YES: is the reason financial, or have you chosen to discontinue use for another reason?

_____

_____

RX COVERAGE

How much do you currently pay towards your medications monthly? _____

Is the cost of your medication covered by Medicaid, Medicare, private insurance or another source?

_____ yes _____ no _____ don't know

I am going to ask you now about the health of your immediate family. It is important to know if there are any conditions that run in your family.

Do you have any siblings? _____ yes _____ no

What is the age and state of health of your siblings?

RELATIONSHIP	DOB	HEALTH CONCERNS	DEATH YR

What is the age and health status of your parents?

RELATIONSHIP	DOB	HEALTH CONCERNS	DEATH YR

PAST MEDICAL HISTORY

I am now going to ask you some questions about your past health. These questions are important to understand all the events that may have affected your health in the past.

How is your health overall? _____

Has your weight been stable over the past 5 years? _____ yes _____ no

MEDICAL CONDITIONS

Has a doctor ever told you that you have…

If YES: Have you been treated for it in the past year (including taking meds)?

CODE (Choose one):
1 = No, never told I have this problem
2 = Yes, but not treated in the past year
3 = Yes, and treated by a doctor/healthcare professional

High blood pressure	_____ No	_____ Yes No TX	_____ Yes With TX
Lung trouble	_____ No	_____ Yes No TX	_____ Yes With TX
Hearing, ear, nose or throat condition	_____ No	_____ Yes No TX	_____ Yes With TX
Eye or vision problem (NOT just wearing glasses)	_____ No	_____ Yes No TX	_____ Yes With TX
Cancer	_____ No	_____ Yes No TX	_____ Yes With TX
Heart trouble	_____ No	_____ Yes No TX	_____ Yes With TX
A stroke	_____ No	_____ Yes No TX	_____ Yes With TX
Bladder trouble	_____ No	_____ Yes No TX	_____ Yes With TX
Arthritis or rheumatism	_____ No	_____ Yes No TX	_____ Yes With TX
An HIV positive test or AIDS	_____ No	_____ Yes No TX	_____ Yes With TX
Problems with your kidneys	_____ No	_____ Yes No TX	_____ Yes With TX
Diabetes	_____ No	_____ Yes No TX	_____ Yes With TX
Stomach or digestive disorder	_____ No	_____ Yes No TX	_____ Yes With TX
Sickle cell	_____ No	_____ Yes No TX	_____ Yes With TX
Seizure disorder	_____ No	_____ Yes No TX	_____ Yes With TX
Abnormal PAP smear?	_____ No	_____ Yes No TX	_____ Yes With TX
Asthma	_____ No	_____ Yes No TX	_____ Yes With TX
Liver problems	_____ No	_____ Yes No TX	_____ Yes With TX
Any other serious medical condition	_____ No	_____ Yes No TX	_____ Yes With TX

specify: _____

SURGICAL HX

TYPE OF SURGERY	DATE	CONDITION AFTER SURGERY

MEDICAL HOSPITALIZATIONS

Tell me about any recent hospitalizations you have had for medical concerns:

REASON FOR HOSPITALIZATION	TREATMENT	LENGTH OF STAY	WHAT YEAR

MENTAL HEALTH

MENTAL HEALTH HX

What mental health concerns have you been treated for in your life?

CODE (Choose one):
1 = No, never told I have this problem
2 = Yes, but not treated in the past year
3 = Yes, and treated by a psychiatrist/mental health provider

Schizophrenia or schizoaffective disorder	_____ No	_____ Yes No TX	_____ Yes With TX
PTSD	_____ No	_____ Yes No TX	_____ Yes With TX
Depression	_____ No	_____ Yes No TX	_____ Yes With TX
Bipolar disorder or Manic Depression	_____ No	_____ Yes No TX	_____ Yes With TX
Anxiety disorder	_____ No	_____ Yes No TX	_____ Yes With TX
Alcohol Abuse	_____ No	_____ Yes No TX	_____ Yes With TX
Drug abuse	_____ No	_____ Yes No TX	_____ Yes With TX
Other serious emotional condition	_____ No	_____ Yes No TX	_____ Yes With TX

CURRENT MH SX

Do you have feelings of panic/anxiety?	_____ Yes	_____ No	_____ Don't know
Are you feeling depressed?	_____ Yes	_____ No	_____ Don't know
Are you feeling irritable?	_____ Yes	_____ No	_____ Don't know
Are you having mood swings?	_____ Yes	_____ No	_____ Don't know
Do you have any unresolved grief?	_____ Yes	_____ No	_____ Don't know
Do you have trouble concentrating/paying attention?	_____ Yes	_____ No	_____ Don't know
Are you feeling suicidal?	_____ Yes	_____ No	_____ Don't know
If YES:			
Do you have a feasible plan to commit suicide?	_____ Yes	_____ No	_____ Don't know
How likely are you to carry out this plan?	_____ Yes	_____ No	_____ Don't know
Are you feeling homicidal?	_____ Yes	_____ No	_____ Don't know
If YES:			
Feelings directed toward someone in particular?	_____ Yes	_____ No	_____ Don't know
Do you have access to this person?	_____ Yes	_____ No	_____ Don't know
Do you have a feasible plan for killing this person?	_____ Yes	_____ No	_____ Don't know
How likely are you to carry out this plan?	_____ Yes	_____ No	_____ Don't know
Are you having hallucinations?	_____ Yes	_____ No	_____ Don't know
Are you having delusions?	_____ Yes	_____ No	_____ Don't know
Are you feeling paranoid?	_____ Yes	_____ No	_____ Don't know

PREVENTIVE CARE HX

In the past 12 months, have you had any of the following?	_____ Yes	_____ No	_____ Don't know
Physical examination	_____ Yes	_____ No	_____ Don't know
Blood pressure reading	_____ Yes	_____ No	_____ Don't know
Eye exam	_____ Yes	_____ No	_____ Don't know
Height and weight	_____ Yes	_____ No	_____ Don't know
Oral or dental exam	_____ Yes	_____ No	_____ Don't know

FOR WOMEN

Ages 21-65 PAP smear exam in past 3 years (if has uterus)	_____ Yes	_____ No	_____ Don't know
Ages 50-74 Mammography in past two years	_____ Yes	_____ No	_____ Don't know

HABITS & PATTERNS

How much alcohol do you drink in a typical week? _____

Do you smoke? _____YES _____NO

If yes, how many cigarettes per day? _____

How old were you when you started smoking cigarettes? _____

Do you currently use any of the following drugs?

CODE FOR PATTERN OF USE: 0=<1X/MON 1=1-4X/MON 2=1-5X/WK 3=1X/DAY 4=1X/DAY

DRUG	NO USE	1ST USE	LAST USE	AMT	PATTERN	ROUTE
ALCOHOL						
MARIJUANA						
OPIATES						
BARBITUATES						
CRACK COCAINE						
OTHER COCAINE						
AMPHETAMINES						
HALLUCINOGENS						
DESIGNER DRUGS						
INHALANTS						
OTHER						

APPEARANCE & MENTAL STATUS

APPEARANCE

AGE _____

POSTURE _____

HYGIENE _____

DRESS _____

COOPERATION _____

MOOD

_____

AFFECT

_____

_____

ORIENTATION

_____Person _____Place _____Time _____Situation

MEMORY

IMMEDIATE _____Intact _____Impaired

RECENT _____Intact _____Impaired
REMOTE _____Intact _____Impaired

CONCENTRATION

_____Intact _____Impaired

REPEATING

_____Intact _____Impaired

SPEECH

Latency, volume, rate, aphasia, syntax, clarity, loosening of associations, flight of ideas, pressured speech

THOUGHT CONTENT

Illusions, hallucinations, HI, SI, paranoia, goal-oriented

SOMATIC SX

Appetite, physical activity/energy level

Appendix D: B-CTI Phase Plan

Brief Critical Time Intervention Phase Plan

Priority Areas:

□ Integrated Medical & Psychiatric Care □ Family/Network Involvement

□ Medication Adherence □ Housing and Income

□ Practical Needs Assistance

□ Substance Abuse Tx Motivation

Participant ID Number**:** _____

Service Coordinator: _____

Date Member Enrolled: / / _____ _____ _____

Provider Organization: _____

Phase 1

Date:

____/____/_____ Attended Discharge Disposition Meeting

____/____/_____ Met with Patient Prior To Discharge

Phase 2 *(approx. 2 months)*

Priority Area #1: Integrated Medical and Psychiatric Care
Reason(s) for choosing this area:

Goals/needs for this area:

Priority Area #2:
Reason(s) for choosing this area:

Goals/needs for this area:

Priority Area #3:
Reason(s) for choosing this area

Goals/needs for this area:

Date:

____/____/____ Conducted Needs Assessment

____/____/____ Completed Initial/Baseline Treatment Plan

____/____/____ Identified/Arranged for Connections to Outpatient Providers

____/____/____ Completed Recovery Plan

____/____/____ **Patient Signature:** _____

Phase 3 *(approx. 1 month)*

Priority Area #1: Integrated Medical and Psychiatric Care
Reason(s) for choosing this area:

Progress/needs for this area:

Priority Area #2:
Reason(s) for choosing this area:

Progress/needs for this area:

Priority Area #3:
Reason(s) for choosing this area:

Progress/needs for this area:

Date:

____/____/____ Completed Early Phase 2 Treatment Plan

____/____/____ Updated/Reviewed Recovery Plan

____/____/____ **Patient Signature:** _____

Appendix E: Crisis Plan

CRISIS PLAN

Sometimes a crisis cannot be prevented. For me, a true crisis might look like this (describe in a way you and others would be able to recognize it):

Behaviors:

Feelings:

Intensity:

If I am experiencing a crisis, I would like the following plan to be followed:

1) If it's during business hours call _____
2) Call_____at phone number _____
3) My psychiatrist is_____at phone number _____
4) My social worker / therapist / other is_____at phone number _____
5) Another person I'd like to contact is_____, my_____, at phone number _____
6) Other steps to follow _____
7) In the past, things that have worked when I was in a crisis were:
    a.
    b.
    c.

8) Things that didn't work were:

   a.

   b.

   c.

People that this document may be shared with:

Name: _____ Contact Info: _____

Name: _____ Contact Info: _____

Name: _____ Contact Info: _____

Name: _____ Contact Info: _____

n.b. be sure to get needed release forms to share this any other member information

Appendix F: My Health Record

Things that are bothering me

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____

5. _____

_____

_____

My Health Information

My Name:_____

Date: ____/____/_____

My Primary Care Physician is:

_____

Address: _____

_____

Phone Number: _____

_____

My Care Manager is:

_____

Address: _____

_____

Phone: _____

_____

My Mental Health Provider is:

_____

Address: _____

_____

Phone: _____

_____

My Medical Conditions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

My Medication

Medication	Dose	Reason	Notes

Allergies: _____

_____

Any new medications? _____ **Yes** _____ **No**

_____

Appendix G: B-CTI Progress Note

PROGRESS NOTE

1. Phase (select one): ☐ Phase 1 ☐ Phase 2 ☐ Phase 3

2. Date of Contact: ____/____/_____

3. Provider Organization: _____ 4. Care Manager: _____

5. What Type of Contact Was This? (Please select one response)

☐ Spoke by Phone / You Made Call
☐ Spoke by Phone / Received Call
☐ Met in Person / In Your Office
☐ Met in Person / Outside Office
☐ Email / Fax / Phone Message (sent or received)
☐ Attempted Call(s) but busy or no answer: specify # attempts_____
☐ Attempted Community Meeting but no show
☐ Attempted Office-Based Meeting but no show

6. With Whom Was This Contact? What Was Nature of Contact? And What Priority Areas Were Addressed?

With Whom Was This Contact? Please list the Name/Relationship and Title/Agency	**Nature of Contact With This Person?** (Please select one response)	**Priority Areas Discussed?**
	☐ Engagement / Assessment ☐ Ongoing Monitoring ☐ Care Linkage ☐ Transfer of Care	☐ Integrated Medical & Psychiatric Care ☐ Systems Engagement ☐ Substance Abuse ☐ Medication Adherence ☐ Family / Social Network ☐ Housing / Income ☐ Practical Needs Assessment

7. PROGRESS NOTE DETAILS:

Appendix H: Ascertainment and Recruitment Protocol

Ascertainment and Recruitment Protocol

BronxCare

HealthFirst will identify eligible patient via predetermined algorithm. HF will securely email Natalie Cruz, Dr Liz Defillo, Andy Benejam. This team will decide amongst themselves who will approach the patient to guage interest and ask for permission for the study team to contact. The patient's medical record will be reviewed to assess for presence of eligible medical condition and the patient will be discussed with the inpatient clinical team to confirm that the patient is appropriate for research. Natalie/Andy's team will approach patient to discuss study using the study information sheet provided by the research team and if patient is eligible and interested in participating, they will sign the permission to contact form. If the patient is not eligible or declines participation the BronxCare team will complete only the bottom portion of the permission to contact form (**do not complete top with patient info**) stating the reason for ineligibility or declined participation, if known. The form will be faxed to the PI's office (Dr. Thomas Smith: FAX: 646 774-8740) and the BronxCare team will also call to notify Dr. Marino (contact info on permission to contact form). Once the research team is notified, the RA will travel to the hospital with one of the CTI care managers to discuss the study with the patient and complete the consent process. At this time, the RA will initiate the randomization procedure (but will remain blinded to assignment) and then conduct the baseline research interviews. The CTI team and hospital site team will be notified via text message service of the patient's assignment to CTI or control group. The CTI care manager will inform the patient. For patient's randomized to receive the intervention, the CTI care manager will begin the Phase 1 engagement process.

Montefiore

HealthFirst will identify eligible patient via predetermined algorithm. HF will securely email/call Dr. Mary Alice O'Dowd. Dr O'Dowd will check the patient's chart to assess for presence of eligible medical condition and discuss with the patient's inpatient clinical team whether the patient is appropriate for research. She will then approach patient to discuss study using the study information sheet provided by the research team and if patient is eligible and interested in participating, they will sign the permission to contact form. If the patient is not eligible or declines participation Dr. O'Dowd will complete only the bottom portion of the permission to contact form (**do not complete top with patient info**) stating the reason for ineligibility or declined participation, if known. The form will be faxed to the PI's office (Dr. Thomas Smith; FAX: 646 774-8740) and Dr. O'Dowd will also call to notify Dr. Marino (contact info on permission to contact form). Once the research team is notified, the RA will travel to the hospital with one of the CTI care managers to discuss the study with the patient and complete the consent process. At this time, the RA will initiate the randomization procedure (but will remain blinded to assignment) and then conduct the baseline research interviews. The CTI team and hospital site team will be notified via text message service of the patient's assignment to CTI or control group. The CTI care manager will inform the patient. For patient's randomized to receive the intervention, the CTI care manager will begin the Phase 1 engagement process.