Innovative Project Plan Description

**County:**  San Diego County **Original Budget**: $3,334,347

**Project Name:** Peer Assisted Transitions **Original Budget for Evaluation:**  $ 166,717 (5% of total)

**MHSOCA Approval Date:** 2/26/2015 **Original Program Dates:** July 1, 2015 – June 30, 2018

**Program Overview**

1. **Primary Problem**

Many individuals who use the most acute services do not become effectively connected with relevant follow-up services and have limited social supports. The San Diego Behavioral Health Services (BHS) system has identified the need for better engagement of persons diagnosed with serious mental illness to connect with the variety of services and supports available in the community.

Peer support staffing and programs have become firmly established in our system of care since establishment of MHSA and are congruent with the practices and principles of recovery. However, the literature solidly correlating peer support staffing to better outcomes or cost-effectiveness does not exist. For example, the State of Georgia has a well-established peer support system which has billed for peer support since 2001; however, an examination of the impact of Medicaid peer support utilization on cost, a study done by Landers and Zhou (2014), found that peer support was associated with a significantly higher total Medicaid cost. The basis of the study was to recognize that peer support programs have continued to grow, building on recovery oriented programming, yet relationships between peer support services and the costs to public programs had not been well described in literature. The study aimed to fill that gap and identified that the implementation of Medicaid financed peer support programs did not necessarily result in savings from reductions in costly crisis stabilizations and psychiatric hospitalizations, it did support the principles of self-direction and recovery from severe mental illness.

1. **What Has Been Done to Address Your Primary Problem?**

Behavioral Health Services created an Innovations project called Peer Assisted Transitions, beginning in July 2016, with the goal of increasing the depth and breadth of services to adults (18+) diagnosed with serious mental illness (SMI) who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports. The target population is adults who present at Scripps Mercy and University of California at San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as at the Community Research Foundation’s (CRF) Vista Balboa and New Vistas crisis residential facilities contracted by BHS.

The Peer Assisted Transitions program employs Peer Support Coaches (PSC), who work closely with the client, crisis house, and hospital-assigned discharge planner to participate in the discharge planning team by promoting use of shared decision-making and ensuring the client is actively involved in his/her discharge planning process. After discharge, the PSC engages in the active provision of and coaching about shared decision-making, linkage to relevant community services, and social/recreational outings. Caseloads are low to ensure service providers have sufficient time to provide highly individualized support to each person, as well as coordinating and participating in social outings with individuals and groups of persons served.

While the contract for Peer Assisted Transitions began in July 2016, there was a three month start-up period to allow for the recruitment and training of staff, facility issues, and procedure development. Enrollment for services began at the New Vistas and Vista Balboa crisis residential facilities in November 2016. Between November and December 2016, 19 unduplicated clients were enrolled in the program. No clients have been enrolled in the program through Scripps Mercy and UCSD hospitals. The process to become embedded in a hospital setting requires additional medical clearances and protocols, which are not present in a crisis residential facility.

Although the program is too new to have any completed treatment outcomes, one barrier that has been identified is the program’s inability to engage in random controlled trials. The primary reason for this is the need for a large sample size for results to be statistically significant. Other reasons include ethical issues around not providing services for those in need when services are available and our inability to use people who elect not to participate as the “control group” to account for selection effect.

Additionally, the initial Innovations project was designed to only include two of the three crisis residential facilities in the Central San Diego region due to budgetary constraints. The omission of this third crisis residential facility inhibits the ability to compare the efficacy of the project on a regional basis. The ability to compare between regions is important due to a number of region-specific factors including, but not limited to demographics of clients, access to services, and capacity of programs. While randomized controlled trials is not a viable learning tool at this time, adding a third site will allow us to test if the usage of peer support staff, as opposed to those who have comparable training but without lived experience, impacts the outcomes of those clients linking to services. This comparison would provide evidence if the specific usage of PSC is effective or if it is another factor.

1. **Primary Purpose/Change Request**
2. Increase the quality of mental health services, including measurable outcomes
3. An increase in expenditures, such that more funds are expended than previously approved
4. **The Proposed Change**

San Diego County requests that the Peer Assisted Transistions program be extended an additional year to allow for more time for data collection. More importantly, it is also requested that the program be expanded to Jary Bareto, the third crisis residential facility in Central San Diego. This expansion would allow for better data analysis of the program relative to the other regions in San Diego County that have crisis residential facilities, but are not part of this innovative projected.

As mentioned above, the addition of this third crisis residential facility would allow the ability to test if the usage of peer support services really do impact outcomes when compared with those staff hired who may have equal training, but without lived experience. Peers trained in a number of recovery principles are currently used in the teams at both Vista Balboa and New Vistas crisis residential facilities. The control group at the third crisis residential facility, Jary Bareto, would be staffed with individuals who are trained in recovery principles, but do not posses lived experience to qualify as a peer.

Prior to the inception of Peer Assisted Transitions, stakeholders such as the Adult Council and NAMI San Diego were supportive of the peer support model. An example of the program utilizing stakeholder input is the change from the usage of a “welcome-home basket” filled with bedding, towels, linens, sundries, etc. to a “welcome-home backpack” filled with reflective clothing, shampoo, soap, toothbrush, toothpaste, brush/comb, refillable water bottle, snack, blanket, calendar/planner (to keep track of appointments), flash light, and sunscreen to more appropriately address individuals who are homeless and the younger population. Additionally, it is in conjunction with the contractor (NAMI San Diego) of Peer Assisted Transitions that the idea to expand to a third crisis residential facility to test the effectiveness of PSC was developed. This request does not include any changes in approved purpose or expected outcomes.

1. **Population**
2. Number served- Current target is 240 adults; proposal increases target to 300 adults
3. Target groups- adults (18+) diagnosed with serious mental illness (SMI) who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.
4. **Innovative Component**

The Peer Assisted Transitions program makes specific use of shared decision-making tools and coaching to support and promote the person’s primary decision-making role in identifying relevant services and supports and in actively planning for their discharge. Shared decision making is a clinical method that is supported by various technologies and has its roots in medicine. It is the process by which the clinician and the client discuss and exchange information until they reach a mutually agreed upon decision regarding the next step in treatment. Studies show that doctors just cannot predict patient’s preference for treatment when other factors are equal. It is a process in which there are two experts in the room: the physician is an expert in the scientific evidence and the practice of medicine and the patient is an expert in what matters to them in their life. The concept of shared decision-making is innovative as there has been little use of formal resources to promote this beyond the specialized use of ‘CommonGround’ in mental health. CommonGround is a Web application that allows the client to create a health report and summary about how they are feeling before going into the doctor’s office. This enables both the doctor and the client to make better use of their time by focusing on the important things and participate in the decision making process in terms of treatment and therapy. Allowing the client to play a vital role in their decisions makes the process for their treatment and recovery to be empowering and helps them further in their journey towards recovery.

Through the provision of PSC incorporating shared decision-making and active social supports, this project is designed to increase the depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are not effectively connected with community resources.

1. **Learning Goals / Project Aims**

This project seeks to answer the following:

1. Does incorporating a major shared decision-making element into this program, by utilizing resources such as SAMHSA’s Shared Decision-Making tools and/or other shared decision-making tools (e.g., elements of the web-based application CommonGround), result in improved outcomes in clients participating in this project versus clients in another acute setting.
2. Can PSC at a privately operated psychiatric hospital, with the addition of the shared decision-making and social/recreational components, be effectively used at privately operated, non-County-operated psychiatric hospital (i.e. Scripps Mercy and UCSD hospitals)?
3. Does the project’s focus on providing a peer coach/mentor support, welcome home backpack, and experiences in social/recreational outings increase client engagement, improve well-being, level of functioning and promote the continuation of social activities after their involvement with this program ends?
4. Does the specific usage of individuals with lived experience (PSC) increase outcomes or can individuals without lived experience yield the same results?
5. **Evaluation or Learning Plan**

The following items will be tracked and measured. The project will be assessed on an annual basis and the resultant report will be made available to the County of San Diego’s Adult System of Care Council, Older Adult Council, and Transition Age Youth Workgroup. The County’s internal Performance Outcomes Team will also review the reports.

Data to be gathered and evaluated includes, but is not limited to, the following:

1. Number of hospitalizations and hospitalization days
2. Number of crisis house admissions and days
3. Linkage with formal support services
4. Number of people in a person’s active social support network
5. Level of recovery as measured by participant report and scale (e.g., Recovery Markers Questionnaire)
6. Level of recovery as measured by provider report and scale (e.g., PHQ-9, IMR)
7. Client input, including focus groups, about shared decision-making element of the project
8. Client input, including focus groups, about the ‘welcome home basket’ element of the project
9. Client input, including focus groups, about social/recreational activities element of the project
10. Other outcomes as indicated by stakeholders during the review process
11. **Contracting**

Quality and regulatory compliance elements are included in each contract, specific to the funding source and purpose of the service. A Contract Officer’s Representative (COR) with Behavioral Health Services assumes responsibility for ongoing monitoring of the contract for compliance and outcomes, working with the Department of Purchasing and Contracting (DPC), along with Administrative Contract Support (ACS). Monitoring includes regular site visits, review of documentation, and oversight of applicable laws and regulations.

Contractors will have a dedicated COR or Program Monitor from Behavioral Health Services who will develop a contract monitoring plan containing activities that will be conducted each year on their Statement of Work (SOW). Monthly COR meetings are routine.

There will be a minimum of four (4) monitoring activities per contract year, including a minimum of one (1) site visit, with subsequent visits, as needed, if identified issues have not been resolved. Monthly COR meetings and site visit activities include but are not limited to deliverables review, technical assistance and consultation, review of fiscal and claim documentation and annual inventory update, emergency planning documentation, corrective action plans, discussion of strengths and weaknesses of contractor’s deliverable outcomes.

There will be monthly review of SOW contract deliverables to determine contractor’s performance in meeting contract objectives, review contractor exclusion/debarment/Medi-Cal Sanctions lists employee review process as well as a minimum of one in-depth invoice review annually.

A total of 5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego.

1. **Community Planning**

During August through October, 2016, more than 650 individuals participated in BHS’ 2016 Community Engagement process: 551 community members and providers at twelve (12) regional forums and more than 100 representatives from targeted populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers) who attended six special focus groups. Behavioral Health Services (BHS) engaged consultant Hoffman & Clark to facilitate the forums and focus group and analyze feedback. Participants provided commentary through a group process that asks questions aimed at strengthening system capacity by focusing on productive potential.

The focus of the discussions centered around four topics: Children’s Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects, which had emerged from previous years of the Community Planning Process. Statistical analysis of the forum discussions showed 15 “Essential Themes”.  The themes of Access & Services, Continuum of Care, and Education & Awareness stood out across the three topics and were considered when making decisions for the expansion and extension of existing Innovation programs.

Throughout the year, BHS’ stakeholder-led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. BHS’ MHSA Coordination team presented the proposed expansion and extension of existing Innovation programs to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Family System of Care (CYFSOC) Council, and the Housing Council for their input.  Stakeholders were asked to complete a community feedback questionnaire individually or as a council.  The CYFSOC assigned a sub-committee to consider and provide comment, and the ASOC reviewed the Innovations programs as part of their meeting and provided written feedback.  Additionally, BHS utilized an expansive, stakeholder email listserv to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback.  Furthermore, the proposed Innovation programs were posted on BHS’ MHSA website along with the Survey Monkey link for feedback.

1. **MHSA Innovative Project Category**
2. Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.
3. **MHSA General Standards**
4. Community Collaboration: The concept for this work plan was developed from ideas and needs presented by a wide variety of community partners and service providers that support peer provision of services, shared decision-making, and the importance of social connectedness.
5. Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to serve persons diagnosed with serious mental illness through provision of services provided by persons who have first-hand experience of having been diagnosed with a mental illness. Shared decision-making strategies will further promote person-directed services and will support the cultural competence of delivered services. Marked disparities by race/ethnicity exist in the treatment of SMI. We know the course of psychiatric disorders for people who are members of racial/ethnic minority groups and for people living with SMI, regardless of race/ethnicity tends to be more chronic and disabling. Treatment engagement, along with other factors, appears to contribute to this pattern. Based on current data related to mental health disparities in San Diego County, we know that racial/ethnic minorities have been reported to have poorer access to care, receive lower quality services, and have higher attrition rates when compared with non-ethnic groups, regardless of diagnosis. This project seeks to address that by utilizing a cultural diverse staff to provide the outreach and engagement within the crisis residential or hospital setting, and, in turn, promote successful connections that will lead to successful outcomes.
6. Client-Driven Mental Health System: This program includes the ongoing involvement of clients in roles such as, but not limited to, implementation, evaluation, and future dissemination.  Ultimately, the program strives to create healthier individuals and families in our community through increased engagement and support of persons diagnosed with serious mental illness who have not previously become effectively engaged with helpful support systems.
7. Family Driven Mental Health System: This program focuses on persons who are not connected or engaged with ongoing services, and will support family values of effective engagement, support, and linkage for loved ones with serious mental illness.
8. Wellness, Recovery and Resilience Focus: This program increases resilience and promotes recovery and wellness for adults age 18+ diagnosed with serious mental illness and their families and friends by instilling hope through peer role models, providing social supports and recreational activities, and promoting shared decision-making.
9. Integrated Service Experience: This program encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients and family members. The program follows a person from the time of a mental health crisis through when they have become solidly connected with useful community supports.
10. **Continuity of Care for Individuals with Serious Mental Illness**

If the County is not able to continue with this program, Behavioral Health Services will link clients to the appropriate level of care for continued mental health services.

1. **INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement**
2. Ensure cultural competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services to improve outcomes and to implement treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations
3. Ensure meaningful stakeholder participation: Program will ensure that the client identifies the goals important to them for ongoing stability to make certain that treatment planning remains a collaborative process. Continued opportunities are available to engage community members through the System of Care Councils, community forums, etc.
4. **Deciding Whether and How to Continue the Project Without INN Funds**
   1. Throughout the duration of the project, steps will be taken to review the effectiveness of the approach.
   2. If effective, alternative funding streams will be considered.
5. **Communication and Dissemination Plan**
6. Information regarding this project will be disseminated through multiple collaborative groups, such as the Behavioral Health Advisory Board, the Children’s System of Care Council and the Adult System of Care Council. Information regarding the program will also be available on the County of San Diego website.
7. Involvement of program participants and other stakeholders
8. Five keywords of phrases for this project to assist with search: Parent Care Coordinator; Caregiver Stress; Motivational Interviewing; Caregiver Stigma; Children with Complex Needs
9. **Budget**
10. Original Total: $3,334,347
11. Proposed Addition: $3,152,592
12. New Total: $6,486,939
13. Proposed New Evaluation Total: $324,347 (5% of Total)
14. **Timeline**
15. Proposed extension of program: 7/1/18 – 12/31/19 (1 year, 6 months)
16. Proposed Expansion Program Dates: 7/1/2017- 12/31/19 (2 years, 6 months)
17. Key activities timeline and milestones TBD

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| 7/2017 | Expansion of program into additional third crisis residential facility, Jary Bareto. |
| 7/2017-6/2020 | Annual evaluations completed and reviewed by Behavioral Health Services to review effectiveness of program specific to target population and planned interventions. (Annual evaluations of program to be provided annually for the duration of the program) |
| 07/2020-12/2020 | Evaluation by Behavioral Health Services to determine, results and feasibility of integrating into existing programs or replication. Results to be disseminated at the conclusion of the evaluation. |