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

Mary Jane Alexander
David Lindy
Antonio Munoz
Neil Pessin
Pablo Sadler

NAMI National Convention
Denver. July 6-9, 2016
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
Parachute as Innovation
Background & Model

Pablo Sadler, MD MPH
Medical Director Bureau of Mental Health
New York City DOHMH
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

• 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*
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

Initial Visit

Mobile Crisis as Usual
(up to 5 visits)

Short Term Assessment & Referral

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

Respite Only

Enhanced Mobile Treatment + Respite

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

Medical Screening & Linkage

LIFENET Eligibility Screen

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

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Parachute NYC - Eligibility Criteria

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

Needs Adapted Treatment Model
Intentional Peer Support
## Parachute’s 2 Models of Care

<table>
<thead>
<tr>
<th>Needs Adapted Treatment Model (Open Dialogue)</th>
<th>Intentional Peer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Help - 24 hours</td>
<td>Hope Based – moving towards</td>
</tr>
<tr>
<td>Social Network Perspective</td>
<td>Connection – fully present, trust</td>
</tr>
<tr>
<td>Flexible &amp; Mobile</td>
<td>Mutuality – sharing vs. ‘helping’</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Worldview – how our own experiences shape it</td>
</tr>
<tr>
<td>Continuity</td>
<td></td>
</tr>
<tr>
<td>Tolerance of Uncertainty</td>
<td></td>
</tr>
<tr>
<td>Dialogism</td>
<td></td>
</tr>
</tbody>
</table>
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)
• Families
  • Should there be a family advocate in the team?
• 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

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

<table>
<thead>
<tr>
<th>Structured Surveys</th>
<th>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 &amp; Non Medicaid Service Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quasi Ethnographic observations &amp; interviews</strong></td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td>Short feedback loop for CQI for DOHMH, Mobile Teams, Respites and Trainers</td>
</tr>
<tr>
<td>Sustainability &amp; Research</td>
<td>Design &amp; support a Learning Community Assess the role of culture for Parachute’s diverse participants, settings and workforce Specify the model in action</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th></th>
<th>Mobile Team Clients (n=77)</th>
<th>Respite Guests (n=93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>25 years</td>
<td>39 years</td>
</tr>
<tr>
<td>% Males</td>
<td>69%</td>
<td>47%</td>
</tr>
<tr>
<td>% Non White Hispanic enrollees</td>
<td>91%</td>
<td>83%</td>
</tr>
<tr>
<td>Hospital Use prior 5 years</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td>Substance Use services prior 5 years</td>
<td>10%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Compared to the General Population and to people with SMI diagnoses:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Self Rated MH(^1)</td>
<td>Worse</td>
<td>Worse</td>
</tr>
<tr>
<td>Symptoms of crisis and distress(^2)</td>
<td>Worse</td>
<td></td>
</tr>
<tr>
<td>Social Functioning(^3)</td>
<td>Worse</td>
<td>Worse</td>
</tr>
</tbody>
</table>

\(^1\) Ware & Shelbourne, 1992  \(^2\) Boothroyd & Chen, 2008;  \(^3\) Birchwood, Smith et al., 1990
Did Parachute Participants weather crisis without hospitalization?

<table>
<thead>
<tr>
<th>Probability of Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
</tr>
<tr>
<td>% hospitalized</td>
</tr>
<tr>
<td>Mobile Team Clients</td>
</tr>
<tr>
<td>Respite Guests</td>
</tr>
</tbody>
</table>
Weathering Crisis – Parachute Mobile Team Clients’ Well Being

**Crisis Symptoms**

<table>
<thead>
<tr>
<th></th>
<th>Parachute Entry</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parachute Entry</td>
<td>8.21</td>
<td>7.53</td>
<td>7.45</td>
<td>7.16</td>
<td>7.26</td>
</tr>
</tbody>
</table>

**Distress Symptoms**

<table>
<thead>
<tr>
<th></th>
<th>Parachute Entry</th>
<th>3 Months</th>
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<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parachute Entry</td>
<td>23.13</td>
<td>20.9</td>
<td>20.16</td>
<td>21.24</td>
<td>21.31</td>
</tr>
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</table>

**Days out of Role**

<table>
<thead>
<tr>
<th></th>
<th>Parachute Entry</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
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</thead>
<tbody>
<tr>
<td>Parachute Entry</td>
<td>6.89</td>
<td>4.65</td>
<td>5.07</td>
<td>5.13</td>
<td>6.74</td>
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</table>

**Self Rated Mental Health**

<table>
<thead>
<tr>
<th></th>
<th>Parachute Entry</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parachute Entry</td>
<td>36.59</td>
<td>41.69</td>
<td>41.71</td>
<td>40.43</td>
<td>41.87</td>
</tr>
</tbody>
</table>
Weathering Crisis: Parachute Respite Guests’ Well Being

**Crisis Symptoms**

<table>
<thead>
<tr>
<th>Time</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>8.75</td>
<td>8.94</td>
<td>8.12</td>
<td>7.58</td>
</tr>
<tr>
<td>3 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Months</td>
<td></td>
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<tr>
<td>9 Months</td>
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<td>12 Months</td>
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**Distress Symptoms**

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<tr>
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<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>29.68</td>
<td>27.7</td>
<td>26.35</td>
<td>26.06</td>
</tr>
<tr>
<td>3 Months</td>
<td></td>
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<tr>
<td>6 Months</td>
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<td>9 Months</td>
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**Days Out of Role**

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<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>11.38</td>
<td>9.16</td>
<td>10.54</td>
<td>7.82</td>
<td>8.75</td>
</tr>
<tr>
<td>3 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Months</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td></td>
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**Self-Rated Mental Health**

<table>
<thead>
<tr>
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<th>Parachute Entry</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>31.29</td>
<td>33.91</td>
<td>34.51</td>
<td>36.2</td>
<td>34.3</td>
</tr>
<tr>
<td>3 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Months</td>
<td></td>
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<tr>
<td>9 Months</td>
<td></td>
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<td></td>
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<tr>
<td>12 Months</td>
<td></td>
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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.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>12 months</th>
<th>Norm¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Team</td>
<td>2.0**</td>
<td>1.2**</td>
<td>3.8</td>
</tr>
<tr>
<td>Respite Guests</td>
<td>1.6 **</td>
<td>2.6**</td>
<td></td>
</tr>
</tbody>
</table>

Parachute’s Support for Shared Decisions

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

<table>
<thead>
<tr>
<th>Health Care Climate Questionnaire</th>
<th>Baseline</th>
<th>12 Months</th>
<th>Norm&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Team Clients</td>
<td>91.61 (12.27)**</td>
<td>93.66 (10.14)**</td>
<td>78.5 (16.6)</td>
</tr>
<tr>
<td>Respite Guests</td>
<td>94.52 (11.97)**</td>
<td>91.82 (10.82)**</td>
<td></td>
</tr>
</tbody>
</table>

## Outcomes Summary

<table>
<thead>
<tr>
<th></th>
<th>Mobile Team Clients</th>
<th>Respite Guests</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-3 months</td>
<td>4-12 months</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Lower probability</td>
<td>Sustained</td>
</tr>
<tr>
<td></td>
<td>Lower probability</td>
<td>Sustained</td>
</tr>
<tr>
<td>Well Being</td>
<td>0-10 months</td>
<td>10-12 months</td>
</tr>
<tr>
<td>Self Rated MH</td>
<td>Improve</td>
<td>Improve</td>
</tr>
<tr>
<td></td>
<td>Improve</td>
<td>Sustained</td>
</tr>
<tr>
<td>Crisis Symptoms</td>
<td>Improve</td>
<td>Sustained</td>
</tr>
<tr>
<td></td>
<td>Improve</td>
<td>Sustained</td>
</tr>
<tr>
<td>Distress Symptoms</td>
<td>Improve</td>
<td>Sustained</td>
</tr>
<tr>
<td></td>
<td>Improve</td>
<td>Sustained</td>
</tr>
<tr>
<td>Functional Role</td>
<td>Improves</td>
<td>Declines</td>
</tr>
<tr>
<td></td>
<td>Improve</td>
<td>Sustained</td>
</tr>
<tr>
<td>MH Confidence</td>
<td>Improves</td>
<td>Sustained</td>
</tr>
<tr>
<td></td>
<td>No Change</td>
<td>Declines</td>
</tr>
</tbody>
</table>
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
The Role of Peers in Crisis
The Parachute Approach

Antonio Munoz,
Certified Peer Specialist
Parachute NYC &
Visiting Nurse Service of New York
From Helping to Learning
From Individual to Relationship
From Fear to Hope

Connection
Worldview
Mutuality
Moving Towards

Sherry Mead Consulting © 2014

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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 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
Parachute’s Future: Financial Sustainability

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

- 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
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 Examples

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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!

Presenters’ Contact Information:

psadler@health.nyc.gov
MaryJane.Alexander@nki.rfmh.org
Antonio.Munoz@vnsny.org
David.Lindy@vnsny.org
Neil.Pessin@vnsny.org