NEW YORK STATE | Department of Health | Medicaid Redesign Team

Outreach Activities for Member Engagement in New York State Medicaid

Douglas G. Fish, MD

Medical Director
Division of Program Development and Management
Office of Health Insurance Programs
New York State Department of Health

April 2016

Agenda

- Outreach by Health Homes and Care Management Agencies
- Outreach and Community Health Workers/Peers in DSRIP
- Lessons Learned from Community Health Workers/Peers in HIV Care and Retention

Health Homes and Care Management Agencies

Strategic Task Force for Outreach & Enrollment of HARP Members into Health Homes

- Strategic Task Force started for Outreach and Enrollment of HARP-Eligible and HARP Members into Health Homes (HH)
  - Includes OMH, DOH, OASAS, NYCDOHMH, HHs, Managed Care Organizations and some Care Management Agencies
  - NYC Task Force convened regularly since 4/2015 for HARP-Eligible and subsequently HARP members as of October 2015
  - Rest of State Task Force convened beginning 1/2016 for HARP-Eligible Members

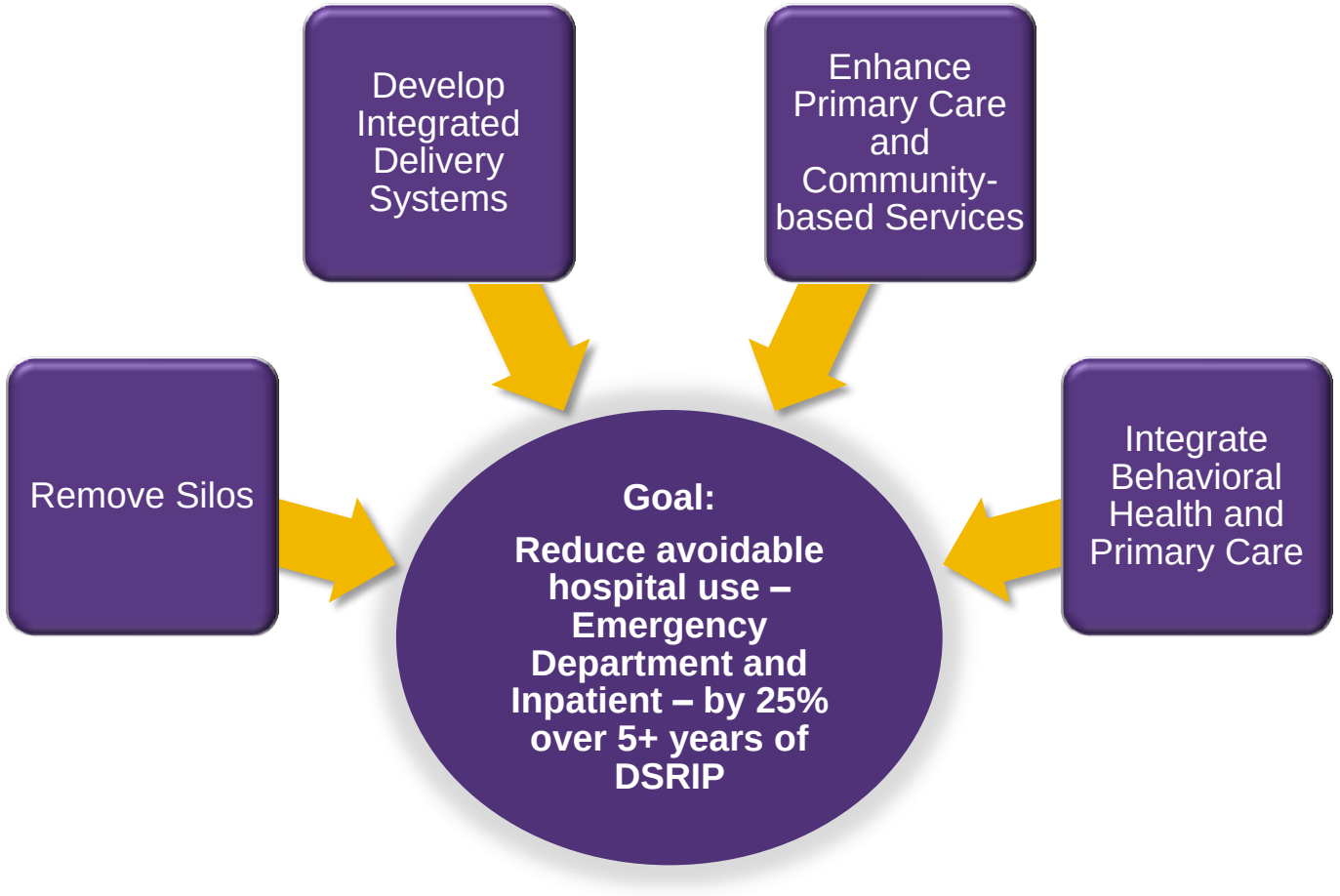
- Outreach and Enrollment Data
  - NYC – 6,325 HARP members are in Outreach and 11,907 are Enrolled in a HH, as of April 5, 2016
  - Rest of State - 5,397 HARP-Eligible members are in Outreach, and 11,829 HARP-eligible members are Enrolled in a HH, as of March 24, 2016.

Strategic Task Force for Outreach & Enrollment of HARP Members into Health Homes

- HH works from the Assignment files
- HH/Care Management Agency (CMA) may locate members through emergency department (ED) and hospitalization
  - Includes behavioral health admissions and medical admissions
  - Notifications may by the Health Plans for those in Outreach or those who are Enrolled
  - Notification may come from the Regional Health Information Organizations (RHIOs) for HH Enrolled members
- HH/CMA may have an ongoing working relationship with a given provider/practice and be able to engage members who present to that provider/practice for care
- Managed Care Organization may employ community health workers to help find those members who the HH is unable to reach

Delivery System Reform Incentive Payment (DSRIP) Program and Community Health Workers/Peers

DSRIP Explained



- Built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health
  - Reducing costs

DSRIP and Patient Navigators/Community Health Workers/Peers

Domain 2 System Transformation Projects

- Project 2.a.i. Integrated Deliver Systems
  - Utilize, where appropriate, community health workers, peers and culturally competent community-based organizations to assist with patient outreach and navigation

- Project 2.c.i Development of community-based health navigation services

- Project 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community-based Care
  - Utilizes the Patient Activation Measure (PAM ®) tool by Insignia

DSRIP and Patient Navigators/Community Health Workers/Peers

Domain 3 Clinical Improvement Projects

- Project 3.a.iv Withdrawal management services in outpatient setting
  - Care management may be enhanced by peer supports
- Projects 3.b.i. and 3.c.i. Cardiovascular Disease and Diabetes Mellitus
  - Practices will develop care coordination teams including use of nursing staff, pharmacists, dietitians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
- Project 3.f.i Perinatal Project to increase support programs for maternal and child health (including high risk pregnancies)
  - Model 3 - Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program.

DSRIP and Patient Navigators/Community Health Workers/Peers

Domain 4 Population-Wide, Prevention Agenda Projects

- Project 4.c.i and 4.c.ii Prevent HIV and STDs
  - Increase peer-led interventions around HIV care navigation, testing and other services.
  - Launch educational campaigns to improve health literacy and patient participation in health care, especially among high-need populations, including Hispanics, and lesbian, gay, bisexual and transgender (LGBT) groups.
  - Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.

- Project 4.d.i. Reduce Premature Births
  - Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education and health care service utilization and enhance social support to high-risk pregnant women.

NYC HIV DSRIP Projects: Increase Access and Retention in Care

DSRIP HIV Domain 4.c.ii Project	NYC Performing Provider System (PPS)						
4.c.ii – Increase early access to, and retention in, HIV care	**HHC Facilities**	**Community Care of Brooklyn (CCB) Maimonides**	**St. Barnabas**	**Lutheran Medical Center**	**Bronx Lebanon**	**Mount Sinai**	**NY Hospital Queens**
1. Viral Load Suppression (VLS) project	x	x	x	x	x		x
2. Integration of HIV Screening /Improved Linkages	x	x	x	x	x	x	x
3. PrEP for High Risk Negatives	x	x		x	x	x	x
4. Peer Support Program	x	x	x	x	x		x
5. Peer Specialist Health Navigation Services			x	x	x	x	x
6. Improve Cultural Competency	x	x	x	x			x
7. Virology Fast Track Plus	x	x	x		x		
8. Education Campaign/Social Marketing	x	x	x	x	x		
9. Partner Services	x						x
10. Therapy for Depression				x			x
11. HIV Registry				x			
12. Link Needle Exchange Services						x	

DSRIP & Medicaid Peer Initiatives

Initiative	Role of Peers
Delivery System Reform Incentive Program (DSRIP)	Peers will serve as navigators and/or staff of self management programs; and conduct support groups and/or outreach for patient activation in community settings (Project 11), among other activities. In addition, numerous projects utilizing Community Health Workers (CHWs) for outreach and management of chronic conditions will begin(CHWs are not required to be peers).
Health and Recovery Plans (HARPs)	Offer 1915i Home and Community Based Services (HCBS) include vocational & peer services.
Harm Reduction Counseling as a Medicaid billable service	Peers provide or assist in providing a wide range of services including outreach, individual- and group-level interventions, client navigation, support groups and referrals. A State Plan Amendment (SPA) process for federal approval is underway.
Health Homes	Utilizes a flexible care team composition which may employ community members. There are 42 legacy HIV COBRA case management providers who have transitioned to be Health Home providers.
AIDS Adult Day Care (ADHC)	Utilize peers as stipend workers who provide assistance at the program sites, including reception area support, light maintenance, etc. The intention is to foster vocational interests and to build employment-related skills.
HIV Special Needs Plans (SNPs)	Some SNPs currently utilize peers in care delivery teams.

Lessons Learned from Community Health Workers/Peers in HIV Care and Retention

Medicaid Members with HIV Infection

- High burden of Mental Health and Substance Use Disorder co-morbidities
- The AIDS Institute (AI) has, for many years, recognized the important role that peers can play in improving health outcomes
- Peer certification is highlighted in the NYS Blueprint for Ending the AIDS Epidemic
  - Peer services can play a key role in meeting the State's goals of increasing linkage and retention in care, rates of viral suppression and preventing new infections.

Advancing Ending the Epidemic Goals through the Community Workforce

- **Goal 1: Identifying persons with HIV who remain undiagnosed and linking them to care.**
  - Long-term follow-up and outreach (Patient Centered Medical Home [PCMH] model)
  - Peer Educators
  - Community Health Workers

- **Goal 2: Linking and retaining persons diagnosed with HIV/AIDS in care to maximize viral suppression so they remain healthy and to prevent further transmission.**
  - Treatment adherence interventions: mobile communications devices; patient incentives; treatment adherence counselors
  - Care coordination: integrated and coordinated care by leveraging existing data infrastructure such as the Regional Health information Organizations (RHIO); incentivizing patient tracking; Health Home care management; Clinician Case Conferences
  - Housing: housing placement and referral; employment and food security support

- **Goal 3: Facilitating access to Pre-Exposure Prophylaxis (PrEP) and non-occupational Post-Exposure Prophylaxis (PEP) for high-risk persons to keep them HIV negative.**
  - Medication Access staffing
  - HIV and PrEP outreach
  - Follow-up ongoing screening (STI)

AIDS Institute's Peer Certification Program

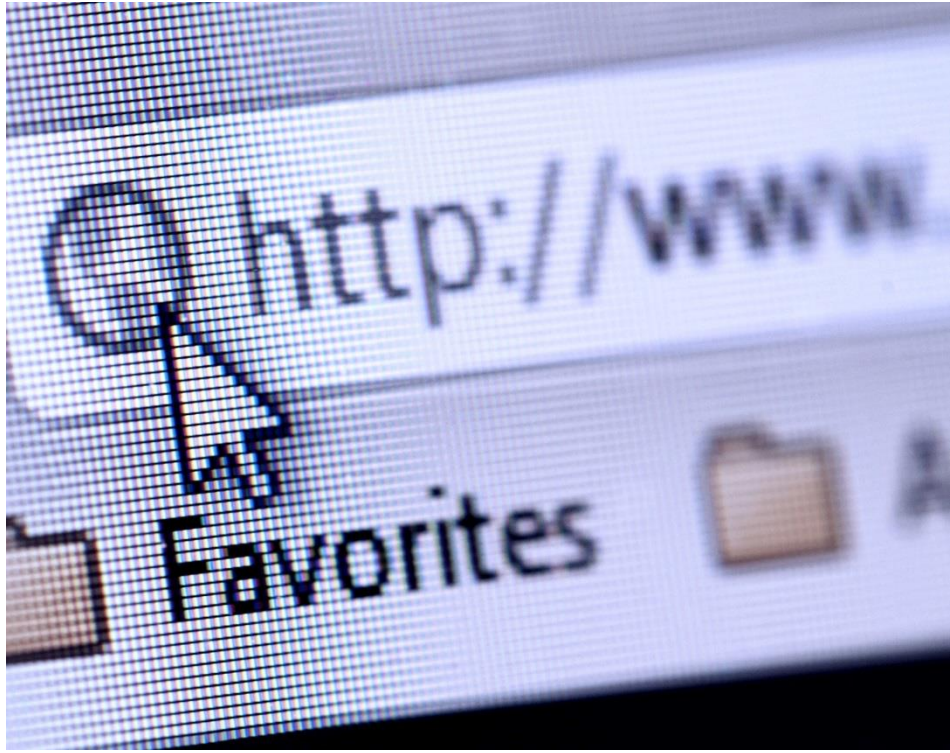
- The AIDS Institute has a long history of supporting peer-based interventions
- Well-established community workforce of peers who are embedded in HIV, HCV, Harm reduction, prison re-entry and substance abuse treatment models of care
- Community agencies have trained and integrated peers
- Growing body of evidence-based interventions with demonstrated success

NY State AIDS Institute Peer Services

- Peer Certification FAQ
- Peer Certification Course Catalog
- AIDS Institute Course Catalogue by track (HIV, HCV, Harm Reduction)
- Peer Certification Code of Ethics
- Course Tracker Forms
- Core Competencies
- Organizational Assessment for Peer Delivered Services
- Foundational Training

All of the AIDS Institute's most recent documents are available on the SDOH website, here: https://www.hivtrainingny.org/Home/PeerCertification

Thank you! Questions?



Additional information available at:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

DSRIP e-mail:
dsrip@health.ny.gov

Follow the MRT on Twitter: @NewYorkMRT

'Like' the MRT on Facebook: http://www.facebook.com/NewYorkMRT

Subscribe to our listserv:
http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm


WellCare®
Health Plans

Effective Strategies to advance outreach and engagement – a health plan perspective

Carole A Matyas, MSW, Vice President Behavioral Health Operations, WellCare Health Plans, Inc.

NYAPRS- Collective- Executive Seminar April 21, 2016

What does a health plan want?

Help us achieve the IHI Triple Aim

The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance.

It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Outreach and engagement of members is essential for us to achieve the Triple Aim

What does a health plan want ?

Better coordination of care for our members-

- improved member care experience through a more efficient, patient/member centered and coordinated system with less system fragmentation and less inpatient care and more integrated community-based care

- Movement from a reactive, provider-focused system to a proactive, member focused system that includes the use of peers and caregivers

- more collaborative process that reflects the needs of the populations we serve; care provided in the communities where our members live and attention to the social environmental factors that affect member care

Outreach and engagement happens when there is a strong commitment to coordination and attention is paid to the individual members needs not the providers needs.

Outreach and Engagement Strategies Health Plans support that are provided by peer/recovery based programs

- Use of peer specialist to facilitate transition of care from acute hospital settings to community based treatment
- Use of peer specialist to be part of the Integrated Health Home (BH Health Home) programs
- Use of community drop in centers and peer recovery programs to engage members on social level
- Use of peer specialist and caregivers to engage/ support non medical/behavioral interventions such as getting members enrolled in weight watchers or exercise programs
- Use of consumer run organizations to support employment and promote a peer operated business
- Use of peer specialist as staff members to do outreach and try to locate members in the community
- Use of peer specialists as health coaches who keep in touch and follow up with members to assure they are monitoring both medical and behavioral health conditions

How can providers/ peer organizations prepare for value based purchasing?

Understand and embrace that the care delivery system is ever changing and if your organization does not change it is likely to be left behind

Understand and embrace the fact that how you do business today is not how it will be in the future

Prepare your organization by educating them and engaging in activities that promote the culture changes needed to build a new business model; include your boards too

Incorporate member/patient centered activities today – be able to coordinate care and communicate across provider systems, with the health plans and other stakeholders

Determine your best strategy for integration: co-location, collaboration- include peer/recovery services in your integration activities

Current VBP strategies at WellCare

- **Medical and Behavioral Co-location** – Wherever possible realizing there are many iterations of this; we are starting to look at outcomes and driving to models that show promising results
- **Incentivizing Providers** – Pay-for-performance that rewards BH providers who improve HEDIS measures related to medical conditions
- **Alignment of BH Providers and PCP's** to assist each other in consultative roles and identify ways to "share patient" treatment goals
- **Developing Integrated Health Homes** – Health home strategies are gaining momentum and showing results more quickly than any other strategy we have implemented

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Community Health Workers
Effective Strategies to Advance Outreach and Engagement

NYAPRS Collective - Beyond Survival to Success
April 21, 2016

Romelia Corvacho, Patient Navigator Program Manager
NewYork-Presbyterian Hospital

Sergio Matos, ED
Community Health Worker Network of NYC

Community Health Worker Network of NYC

The Community Health Worker Network of NYC is a professional association of CHWs that exists to advance the practice through education, advocacy, and research, while preserving the identity and character of CHWs.

Who Are CHWs?

Community Health Workers (CHWs) are **frontline public health workers** who are ***trusted*** members of and/or have an ***unusually close understanding of the community served***. This trusting relationship enables CHWs to serve as a ***liaison/link/intermediary*** between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also ***build individual and community capacity*** by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

– American Public Health Association, 2008

Note: Submitted to the US Department of Labor Bureau of Labor Statistics for use in description of Standard Occupational Classification #21-1094 – Community Health Worker

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

CHW Interactions

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

What Do CHWs Do?

Outreach/Community Mobilizing

Preparation and dissemination of materials
Case-finding and recruitment
Community Strengths/Needs Assessment
Home visiting, Promoting health literacy
Community advocacy

System Navigation

Translation and interpretation
Preparation and dissemination of materials
Promoting health literacy, Patient navigation
Addressing basic needs – food, shelter, etc.
Coaching on problem solving
Coordination, referrals, and follow-ups
Documentation

Community/Cultural Liaison

Community organizing, Advocacy
Translation and interpretation

Participatory Research

Preparation and dissemination of materials
Engaging participatory research partners
Facilitating translational research
Interviewing
Documentation

Case Management/Care Coordination

Family engagement
Individual strengths/needs assessment
Addressing basic needs – food, shelter, etc.
Promoting health literacy
Goal setting, coaching and action planning
Supportive counseling
Coordination, referrals, and follow-ups
Feedback to medical providers
Treatment adherence promotion
Documentation

Home-based Support

Family engagement, Home visiting
Environmental assessment, Promoting health literacy
Supportive counseling,, Coaching on problem solving
Action plan implementation
Treatment adherence promotion, Documentation

Health Promotion & Coaching

Translation and interpretation
Teaching health promotion and prevention
Treatment adherence promotion
Coaching on problem solving
Modeling behavior change
Promoting health literacy
Harm Reduction

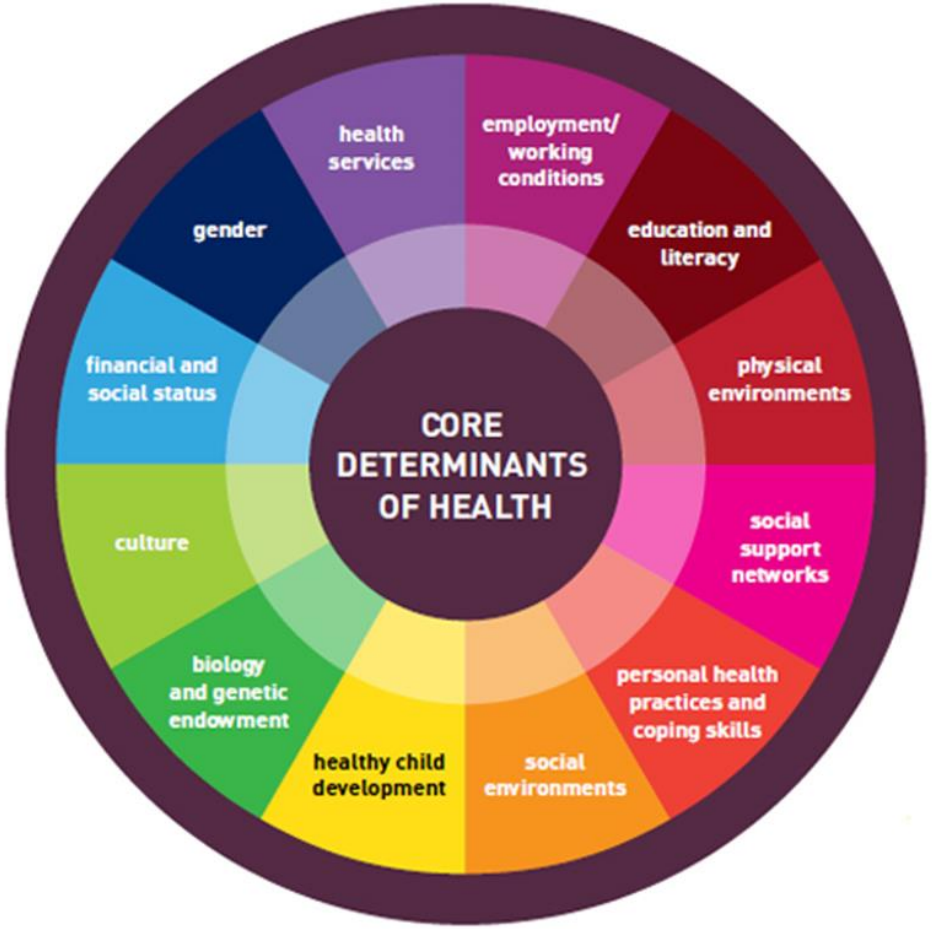
NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Health and its Social Determinants

Health is the state of complete physical, mental and social wellbeing – and not merely the absence of disease.

This state of being is a fundamental human right…



NewYork-Presbyterian Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

What CHW Employers Seek

1. Shared life experiences
   - Socio-economic, educational, racial/ethnic
   - Most essential element considered by employers
   - Single largest contributor to success
2. Personal Attributes
   - Essential to CHW work – relational experiences
   - Not just anyone can be a CHW
3. Work Experience
   - Roles, Tasks, Skills
4. CHW Training
   - Core competencies
   - Specialty topics
   - Least important

NewYork-Presbyterian
Performing Provider System

CHN NETWORK NYC
Community Health Worker Network of New York City

Preferred CHW Attributes

Connected to Community

Resourceful, Creative

Mature, Prudent, Persistent, Courageous

Empathetic, Caring, and Compassionate

Open-minded, Non-judgmental, Relativistic

Respectful, Honest, Polite, Civil, Courteous

Friendly, Outgoing, Sociable, Charismatic

Dependable, Trustworthy, Responsible, Reliable

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

New York State Recommendations

- CHW Definition
  - Endorsed and adopted APHA definition
- CHW Labor Market Analysis
  - Original scientific research, analysis and publication
- CHW Scope of Practice
  - Functional Task Analysis
- CHW Training Recommendations
  - Content and Pedagogy
- CHW Certification Guidelines
- CHW Business Case
  - Outcomes, health care utilization, value-added, cost-savings, return-on-investment
- CHW Financing Recommendations

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Study/site	CHW activities and outcomes	ROI (per year)	Sources for data
Homeless mentally ill	CHW home visits and behavioral change support reducing institutional care costs	1.15	Calculated from case-control data in Wolff et al. , 1997, reported in Viswanathan
Childhood asthma management, Seattle, WA	High intensity CHW intervention w. home visits, reducing urgent visit/hosp costs	1.21	Calculated from pre-post data in Krieger et al, 2005
Childhood asthma management, New York, NY	CHW provides education and care coordination reducing urgent visits/hosp.	4.01	Calculated from pre-post in Peretz et al., 2012 [1]with additional data from Nieto and Peretz
Theoretical savings for pediatric patients making clinic visits in Harrisonburg,VA	CHW will do primary care triage and manage limited protocol of conditions, reducing clinic visits	1.60	Calculated from comparison data in Garson et al 2012
Diabetes control along Texas border	Diabetes education and support in making lifestyle changes, reducing care costs through lower A1c	4.62	Calculated from comparative cost data in Culica et al., 2008
Employees of Langdale Mft in Lowndes County, Georgia	Case management support to workers with chronic disease, reducing acute care costs and work loss days	4.80	Calculated by Miller, 2011
Chronic illness patients in Denver Health Plan, Colorado	CHW intervention with care management, reduced urgent/hosp costs	2.28	Calculated by Whitley, Everhart & Wright, 2006
Arkansas Medicaid managed care program	CHW community connector program provided by state managed care program	2.92	Calculated by Felix et al, 2011
Molina Healthcare, Medicaid Managed Care, New Mexico	CHW with high-user, complex patients, providing navigation, health coaching, & chronic disease mgt	2.18	Calculated from pre-post data in Johnson 2011
Diabetes management for low-income patients in Baltimore, MD	Volunteer CHW educates & provides care coordination, reducing diabetes-related costs	6.10	Calculated from pre-post data in Fedder et al, 2003
Diabetes management for low-income patients, New York, NY	CHW provides education and care coordination, reducing urgent visit/hosp costs	2.32	Calculated from pre-post data supplied to the authors, reported in Findley, Matos & Reich 2012

Certification Pros?

- Increased access to funding/sustainability
  - Business case and evidence for CHW effectiveness more impactful
- Better opportunities and wages
  - Experienced employers are not asking for certification
- Prestige, recognition, stability
  - No existing evidence
- Increased cooperation with health care community
  - Role understanding and CHW effectiveness more relevant
  - When providers witness CHW success cooperation increases

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Certification Cons

- Could redefine the practice – loss of identity and CHW power
- Establishes restrictions on the practice
  - Limit scope of practice
  - educational requirements, immigration status, language, financial
  - criminal background
- Not necessary
  - Nobody is asking for it
    - Business case is extensive and increasingly published
    - Employers prefer personal qualities and shared life experience
  - Certification alone does not provide recognition, security, increased employment nor better wages
- Legislative agenda requires state funding
  - Build credentialing structure
  - Test, evaluate, record, register, enforce
  - States are generally reluctant to expand government or spending

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

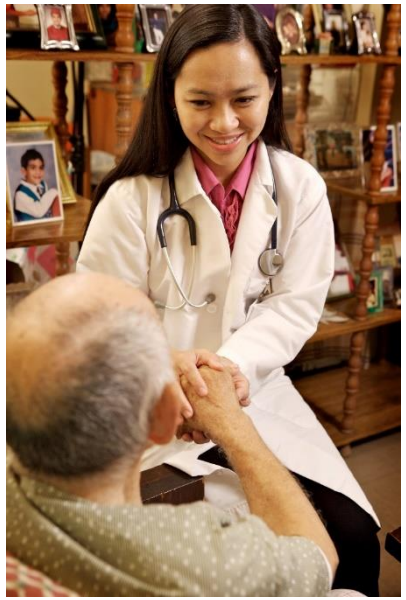
Challenges to Primary Care Access

- Lack of primary care provider
- Deferred attention to disease management
- Assumptions of health
- Acute medical experiences
- Perceived acute incident
- Immigration Status
    - Non-status
    - Visa restrictions
    - Permanent status pending
    - Fear of public charge designation
- Fear of government
- Fear of financial consequences

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Provider visits with CHWs



NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Solutions to Challenges

- Trust/Shared life experiences
- Provide safety
- Give honest and accurate explanations
- Provide education
- Offer support/assistance
- Explore resources

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

CHWs at Health Fairs and Youth Events

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Engagement

- Meet them where they are
- Validate that they have fears/concerns
- Correct myths or misunderstandings
- Explain available resources
- Provide support
- Follow-up. Stay in touch
- Set SMART goals
- Celebrate accomplishments

NewYork-Presbyterian
Performing Provider System

CHW NETWORK NYC
Community Health Worker Network of New York City

Effective Strategies and Innovations to Advance Outreach and Engagement

NYAPRS Executive Seminar

April 21, 2016

Tanya Stevens

NYAPRS Deputy Director

New York Association of Psychiatric Rehabilitation Services (NYAPRS)

A peer-led state and national change agent that is dedicated to improving services, social conditions and policies for people with psychiatric disabilities and/or diagnoses by promoting their recovery, rehabilitation, rights and full community inclusion.

Strategies: Advocate, Educate and Innovate

harveyr@nyaprs.org tanyas@nyaprs.org

www.nyaprs.org

NYAPRS Peer Bridger Model

* Developed in 1994 by NYAPRS to assist state hospital residents with long or frequent stays in 6 state hospitals to successfully transition to the community
* Support individuals to successfully transition from hospital to community
* Training hospital and community providers on recovery and peer support

Key Values and Value

* Trusted, Safe Relationships
* Person driven and Directed
* Acceptance, Empathy and Example
* Honesty and Shared Accountability
* Hope, Respect and Dignity
* Empowerment and Choice

State Hospital Program Mission

Program Evaluation Data

* 1998 National Health Data Systems: In the 2 years prior to involvement in our program, 60% of program participants had been hospitalized. After enrollment in the program, 19% were re-hospitalized during the following year, a **40% reduction.**
* 2009 NYAPRS program evaluation data: **71%** (125 of 176) of program participants were **not readmitted** in the year following discharge from the hospital

Unique Appeal of Peer Support

* *"She talked to me. She talked straight at me. She's the only one who did this. 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."* MacNeil dissertation 2003

Medicaid Managed Care Adaptations

* 2008-11 DOH Chronic Illness Demonstration Program with Optum in Queens
* 2012- present Optum Peer Bridger initiative
* 2014-present Health First Peer Bridger initiative

NYAPRS Peer Bridger Competencies

* Successful management of recovery
* Trained facilitators in Mary Ellen Copeland's Wellness Recovery Action Program
* Trained in Shery Mead's model of Intentional Peer Support
* Completed the Rutgers credentialed program on Peer Wellness coaching (see next slide)
* OASAS certified Addiction Recovery Coach

Wellness Tools

* Wellness Recovery Actions Plans
* Advance Directives
* Health Literacy Education
* Shared Decision Making, Person-centered Planning
* Whole Health Peer Support
* Whole Health Action Management

"Why Don't these Individuals Show Up, Follow Through and Get Better?"

* Unstable housing or homelessness
* Poverty and joblessness
* Inadequate social supports, isolation
* Hopelessness
* Addictions
* Trauma, chronic sense of chaos and crisis
* Disorganization and chaos
* Multiple medical needs

Outreach Takes Time!
Starting at the Hospital

* Traveling to hospitals
* Gaining hospital approval to see individuals
* Waiting for the individual

Outreach Takes a lot More Time!
Starting in the Community

* Finding correct addresses or phone numbers
* Searching homeless shelters
* Talking with providers
* Talking with family members over several visits
* Traveling out to numerous locations before contact is made

Evidence-Based
Outreach & Engagement

* Relentlessness… especially to overcome bad addresses and other barriers
* Repeated contact; follow-up is essential
* Relationship, reliability, trust building are central
* Meet people where they are, both regarding what they identify as immediate needs and where they live, bringing services to them rather than to expect them to visit a service agency for help
* Linkage to supports, services and social networks

Outreach and Engagement by the Numbers

* On average, our Bridgers spend between 15 and 30 hours conducting outreach on each referred member.
* NYAPRS Peer Bridgers have a success rate of approximately 75% of locating individuals and once located, we are able to engage approximately 56% of total individuals referred.
* Compare this to the current Health Home engagement rate of 18% or the typical case management engagement rate of 34%.

NYAPRS Peer Bridger Outreach by the Numbers

* In 2015, our Bridgers billed for an average of 402 service hours per month. 37% (101) of those hours were for outreach.
* Update: on average over the past 5 months, our Bridgers have been able to successfully engage approximately 72% of all of the individuals referred to the program.

Findings from 2013 Optum External Peer Evaluation for NYAPRS Peer Bridger Initiative

- **6 months pre-post, members who enroll in the program show:**
  - **Significant Decreases in % who use inpatient services**
    - 47.9% decrease (from 92.6% to 48.2%)
  - **Significant Decreases in # of inpatient days**
    - 62.5% decrease (from 11.2 days to 4.2)
  - **Significant Increases in # of outpatient visits**
    - 28.0% increase (from 8.5 visits to 11.8)
  - **Significant Decreases in total BH costs**
    - 47.1% decrease (from $9,998.69 to $5,291.59)

*Among subsample of enrollees in NY (N =) and WI (N = 130) with continuous eligibility 6 months pre-referral and 6 months post-referral and at least one behavioral health claim during that period

NYAPRS/HealthFirst Peer Bridger Initiative

* Contracted to work with 500 individuals
* 98% of engagements in the community
* July-Aug 2014
  * 373 referrals, 256 enrollments (68.63%)
* The number of contacts (either phone or face-to-face) between the Peer Bridger and the enrolled individual ranges from 1 contact to 78 contacts.
* The average number of contacts between the Peer Bridger and an enrolled individual is 18 and the average number of hours spent with enrolled individuals is 15

NYAPRS Wellness Coaching Impact: One Person's Outcomes

* 37 year old Indian man born in Jamaica diagnosed with bipolar, substance use and kidney disease
* 2009-prior to enrollment**: 7 detox stays** (4 different facilities) **$52,282** behavioral health Medicaid spend
* 2010-1 detox, 1 rehab (referred by the CIDP team) **$20,650** Abstinent for 1 year
* 2011-1 relapse with detox/rehab no claim

Reimbursement Must be Adequate

* It's all about the relationship and the beginning! There is no ROI without appropriate engagement, activation and 'retention.'
* Outreach MUST be funded as a service that is essential to success, at the right rate and for the time needed
* Funding should reflect the increased cost of conducting outreach in large sparsely populated areas, including long travel time and the need for transportation.

Essential Factors for True Peer Support

* We work for and with the individual
* We are not assistant case managers or transportation aides; nor are we ‘cheap staff who get people to take their medicine’.
* On the other hand, we can help a person with appointments and medications if they define those needs as part of their self identified wellness and recovery plan

Essential Factors for True Peer Support

* Best: Properly trained peer professionals working for subcontracted peer run agencies who are supervised by peers
* Challenge: Peers who are embedded in traditional settings without peer supervision
* Groups are developing competency, training, credentialing and accreditation standards for peer delivered services

Peer Bridger Compensation

* In the 1990's, we began with part time bridgers who wanted to remain on disability benefits.
* Peer support specialists are now a fully developed career path
* According to a new survey developed for the College for Behavioral Health Leadership, annual salaries for peer support specialists average $17 per hour in New York State, including healthcare and retirement plan

Resources

* NYS Academy of Peer Services: offers online training to prepare peers to deliver peer services according to field standards

  http://www.academyofpeerservices.org/

* New York Peer Specialist Certification Board: certifies peer specialists and has established a Code of Ethical Conduct and Grievance Procedure.

  http://nypeerspecialist.org/

* For training and technical assistance or to inquire about subcontracting for peer bridger services, please contact NYAPRS at tanyas@nyaprs.org