Crisis As Opportunity:
Parachute NYC as a Promising Crisis Alternative Practice

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Parachute NYC
Workshop Outline

- Parachute as Innovation: Background and Model

  Pablo Sadler, Parachute NYC Project Director

- Participants' Outcomes in Parachute NYC

  Mary Jane Alexander, Parachute NYC Evaluation Director

- Peers in Parachute

  Antonio Munoz, Peer Specialist Parachute NYC and Visiting Nurse Service of New York

- Launching and Sustaining Principle's of Parachute NYC

  David Lindy, Chief Psychiatrist & Clinical Director for Community Mental Health, Visiting Nurse Service of NY

- Is Parachute Sustainable?

  Neil Pessin, Vice President for Community Mental Health, Visiting Nurse Service of NY

Background

- Many services users and families are unsatisfied with treatment options for people with psychosis

- More information about medication limitations, potential side effects and out of control cost

- The system use of coercive interventions decreased but is still a challenge

- Significant lower life expectancy

Where and What

- Decreased hospital LOS without any clear risk/benefit analysis

- Significant percentage of people receive inadequate or time-limited treatment in jail

- Continuity of care remains an elusive target

- The most innovative community-based treatment approach is ACT (over 40 years old)

- The reward for treatment success is d/c to a lower level of care; no creativity around new models of care

- No option for home-based treatment by choice

- Very limited (and late) family participation

Who and When

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- MH professionals are the key players in the system

- Very limited peer participation

- Family's role is ill defined and controversial

- Most of the time people get their first diagnosis while hospitalized

- People must "fail" before receiving the most comprehensive services in the community

- Family participation in ACT mostly limited to when the person is lost to follow up or "non-compliant"

Government-Advocacy-Academic Partnerships

- Political will in Local and Federal Government to:
  - Develop early intervention for FEP and real peer integration; some presence of family advocates
  - Explore alternative interventions in response to financial needs
  - Integrate Health & Mental Health

- NYC DOHMH Recipient Affairs Leadership, Advocates (INTAR) & NIMH funded Center (NKI) partnered to:
  - Conduct a full day seminar on Crisis Alternatives & peer-led respites
  - Develop a product ready for the right opportunity

The Right Opportunity

- Tectonic System (Medicaid) Changes

- Value of Peer Support Penetrates the System – (*through advocacy, & research)*

- Cost Containment

- No Support Line in NYC System

- Limited family participation in their loved one treatment

- Difficult to introduce change in a static environment

- Discussion of Peer Certification

- Hospital Alternatives

- ER Diversion

- Support for Peer Operated Warm Line

- Explore family inclusion as a clinical standard

The Perfect Storm

- Federal Government Stimulus plan addresses crisis in Health Care costs and access
    - Center for Medicare and Medicaid Innovations funds Innovation Grants in Health
- System *talking* about Recovery
    - Peer participation
    - Peer certification
- Medicaid reform
    - HARPS
    - HCBS
- Collaboration between City and State
    - Dual role *Parachute leaders + Advisors to Regulators*

NAMI National Convention

Denver. July 6-9, 2016

What is different in Parachute

- Peers
  - Involved at every level in a non-peer/peer project: design, training, implementation, evaluation
  - Cross training for peers together with non-peers
- Full family participation
- An attempt to implement and reflect Open Dialogue - a model of transparency
- Active Research Participation in Implementation
- Live laboratory for HCBS in Medicaid Waiver
- Committed community partners

Key Strategies

- Approach is based on National & Internationally recognized promising practices
- People with lived psychiatric experience (peers) are integrated into every aspect of the project
- Dedicated borough for first episode psychosis
- Rethinking Risk
- Aggressive engagement approach, including families from day 1
- Continuity of care
- Home based services
- Home-like Crisis Respite Services

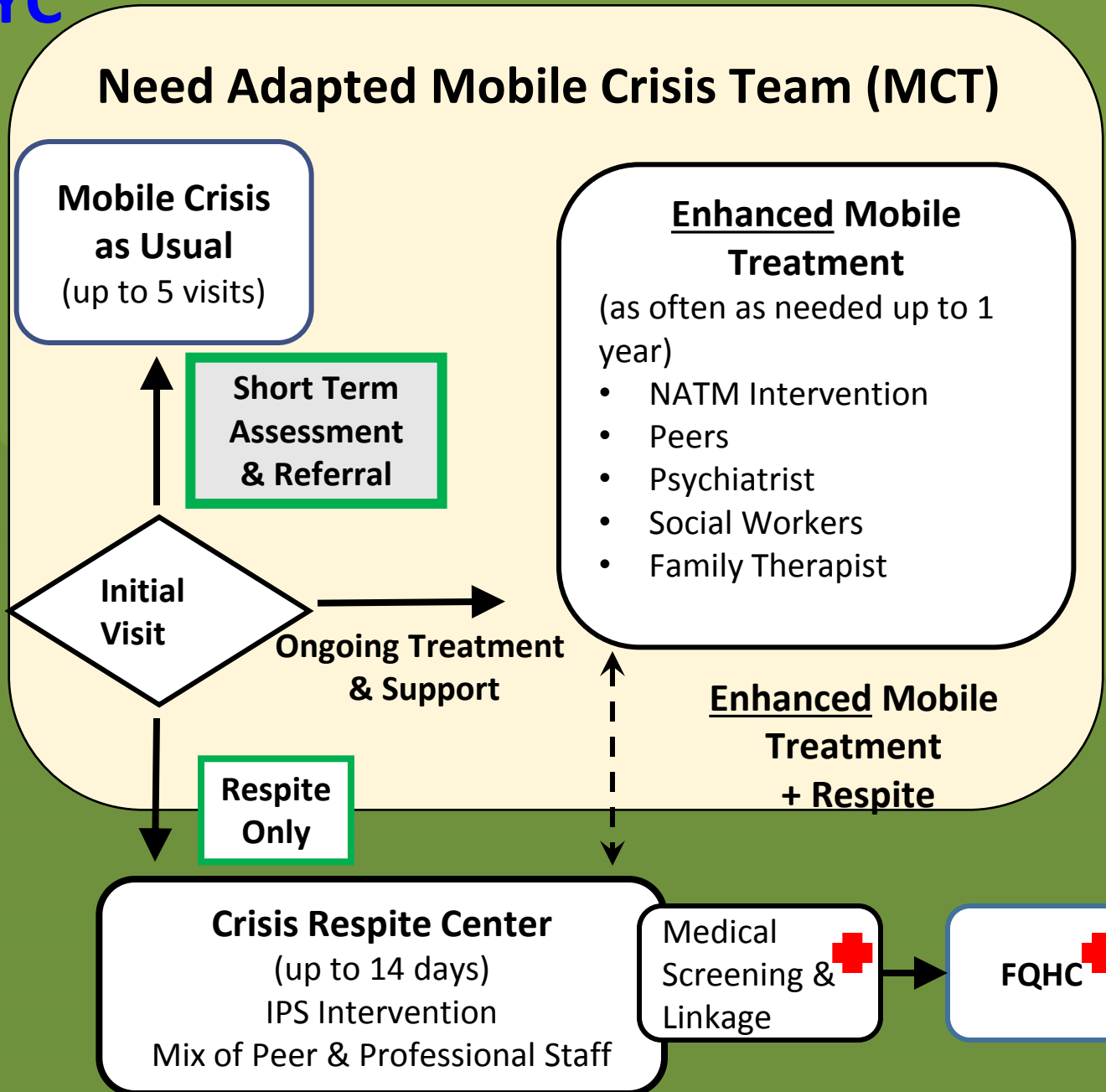# Parachute NYC: A Soft Landing through Variable Levels of Service

Mobile Crisis Team

Crisis Respite Center

Support Line
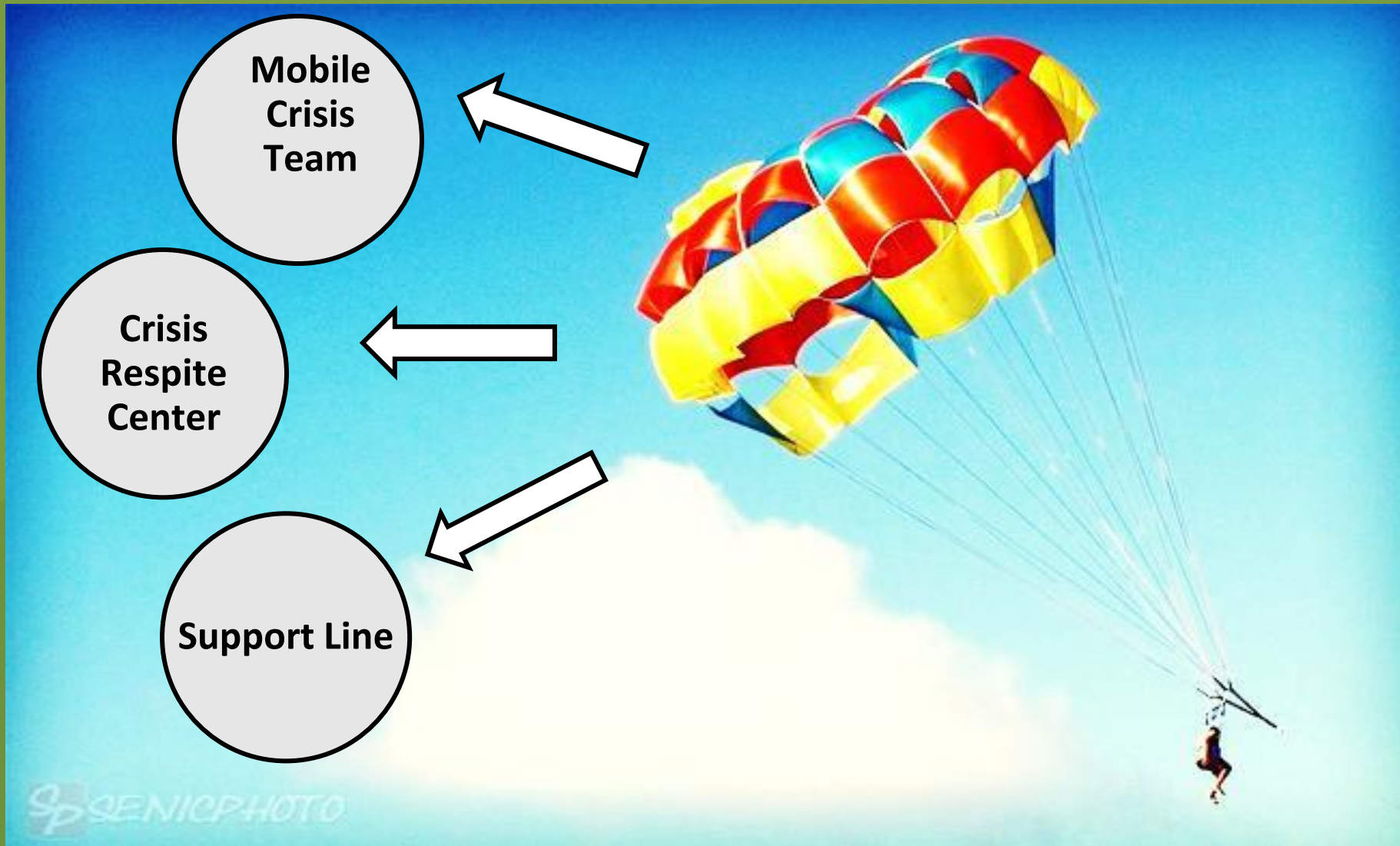
Parachute NYC "the vision"

Referral Sources
- **Provider**
- **Self Referral**
- **Person in Crisis**
- **Family or Friend**

LIFENET Eligibility Screen

Need Adapted Mobile Crisis Team (MCT)

Mobile Crisis as Usual
(up to 5 visits)

Short Term Assessment & Referral

Initial Visit

Ongoing Treatment & Support

Enhanced Mobile Treatment
(as often as needed up to 1 year)
- NATM Intervention
- Peers
- Psychiatrist
- Social Workers
- Family Therapist

Enhanced Mobile Treatment + Respite

Respite Only

Crisis Respite Center
(up to 14 days)
IPS Intervention
Mix of Peer & Professional Staff

Medical Screening & Linkage

FQHC

Parachute NYC- Eligibility Criteria

Resident of the Borough
18-65 years of age (Brooklyn: 16-30 years)
Experiencing a psychosis-related crisis that would otherwise warrant a psychiatric ER visit or Hospitalization (Brooklyn: within 1 year of symptom onset)
Voluntarily seeking or accepting services
Not at imminent risk to self or others
Medically stable
No diagnosis of dementia, organic brain impairment
Stably housed (not homeless)

THE MODELS

Needs Adapted Treatment Model

Intentional Peer Support

Parachute's 2 Models of Care

Needs Adapted Treatment Model (Open Dialogue)	Intentional Peer Support
Immediate Help -24 hours	Hope Based – moving towards
Social Network Perspective	Connection – fully present, trust
Flexible & Mobile	Mutuality – sharing vs. 'helping'
Responsibility	Worldview – how our own experiences shape it
Continuity	
Tolerance of Uncertainty	
Dialogism	

Shared Values NATM & IPS

- Connection and relationship

- Lived experience, and the ability to reflect upon it

- Hearing and honoring all voices

- Explore and co-create meaning and language

- Tolerate uncertainty and discomfort

- Trauma-informed, valuing history and the unfinished, developing narrative

- Common system responses to MH crisis:
    - counterproductive
    - raise human rights issues
    - stem from fear-based stereotypes

- Embracing non-coercion in all engagements

- Recovery as social change, not simply individual struggle

- Self-authored lives, not functional outcomes

- Reorientation to using medications as primary intervention

One size doesn't fit all...does it?

- Are you treating _____?
- Yes means yes, and no means no
  - Eligibility criteria
- The challenge of FEP
  - Cutting down DUP
- Different populations, different timing, different needs
  - CJ, substance misuse, homelessness

In need of close observation

- The challenge of Recovery and peer integration
- Integrating MH/PH without losing identity
  - Most integrating models address people with non-psychotic problems
- Mobile Teams
  - Fidelity criteria development and implementation
  - Long and expensive training
  - Not becoming too selective
  - How to incorporate work/education goals in a pro-active fashion (respecting the model)
- <u>Families</u>
  - <u>Should there be a family advocate in the team?</u>
- Peers
  - Cheap labor force
  - High demand for an untested model
  - Certification: increased power v identity loss
  - Worse case scenario: peers as "treatment compliance" enforcers

We DO Need Government

Federal	State	City
•Leadership for spending when no one else does it • Risk taking for potentially "non-profitable" ventures •Capacity to replicate and scale innovation as needed	•Resources and tools (regulations) to fund innovations even before they become Evidence Based Practices	•Political leverage and linkage with state and federal government • Ability to mobilize people and resources •Ability to identify priorities and influence the public debate •Potential for inter-sectorial coordination within and outside government •Broad shoulders to take on untested alternative interventions

We DO need advocacy & research

- Peers embody possibility and value of recovery
- Advocates amplify hope and voice
- Research systematizes policy discussions

Parachute NYC Participants' Outcomes

Mary Jane Alexander, PhD

Research Scientist

Nathan Kline Institute

New York State Office of Mental Health

Mixed Methods Evaluation

Structured Surveys	
	Conduct quarterly interviews at Baseline and over a 1 year follow-up with a sample of 120 Parachute Participants to track their Mental Health, Care Quality & Non Medicaid Service Use
Quasi Ethnographic observations & interviews	
Implementation	Short feedback loop for CQI for DOHMH, Mobile Teams, Respites and Trainers
Sustainability & Research	Design & support a Learning Community Assess the role of culture for Parachute's diverse participants, settings and workforce Specify the model in action

The Follow-up Interviews Asked:

- Whom did Parachute serve?

- Did Parachute participants weather crisis without hospitalization?

- Did Parachute participants experience services as supporting choice and shared decisions?

Parachute NYC served 2 groups in need of MH Services

	Mobile Team Clients (n=77)	Respite Guests (n=93)
Median Age	25 years	39 years
% Males	69%	47%
% Non White Hispanic enrollees	91%	83%
Hospital Use prior 5 years	50%	70%
Substance Use services prior 5 years	10%	27%
Compared to the General Population and to people with SMI diagnoses:		
Self Rated MH[1]	Worse	Worse
Symptoms of crisis and distress[2]	Worse	
Social Functioning[3]	Worse	Worse

[1] Ware & Shelbourne, 1992 [2] Boothroyd & Chen, 2008; [3] Birchwood, Smith et al., 1990

Did Parachute Participants weather crisis without hospitalization?

Probability of Hospitalization				
	Baseline	**0-3 Months**		**4-12 Months**
	% hospitalized	% hospitalized	Odds Ratio [95% CI]	
Mobile Team Clients	52%	16%	.33 (.19 .57 p<.01)	Sustained
Respite Guests	24%	10%	.56 (.36 .88 p<.05)	Sustained

Weathering Crisis – Parachute Mobile Team Clients' Well Being

Weathering Crisis: Parachute Respite Guests' Well Being

Crisis Symptoms

Parachute… 8.75 | 3 Months 8.94 | 6 Months 8.12 | 9 Months 7.58 | 12 Months 8.12

Distress Symptoms

Parachute Entry 29.68 | 3 Months 27.7 | 6 Months 26.35 | 9 Months 26.06 | 12 Months 25.95

Days Out of Role

Mean Days out of Role

Parachute Entry 11.38 | 3 Months 9.16 | 6 Months 10.54 | 9 Months 7.82 | 12 Months 8.75
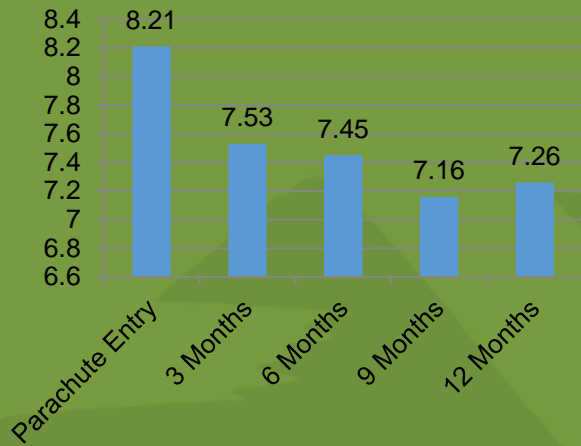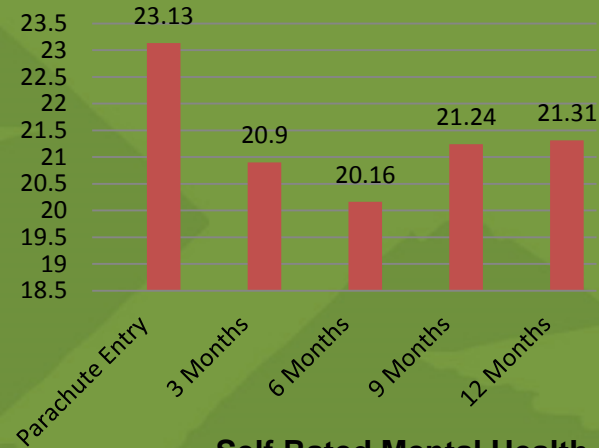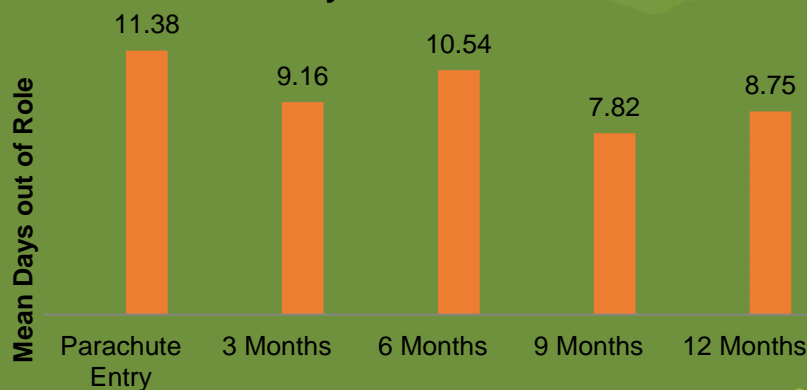
Self-Rated Mental Health

Parachute Entry 31.29 | 3 Months 33.91 | 6 Months 34.51 | 9 Months 36.2 | 12 Months 34.3

Parachute's Support for Choice

Parachute participants reported that the decision to participate in Parachute was theirs.
They experienced less coercion than a comparable community sample

Levels of Perceived Coercion			
	Baseline	**12 months**	**Norm[1]**
Mobile Team	2.0**	1.2**	3.8
Respite Guests	1.6 **	2.6**	

[1] source: Swartz, Wagner, Swanson, Hiday, Burns (2003). The perceived coerciveness of involuntary outpatient commitment: Findings from an experimental study. J Am Academy Psychiatry Law, 30, 207-217.

Parachute's Support for Shared Decisions

Parachute participants reported significantly greater levels of staff support for shared decisions compared to a community based sample

Health Care Climate Questionnaire			
	Baseline	**12 Months**	**Norm[2]**
Mobile Team Clients	**91.61 (12.27)****	**93.66 (10.14)****	**78.5 (16.6)**
Respite Guests	**94.52 (11.97)****	**91.82 (10.82)****	

[2] Source: Silva, Vieira, Coutinho, et al. Using self-determination theory to promote physical activity and weight control: a randomized controlled trial in women. *J Behav Med*. 2010;33(2):110-122.

Outcomes Summary

	Mobile Team Clients		Respite Guests	
	0-3 months	**4-12 months**	**0-3 months**	**4-12 months**
Hospitalization	Lower probability	Sustained	Lower probability	Sustained
Well Being	**0-10 months**	**10-12 months**	**0-10 months**	**10-12 months**
Self Rated MH	Improve	Improve	Improve	Sustained
Crisis Symptoms	Improve	Sustained	Improve	Sustained
Distress Symptoms	Improve	Sustained	Improve	Sustained
Functional Role	Improves	Declines	Improve	Sustained
MH Confidence	Improves	Sustained	No Change	Declines

Take Away

Parachute serves two populations in need of crisis services

- Young, urban minority males
- Slightly older urban residents – male and female – with significant prior use of MH and Substance Use Services

Participants weathered crisis without hospitalization

- Mental Health improved; Symptoms of crisis and distress decreased, Participation in positive social role increased; Hospitalization rates are at the low end of those reported in the literature following crisis (12-56%).
- Few participants experienced jail, shelter use or literal homelessness

Participants experienced high levels of agency & choice

Lessons learned

- We need strategies to sustain gains at about 1 year post crisis; We need to develop opportunities that will improve people's ability to participate in work and school
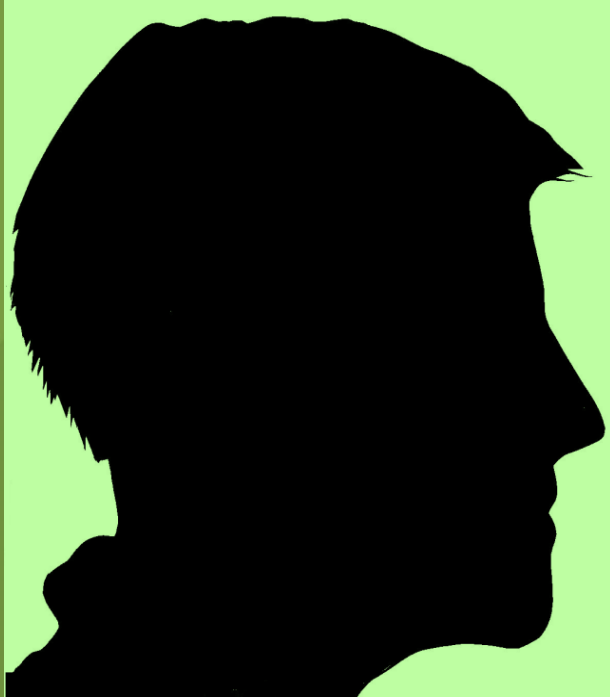
From Helping to Learning
From Individual to Relationship
From Fear to Hope

Connection

Worldview

Mutuality

Moving
Towards

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NAMI National Convention

Denver. July 6-9, 2016

NATM: 7 Principles

Immediate help

Network meetings

Flexibility and mobility

Responsibility

Psychological continuity

Tolerance of uncertainty

Dialogism

Brian

- Brian is 27 year old Hispanic male, he resides with his mother and older brother. Brian was referred to Parachute via NY Presbyterian MCT. Brian was not able to follow-up with his outpatient treatment due to his fear of leaving the home. He thinks people will hurt him if he leaves the home. Brian has not left the house in more than 12 months.

- Brian shared that he spent two days in jail 4-5 years ago when his friend stabbed someone, and after this event he has not been the same. He sold marijuana while in high school and was well liked by his fellow students. He has always been close to his family and cares a great deal about their well-being.

- Brian is concerned when his mother is out in the community. He is fearful that something will happen to her. He super-vigilant until she returns home. Because he fears people will try to harm him, the family has lost close family and friends, because Brian will not allow them into the apartment. He has not seen his close relatives in years because of his fears. Brian struggles with the notion that this is what his life will be until the end.

- His mother Margarita, is a strong supporter of him. She is a strong advocate for her son. She is also very involved in the network meetings. The family struggles financially but is very close and involved in Brian's wellness.

NKOSI

- Nkosi is a 26 year old African-American male, unemployed, currently living with his mother. Nkosi will leave from Mount Sinai Hospital requiring ongoing mental health services. Since 2013, Nkosi has had 6 prior psychiatric hospital stays.

- Nkosi, has agreed to work on himself and with his family, through supportive counseling and peer support services. He will be returning to live with his mother. He expressed that he wants to go home to be "normal," wants to stop his medication, get back to smoking marijuana and drinking.

- Nkosi shared that he is low keyed and likes to stay to himself. He acknowledged struggles with "mind voices", alcohol and substance use and having a hard time expressing himself. He is afraid of talking about his "mind voices" for fear that his mother will have him hospitalized again. He shared his dreams of working for the MTA as a motorman. Nkosi enjoys riding the train system and has been able identify his best cars to ride in and to have conversation with the conductors. Nkosi is interested in obtaining his GED so that he can pursue goal of working as motorman.

- Nkosi's mother is supportive and shared that she wants the best for her son. She is self-employed as child care-taker. She is will join the network when Nkosi invites her to the network meetings. She has shared that other family members have struggled with mental illness and how that has helped her deal with Nkosi's illness.

Launching & Sustaining Principles of Parachute NYC

David C. Lindy, MD

Clinical Director/Chief Psychiatrist

Community Mental Health Services

Visiting Nurse Service of New York

The Visiting Nurse Service of New York: Innovation as tradition

The Visiting Nurse Service of New York (VNSNY):
Innovation as tradition

- Largest certified home health agency in U.S

- A deep tradition (1893) of pioneering public health and social advocacy approaches to providing services to poor immigrant families

- A newer tradition in MH: launched mobile MH crisis teams across NYC after police shooting of a person in crisis during an eviction (1986)

- Provides a broad spectrum of programs throughout NYC - most outreach/home-based – with 300 staff seeing > 15,000 clients annually

Parachute NYC & VNSNY
Radical innovation or Innovation as Tradition?

- Parachute NYC:
  - Radical vision for system change?
  - Opportunity to change realities on the ground - how crisis teams relate to people in crisis?

- NATM very consonant with VNS'
  - person & family centered model, designed to deploy natural resources as found in field
  - notion of "crisis" is a point in time in a person's life reflecting course of their history, strengths, liabilities, best dealt with in ways that balance wishes of client & family, as long as safety is ensured

Parachute NYC, VNSNY, Peers and Families

- A Big Step:
  - Parachute NYC's model of persons with lived experience as fully integrated members of the clinical team was a radical innovation, despite VNS experience in integrating peers into teams

- Parachute NYC
  - Provided outside support (and pressure),
  - Focused on hiring criteria,
  - Highlighted the unique advantages peers offer

- Sustaining Parachute NYC goals:
  - VNS integrates peers &family/NAMI leadership into our organization and governance

Healthcare Cost and Utilization Project: Agency for Healthcare Research and Quality, 2008

- Mental Health (MH) and Substance Abuse (SA) disorders account for 4.5% of all hospitalizations
- MHSA hospital stays cost $9.7 billion in 2008 or 2.7% of all hospital costs

- Average cost per MH hospitalization = $5,700
- Average cost per SA hospitalization = $4,600

- Average length of MH hospitalization = 8 days
- Average length of SA hospitalization = 4.8 days

- State Medicaid programs are the largest payers of MH & SA related hospitalizations

- 28% of MH hospitalizations & 26% of SA hospitalizations are for Medicaid beneficiaries

Future of Parachute: Financial Sustainability

- Government/Grant Funding

- Managed Care

- DSRIP Projects

Financial Sustainable with Government/Grant Funding

Federal, state & local governmental agency grants

Potential source of supplemental funding for uninsured clients which would not be covered under managed care or Medicaid

Financial Sustainable in a Managed Care Context

- Parachute Average Length of Stay: 12 months
- Parachute Longest/Shortest Length of Stay: 2.5 years/2 months

Health and Recovery Plans (HARPs): Managed care product that manages physical health, mental health and substance use services in an integrated way for adults with significant behavioral health needs.

With an evaluation and plan of care, HARP clients may be eligible for Home and Community Based Services (HCBS)
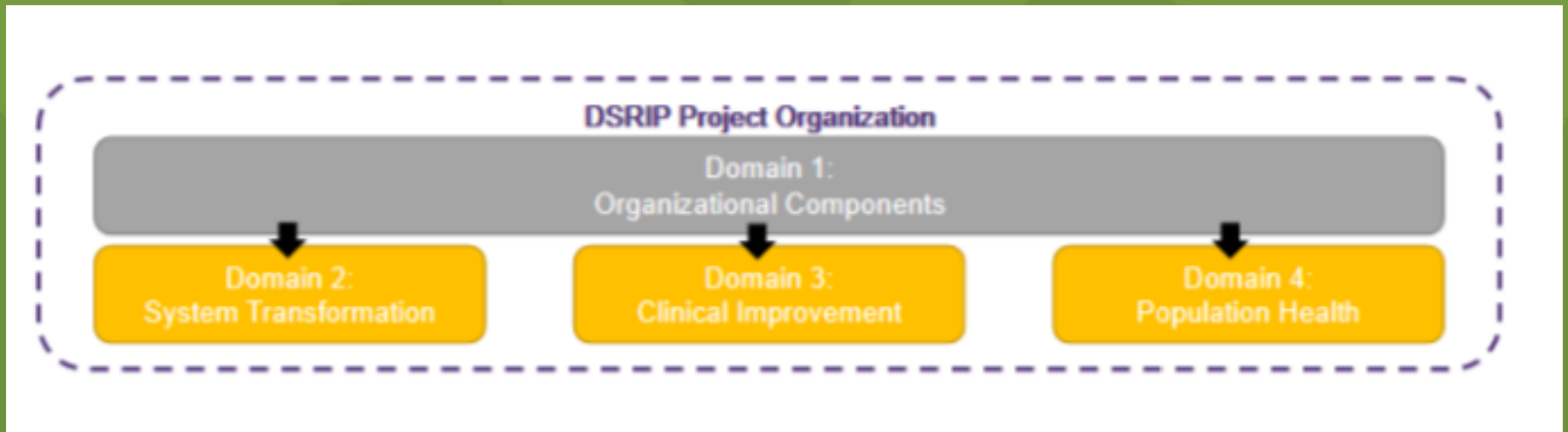
HCBS Recovery Model provides opportunities for targeted Medicaid beneficiaries -people with mental illnesses, intellectual or developmental disabilities and/or physical disabilities - to receive services in their own home or community.

Parachute's staffing and service model meets criteria for HCBS categories:
Peer Support; Community Support and Treatment; Prevocational Services

Financial Sustainability in the NYS Delivery System Reform Incentive Payment (DSRIP) Program

DSRIP´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to $6.42 billion dollars are allocated to this program in NYS with payouts based upon achieving predefined results. Performing Provider Systems (PPS) may choose to participate in a number of DSRIP projects within the categories of system transformation, clinical management and population health.

DSRIP Project Organization

Domain 1:
Organizational Components

Domain 2:
System Transformation

Domain 3:
Clinical Improvement

Domain 4:
Population Health

DSRIP Project Examples

- 2.a.i. Create Evidence Based Integrated Delivery Systems
- 2.b.iv Care transitions intervention model
- 2.b.viii Hospital-Home Care Collaboration
- 2.c.i. Community-based health navigation services
- 3.a.i Integration of Primary Care and Behavioral Health
- 3.a.iii. Medication Adherence Program in Community Sites
- 3.b.i. Evidence-based strategies for disease management (cardiovascular)
- 3.c.i Evidence-based strategies for disease management (diabetes)
- 4.b.ii. Chronic Disease Prevention
- 4.c.ii Increase early access to, and retention in HIV care

Financial Sustainability in the NYS DSRIP Program.

Parachute fits with these DSRIP Projects

Care transitions intervention model to reduce readmissions within 30 days for chronic health conditions

The goal of this project is to provide 30-day supported transition services after a hospitalization to ensure discharge directions are understood and implemented by patients who are at high risk for readmission.

Integration of primary care and behavioral health services

The goal of this project is to integrate mental health and substance abuse services with primary care services to promote access and ensure coordination.

Behavioral health community stabilization services

The goal of this project is to provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.

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Thank You!

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