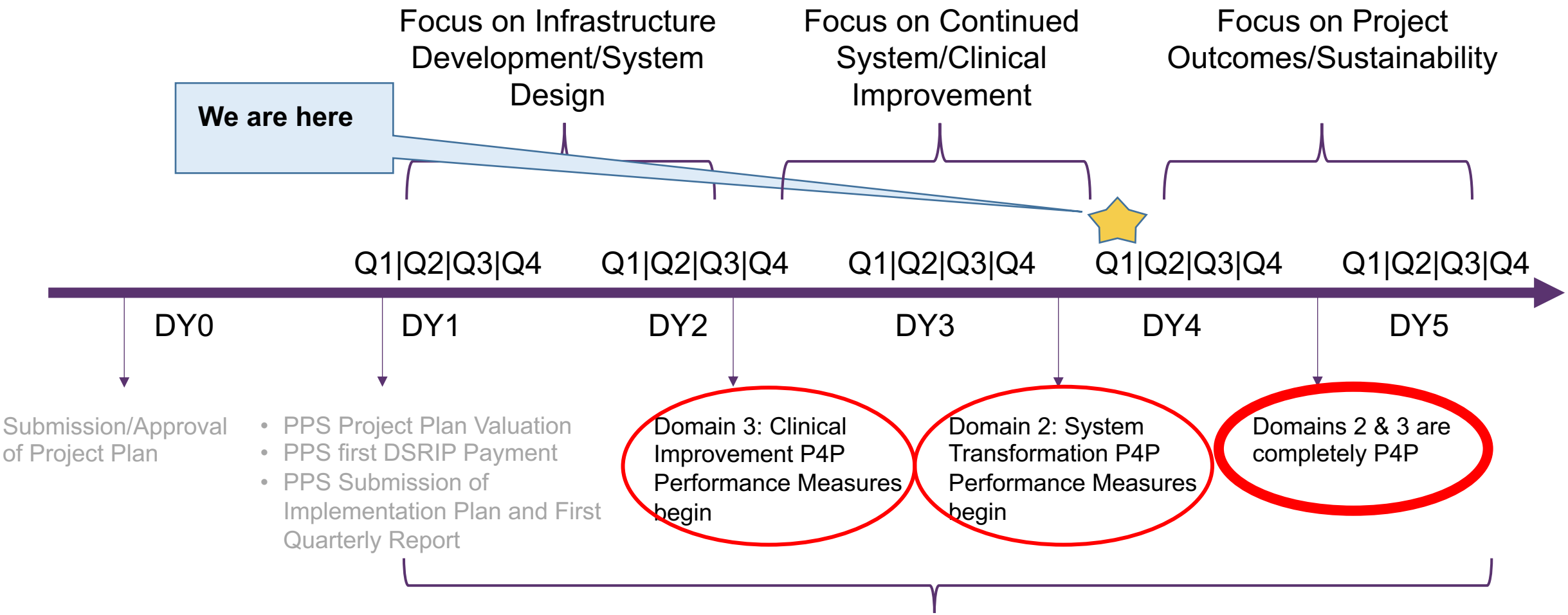
NEW YORK STATE | Department of Health | Office of Health Insurance Programs

DSRIP Peer Support

Peggy Chan
DSRIP Program Director

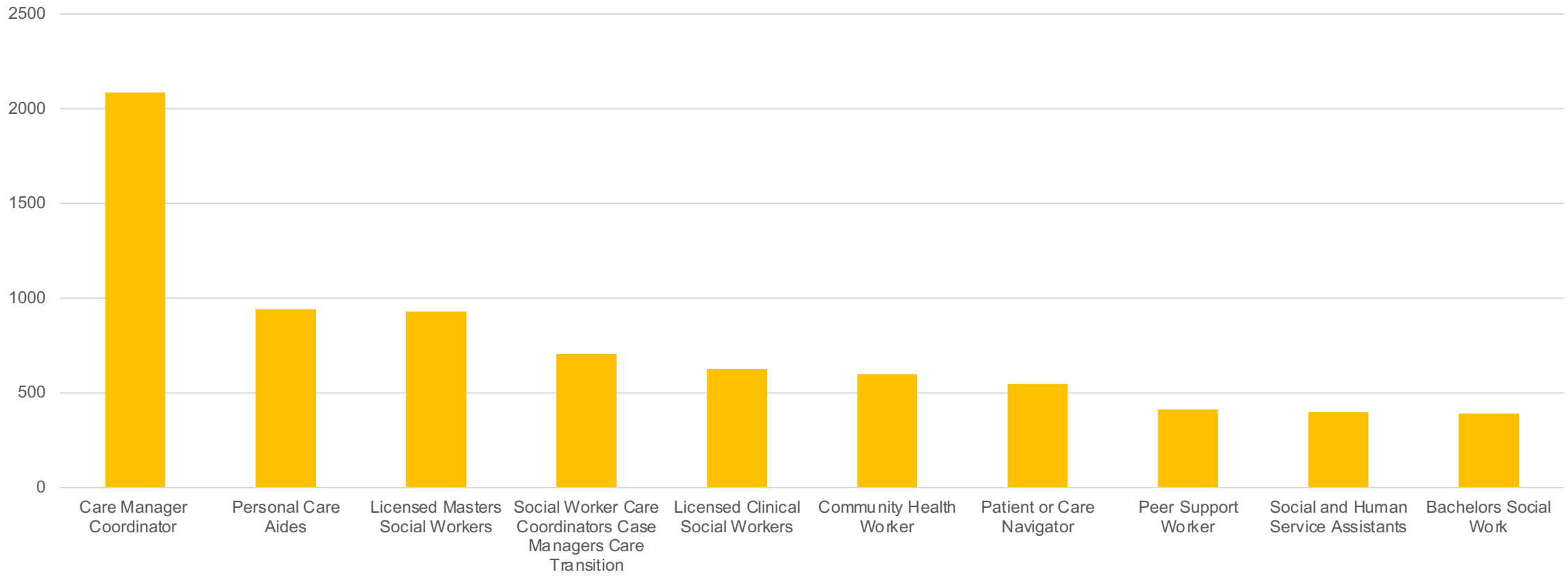
DSRIP Implementation Timeline and Key Benchmarks



Domain 4: PPS working in collaboration with community and diverse set of service providers to address statewide public health priorities; system improvements and increased quality of care will positively impact health outcomes of total population.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Emerging/Transformation Title New Hires through DY3Q2



PPS Peer Initiatives

PPS Peer Initiatives

- Staten Island PPS
  - Placement of peers in multiple settings
  - Peer training and workforce program including career ladder
- Community Care of Brooklyn
  - Placing peer bridgers in EDs and inpatient units
  - Implementing CTI initiatives and including a peer on each team
- Hudson Valley PPS Collaborative (WMC, Refuah, Montefiore PPS)
  - Dutchess County Stabilization Center
  - Rockland County BH Crisis Response Team
- WMC PPS
  - Peers on inpatient units to support transitions of care for BH patients
- Bronx Partners for Healthy Communities
  - Supporting partners to engage peers to combat opioid epidemic

PPS Peer Initiatives

- Montefiore Hudson Valley PPS
  - Peer recovery coaches for transitions of care and Living Room respite program
- Suffolk Care Collaborative
  - Workforce training for peer specialist careers
  - Partner with Assn for Mental Health and Wellness to engage BH consumers
- Nassau Queens PPS
  - Creedmoor Crisis De-escalation Team
  - Expansion of MHANC respite housing
- Mt. Sinai PPS
  - Pilots utilizing peers in crisis respite and connecting with BH high utilizers
  - Peers incorporated into revamped Harlem Mobile Crisis Team
- Bronx Health Access
  - Support peer-run crisis respite for BH patients

PPS Peer Initiatives

- Care Compass
  - Peer Training and Certification; peers in pilots to support those in treatment
- North Country Initiative
  - Supporting delivery of peer services thru Northern Regional CIL
- OneCity Health
  - BH Peer workers for H+H hospitals as part of career pipeline
- Adirondack Health Institute
  - Citizen Advocates Crisis Stabilization Center
- Central NY PPS
  - Expansion of peer respite into all service area counties
- Finger Lakes PPS
  - Contracting peer and recovery coaches for crisis stabilization

DY4 DSRIP Theme

Start A Movement!

Nassau Queens PPS

DSRIP Initiatives that Advance Recovery and Peer Support

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Nassau-Queens PPS
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Nassau-Queens PPS is Comprised of 3 Hospital "Hubs"

1

NuHealth
Together through life.
Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers*
*In partnership with LI Federally Qualified Health Centers, Inc.

3

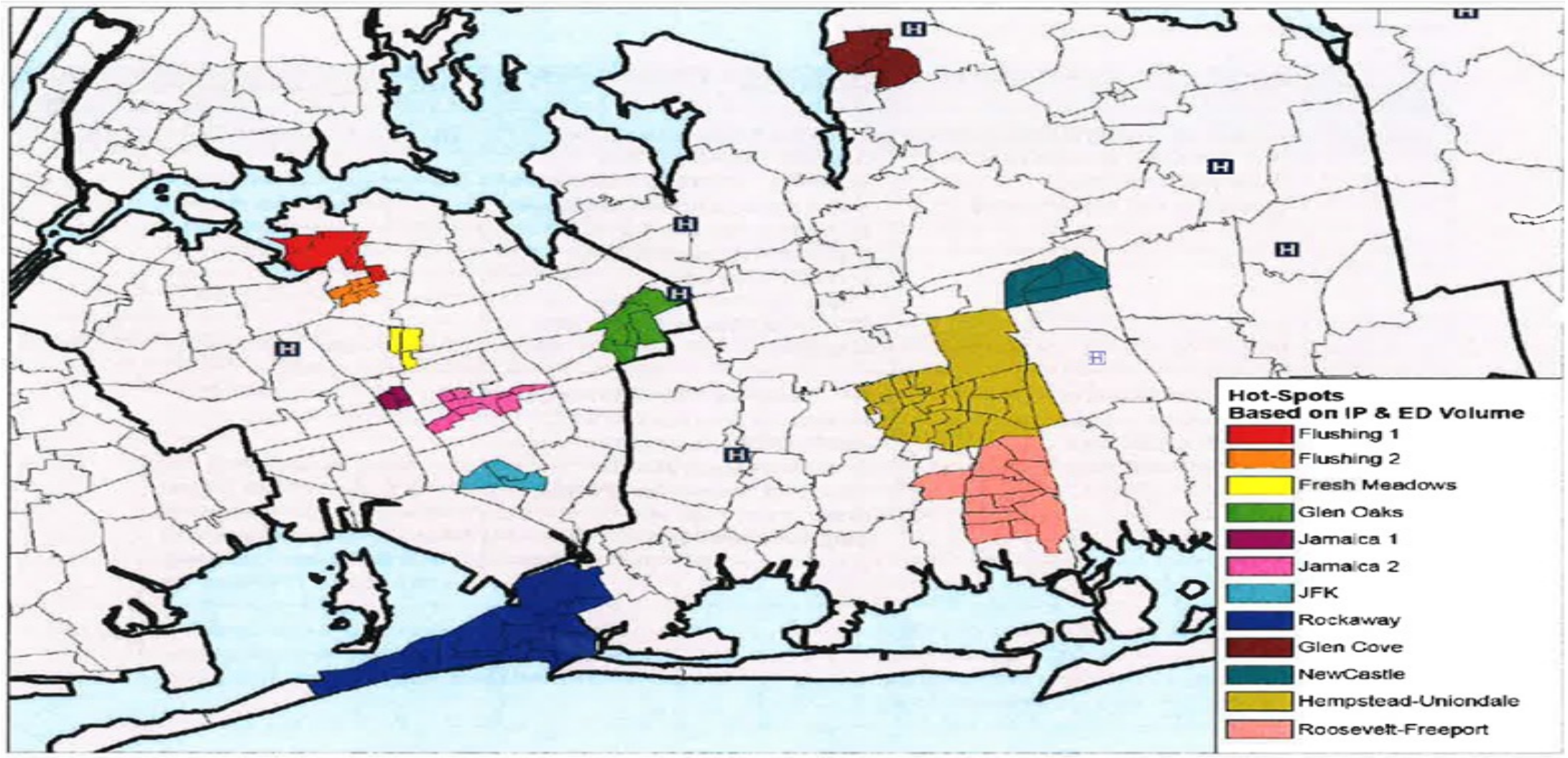
Catholic Health Services
of Long Island
At the heart of health

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

2

Long Island Jewish Medical Center
Northwell Health

Nassau-Queens PPS Hot Spot Map



NQP contracts with Tier 1 CBOs

- **Tier 1 CBO's are classified as non-Medicaid billing, non-profit organizations**
- **NQP has 33 contracts with Tier 1 CBOs (10 directly with Hospital / Hubs and 23 with the PPS directly)**
- **These Tier 1 CBOs cover a wide range of service types, geography and cultural diversity**

Examples of MH Related Tier 1 Contracts

- **NYAPRS: Training / technical assistance for hospitals on recovery, peer support and engagement skills**
- **MHANYS: Training / technical assistance for hospitals on family engagement**
- **LICADD: Training / technical assistance for hospitals regarding improved Substance Use engagement**
- **Venture House: (Clubhouse in Queens) – Basic Engagement, Host a community forum, taking training, reporting on referrals**

Contracting with MH Providers

- **NQP has contracted with 15 mental health providers (that bill Medicaid).**
- **7 providers are contracted directly with Hospitals / Hubs, 8 providers are contracted with the NQP PPS directly.**
- **St. John's – NYAPRS Peer Bridger**

Creedmoor De-escalation Team

- Northwell Health contracted with TSINY.
- Creedmoor Psychiatric Center has OMH residential programs on campus who average one – two calls to 911 calls daily
- TSINY De-escalation Team consists of Peers / Professionals – Encourages the residences to call them instead of 911. Conducts a mobile visit and attempts to have the consumer remain in place, or will offer to have consumer go to the TSI Parachute Program. J
- July 15, 2017-January 2018, the LEAD team had a total of 211 encounters. 205 of these encounters were successfully de-escalated without a subsequent Emergency room visit. (97%)

NQP BH Performance Fund

- NQP contracted with 8 BH Providers in Nassau / Eastern Queens for performance improvement around DSRIP metrics:
- Avoidable ED use (BH)
- 7 / 30 day HEDIS measures
- Blood Labs for Co-Occurring Diabetes / Cardiovascular Disease
- Pharmacy

BH Fund Work Plans

- Agencies self-identified (through data) internal “hot spots” (i.e. Certain Residential services, Clinics, PROS, ACT and / or Health Home Care Management)
- All are enhancing staff with DSRIP funds (Additional Care Managers, Peer Health Coaches, Community Health Workers)
- Agencies are paid a flat rate and can earn bonus $ if NQP achieves metrics.

Behavioral Health on the Rockaway Peninsula

Mental health

Variations in hospitalization rates may reflect differences in rates of illness, access to health care and other social and cultural factors. The rate of adult psychiatric hospitalizations in **Rockaway and Broad Channel** is almost twice the overall NYC rate and the fifth-highest rate in the city.

Psychiatric hospitalizations (per 100,000 adults)

New York State Department of Health, Statewide Planning and Research Cooperative System, 2012

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EPISCOPAL HEALTH SERVICES INC.

Behavioral Health on the Rockaway Peninsula

Substance use

Drug- and/or alcohol-related hospitalizations reflect acute and chronic consequences of substance misuse. In **Rockaway and Broad Channel**, alcohol-related hospitalization rates are higher than the rates in Queens and NYC; **Rockaway and Broad Channel** ranks highest in Queens in alcohol- and drug-related hospitalizations.

Alcohol-related hospitalizations (per 100,000 adults)

New York State Department of Health, Statewide Planning and Research Cooperative System, 2012

Drug-related hospitalizations (per 100,000 adults)

New York State Department of Health, Statewide Planning and Research Cooperative System, 2012

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Peer Bridging at St. John's Episcopal Hospital

- DSRIP goal to reduce readmissions on psychiatric unit PSYCKES Data 2017 Readmission MH:MH 16.81 % and BH:BH 17.15%
- Challenges : Large Behavioral Health population , 50-60 % dually diagnosed with Substance Abuse and/ or significant medical issues
- Housing Variations for people on adult (non-geriatric) unit ; community , homeless , OMH licensed housing and ALPs.
- Services available : OMH licensed clinics , PROS , Continuing Day Treatment Program, OASAS licensed clinic, ACT team
- Systemic Problems on Peninsula: Isolated, housing issues, transportation inefficiencies , high rates of individuals and families below poverty line

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Data Analysis of Re-admissions

- No trends around housing , mental health diagnosis, demographics or outpatient provider for people who were readmitted
- There were equal amounts of people adherent with treatment as non adherent among those readmitted
- Re-admissions did have a significantly higher rate of substance abuse issues
- All people had been linked to outpatient providers , many had followed up with treatment, SJEH clinics have warm hand offs, care coordination referrals were being made and family, when available, were included in treatment
- Thesis : Patients who are readmitted have factors that may be unique to them requiring an intervention that is person focused, individualized, innovative, and empowering so that the real driver of utilization can be identified and managed collaboratively with the individual

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Peer Bridging At St John's Episcopal Hospital Embracing Recovery Model

- Peer Bridging came as the result of clinicians at a SJEH clinic having a positive experience with the Peer Bridging program at Creedmore.

- After several discussions about the framework of a Bridger Program contracted with NYAPRS to bring a pilot program to our non- geriatric psychiatric unit

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The Program Framework

Peer Bridger Program

- Engage with person/family/treatment team and aftercare providers on the inpatient units, prior to patient discharge, follow the person post –discharge up to 6 months
- Focus on high risk/high needs individuals ; facilitate linkage to any outpatient provider and create sustained relationships with these providers
- Certified OASAS recovery coaches
- Teach skills , advocate for, provide support and encourage individual empowerment through a shared lived experience

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Implementation Plan : Develop Referral Criteria

The Peer Bridger Program at SJEH is designed to assist people who are high utilizers of the inpatient psychiatric services "bridge" successfully from the inpatient stay back into the community. The Bridger program can provide support, mentoring and advocacy to help people learn the skills to stay healthy and avoid re-admission.

The following are the criteria for Peer Bridger Referral (individual should have **at least 3 criteria)**

- Two or more admissions in the last six months
- Dually diagnosed Substance use and Psychiatric Illness
- Six or more ED contacts for Behavioral Health in last 6 months.
- Few psychosocial / Family Supports
- Slow to stabilize while on the inpatient unit
- History of missed initial outpatient appointments
- Patient is on the MAX series high utilizer list (This is an automatic referral regardless if any other criteria has been met)
- Other

This is a voluntary service and the individual has the right to refuse to participate.

Implementation: Involve and Educate all the Stakeholders

- Multiple planning meetings with all key leadership (Inpatient, Outpatient, Administration, Population Health) identified anticipated outcomes
- Engagement of front line staff to discuss referral criteria, Bridger's role on the unit and begin education on the role of a Peer Bridger and the uniqueness of his role and the project
- Once NYAPRS identified a Bridger for the position, he met with all leadership staff to ensure a "good fit"
- Developed written policies and procedures
- EDUCATE STAFF GLOBALLY: 3 weeks prior to roll out ,Harvey was invited to provide a grand rounds to the entire Dept of Psychiatry providing opportunity to educate physicians , residents, social workers and nurses on the history and power of Peer Specialists/ Bridging services and the value it will bring to SJEH and the people we serve
- EDUCATE STAFF LOCALLY: On Tyrone's first day, education and program endorsement provided by unit and administration leadership . Education took place in staff meetings for the Dept of Social Work, Care Mgt and Outpatient Clinics

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Peer Bridger Interventions on Unit

- All people admitted to CP4 receive some intervention by the Peer Bridger. Every person works with the Bridger in daily groups that focus on wellness and self care, learning negotiation and advocacy skills, and appropriate interpersonal interaction

- The Bridger also works with the staff on the unit to help prevent the escalation of symptoms through helping to identify the person's needs and tapping into his/her own strengths to manage stressful situations

- The Bridger participates in the team meeting and shares his unique relationship with each person and his own perspective from a lived experience, can offer valuable insights and suggestions in working with the team to help achieve the best outcomes

The Bridger Program benefits the individual while on the unit and when they return to the community but also is a daily reminder for staff that their patients are capable of growth and recovery.

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Peer Bridger Early Outcomes

- Since the start of the program in mid January 2018, there have been 20 people referred to the Bridger who met established criteria .
  - 12 of those people consented to Bridger services
  - Combined, these 12 people have had 32 inpatient admissions at SJEH this past year.
  - One person also has an additional 14 ED contacts in the past 6 months
  - Two are homeless, four live in supported housing or AH, six live in the community
  - Outpatient providers vary

- As of 4/13/18 – of these 12 people only 2 have been re-admitted and one had an ED contact

- Secondary Outcomes:
  - Interventions provided on the unit may have effect of preventing a person from ever becoming a "high utilizer" – an outcome that is hard to measure
  - Staff from all disciplines begin to see and participate in a model of recovery on the unit that improves the experience of every person admitted

The NYAPRS/St John's Peer Bridger Pilot and Partnership

NYAPRS Executive Seminar

April 19, 2018

Harvey Rosenthal, Tyrone Garrett, NYAPRS

The power of peer support is in the quality and power of our relationships

Key Values

- Person driven and directed; in the passenger seat
- Informed choice
- Honesty and Shared Accountability
- Dignity of Risk and Responsibility

Key Practices

- We start where people are, both as to where they live and what they most want….and offer encouragement for people to define and move towards the goals and the life they seek

Key Practices

- We focus on seeing the world through the eyes of the people we support, rather than viewing them through an illness, diagnosis and deficit based lens….or as a HEDIS outcome
- We are respectful….and relentless

NYAPRS State Hospital to Community Peer Bridger Model

- NYS Office of Mental Health 1994-
- Peer Support Meetings in Hospital and Community
- Staff training and education
- Staff and self-referrals
- Engagement and Assistance Funds

NYAPRS Hospital to Community Peer Bridger Model Data

- **1998 National Health Data Systems**
  - Re-hospitalization rate dropped from 60% to 19%, a 41% reduction.
- **2009 NYAPRS Program Evaluation Data:**
  - 71% (125 of 176) individuals were not readmitted in the year following discharge from the hospital

"She talked to me. She talked straight at me. She's the only one. She's got a knack for going on the underlying thing and really getting at it. And I've never had anyone look me straight in the eye, and actually relate to somebody. And I love her for it."

(2003 Qualitative Assessment, MacNeil)

NYAPRS/St. John's Hospital Peer Bridger Model

Offered to all individuals referred by St. John's personnel, irrespective of their health plan or HARP

We will promote the use of recovery focused language (.e.g. people not cases or patients)

Protecting the integrity and trust of the peer role is essential

NYAPRS/St. John's Hospital Peer Bridger Model

- Tyrone will work with 140 'high needs' individuals over the course of a year
- He'll work with an average of 30 people at one time, split between those who are inpatients and those in the community
- He'll facilitate peer support meetings in the hospital and at the clinic
- He can provide periodic staff trainings on recovery values and peer support.

NYAPRS/St. John's Hospital Peer Bridger Model
Hospital Based Approach

- Engagement at the time of admission
- I am here for, will share my experience with and offer support to you
- I am a 'liaison' to but not a member of the treatment team
- My focus is on your personal needs and goals, both during your stay and in the development of your discharge plan

NYAPRS/St. John's Hospital Peer Bridger Model
Hospital Based Approach

- I can drive you home and support you to pursue your recovery and life goals in the community
- We can work together to develop wellness, relapse prevention and crisis support plans to prevent avoidable ER visits and readmissions
- I can support you to better understand and manage your health needs
- With your permission, I can work with but **will not be your case manager or therapist**

NYAPRS/St. John's Hospital Peer Bridger Model Community Engagement Approach

- Services include:
  - Outreach and engagement
  - Crisis stabilization: addressing most urgent needs
  - Wellness coaching and support
  - Relapse prevention and crisis diversion
  - Advocacy and collaboration with treatment and supports
  - Linkage to community and peer supports and providers.

Protecting the Integrity of Peer Support

- Tyrone works for the individuals he serves not for St. John's. He informs and supports the treatment team but is not a member of it.
- Peers frequently work for subcontracted peer run agencies and are supervised by peers

http://www.mhepinc.org/partners/the-coalition-to-protect-the-integrity-of-peer-services/peer-run-services-fact-sheet

Westchester Medical Center Health Network PPS

Maureen Doran, VP, Integrated Care Network

Hal Smith, Sr. Director, Behavioral Health

Aby Diop, Sr. Mgr., Behavioral Health

The Transition of Care Wellness (TOCW) Model Overview

- A triple aim demonstration pilot project targeting improvement of coordination for better recipient access to care and obtain better outcomes:
  - PPV, PPR, FUH-7/FUH-30
- Use of Peer Specialists to engage and support recipients from inpatient hospitalization to community navigation connection and successful reintegration.
- Collaboration designed between BH clinical and community partners. Project design and workflow development. Formation of workflow and roles

Summary

- ***Background and Goal:*** description of the problem you're trying to solve, why your organization is involved, who is doing the work, and/or how the work is structured.

- ***DSRIP Measures Impacted include:***
  - Follow-up after hospitalization for Mental Illness (FUH)
  - Antidepressant Medication Management (AMM)
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

And Patient EXPERIENCE!!!

Process & Implementation

ED

Screening/ Eligibility Criteria

- Medicaid
- County of Residence
- Psychosocial Assessment
- - SDOH

* Stratify based on utilization of services (> 4 ED visits per quarter)

Inpatient

Peer Engagement

- Participate in daily huddle
- Connect with patient upon admission
- Complete intake and explore natural resources and social determinants of health
- Plan logistics for discharge

. Discharge checklist

. 48 hour safety plan

. Wellness survey

Community

Linkage to Community Services

- Conduct a wellness check prior to 48 hour home visit
- Maintain regular contacts to ensure 7 and 30 Day FUH
- Provide transportation for follow up appointments and pharmacy pick-ups
- Link to other community services as appropriate


Communication is Important!
Contact
For more information please contact your assigned Social Worker.
Behavioral Health Services
Mid-Hudson Regional Hospital
241 North Road
Poughkeepsie, NY 12601
(845) 483-5000
WMCHealth Transition of Care Wellness Program
Performing Provider System (PPS)


¡La comunicación es importante!
Contacto
Para obtener más información, comuníquese con su trabajador social asignado.
Bon Secours Community Hospital
Member of the Westchester Medical Center Health Network
160 East Main Street | Port Jervis, NY 12771
845.858.7000
Programa de bienestar para la transición de la atención de WMCHealth
Performing Provider System (PPS)

TRANSITION OF CARE

PEOPLe Inc.

Innovations of PEOPLe, Inc

About PEOPLe Inc.

- PEOPLe Inc. (est. 1990) is a peer-run not-for-profit agency whose mission is to educate, support, and empower people to understand, manage, and overcome mental health challenges.
- Our perspective and services on wellness has afforded our communities to experience valuable additions and alternatives to the traditional mental health systems.
- The thousands of people we serve every year consistently give us the highest ratings for service quality, customer satisfaction, and outcomes.
- PEOPLe Inc. has grown from a grassroots peer advocacy and support organization to become one of the most recognized and respected behavioral health organizations, known for:
  - Rose Houses (Respite & Diversion)
  - Stabilization Centers
  - Crisis Intervention Team Trainings for NYS Law Enforcement
  - Transition Of Care Wellness Teams

PEOPLe Inc

Why Transition of Care?

Discharge Plans DO NOT WORK!

- People who are discharged from in-patient care often face some, if not all, of the following challenges:
  - Abrupt and unprepared discharges
  - Entering the home that may have been in disarray prior to entering the hospital
  - Prescriptions that are unfilled
  - Access to paying for and getting to the Pharmacist for prescriptions
  - Compassionate Community supports
  - Access/Transportation to follow up appointments
  - Appointment reminders

PEOPLe Inc

Transition of Care Goals

- Reduce Preventable Hospital Readmissions / Future Admissions
- Improve Patient the Relationship and Engagement to people served
- Build a trusting relationship for people and offer alternatives to traditional crisis care
- Implement a 100% Peer-delivered Model
- Improve Population Health Outcomes
- Meet DSRIP Performance Reporting Targets
- Pave the Way for Value-Based Care

PEOPLe Inc

Service Components

- Peer-to-Peer Engagement & Relationship Building in the Hospital - *Inpatient Behavioral Health Units*
- Hospital-to-Home In-Person Connections
- Ongoing Discharge Plan Review and follow through
- Ex-patient-to-Care Team Liaison Services
- Regular, Ongoing supportive Contact
- Direct Linkages / Warm Handoffs to Services
- Education on Medication Self-Management
- Empowerment and advocacy
- Health Literacy
- Wellness Coaching

PEOPLe Inc

Target Population

- People who are referred to as Patients in Hospital's Inpatient Behavioral Health Units with any of the following characteristics:
  - High Utilization History (*e.g. 4 or more ED visits in calendar year*)
  - Co-Occurring Substance Use Issues
  - Co-Occurring Physical Health Issues – *e.g.*
    - *Cardiovascular Disease*
    - *Respiratory Disease*
    - *Diabetes*
  - High Risk of Readmission – *based on psychosocial assessment and/or peer engagement using Motivational Interviewing*

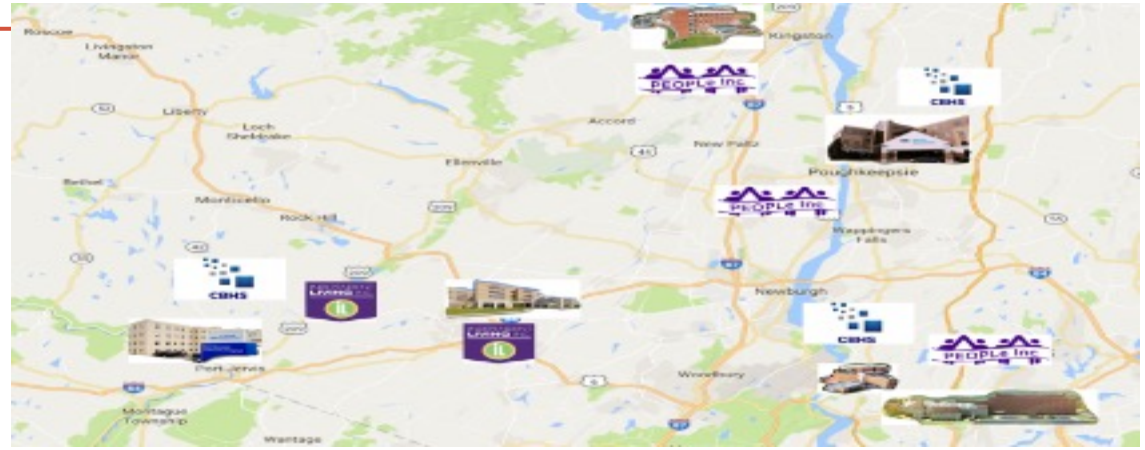
PEOPLe Inc

Challenges

- Culture change- Hospital, Peer organizations and CBOs
- Volume- Anticipate vs actual participation
- Friday Discharges-Need contingency plans for unanticipated weekend discharges
- Reimbursement- MCO negotiations and Dual Medicaid/Medicare
- Wrap around support services (medication co-pay, food…etc.)

Future Considerations

- Use Healthify platform to communicate and track referrals
- Conduct pilot evaluation (3 months, 6 months and 12 months)
- Expand pilot to other PPS hospitals



Target Population in the future

"Anyone and everyone deserves this quality care"

Thank you

Steve Miccio, CEO

PEOPLe, Inc

stevemiccio@projectstoempower.org