

## Innovation Work Plan Narrative: INN-15

**Work Plan Name:** Peer-Assisted Transitions  
**County:** San Diego

### Purpose of Proposed Innovation Project (check all that apply)

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

### Briefly explain the reason for selecting the above purpose(s).

We believe that more solid evaluation is needed in the field of peer support for persons with serious mental illness, and propose designing a project that will add to the knowledge in the field. 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, yet the literature solidly correlating that to better outcomes or cost-effectiveness does not exist. An examination of cost in Georgia was done by Landers and Zhou ("The Impact of Medicaid Peer Support Utilization on Cost," MMR 2014: Volume 4, Number 1), as that state has a well-established peer support system which has billed for peer support since 2001, and they identified that peer support was associated with a significantly higher total Medicaid cost, although it "...does support the principles of self-direction and recovery from severe mental illness."

The two most recent and comprehensive literature reviews of peer support using 'consumer-providers' to work with persons with serious mental illness were done by Pitt, et al ("Consumer-providers of care for adult clients of statutory mental health services," The Cochrane Library 2013, Issue 3) and Lloyd-Evans, et al (A systematic review and meta-analysis of randomized controlled trials (RCT) of peer support for people with severe mental illness," BMC Psychiatry 2014, 14:39). Their review of RCTs did not identify different symptom or service use outcomes, with the exception of some "low quality evidence that involving consumer-providers in mental health teams results in a small reduction in clients' use of crisis or emergency services (Pitt, et al).

Both reviews noted many limitations with obtaining solid findings from the reviewed studies, and noted the importance of further controlled trials. One of the cited reviews by Sledge, et al ("Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations," Psychiatric Services 2011, 62:5) had significant limitations but did have some findings indicating that use of consumer-providers may be helpful in reducing hospitalization. Other studies by Davidson, et al (Psychiatric Services 2000; Journal of Community Psychology 2004) have pointed to the likely importance of supporting social activities to promote successful community tenure for persons who have been hospitalized. We plan to explore the possibility of establishing a RCT with this program, so that we may significantly add to the research in the field. If we are unable to establish a RCT due to research challenges, we will pursue alternative

ways to evaluate data made available through this project through such means as comparison sites and pre/post-measures including items such as hospitalization and crisis house use rates.

Through the provision of peer specialist coaching 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. As many who use such the most acute services do not become effectively connected with relevant follow-up services and have limited social supports, our 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. This program is particularly focused on those persons who, in addition to needing to use hospital and/or crisis house services, have a limited social support network and are most likely to not be effectively connected with relevant services.

Priority for services will be to persons diagnosed with serious mental illness (who have Medi-Cal or are potentially eligible for Medi-Cal) who are not connected or engaged with an outpatient mental health program, Strengths-Based Case Management or Assertive Community Treatment Team program, who present at a particular crisis house or hospital, and who (in order of descending priority):

- Have been hospitalized or in crisis house at least twice in the prior year (in addition to the current visit);
- Have been hospitalized or in crisis house at least once in the prior year (in addition to the current visit);
- Persons who are homeless;
- Persons who live alone and have minimal or no contact with family or friends;
- Persons who may live with others (e.g., at a Board & Care or Independent Living setting) but have a very limited social support network.

The program will make 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. The concept of shared decision-making is welcome in our system, but we have seen little use of formal resources to promote this beyond the specialized use of 'CommonGround' at our ACT programs. The program will also provide a 'Welcome Home Basket' of sundries (e.g., toiletries, plants, healthy food, resource information) to welcome persons back to their home, and provide regular social outings to help persons bridge the gap between use of acute crisis resources and community-based resources, through reducing isolation and building social relationships.

## **Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSa and Title 9, CCR, section 3320. (suggested length - one page)*

This project will employ Peer Specialist Coaches (PSCs) to each year serve approximately 480 adults annually (age 18+) diagnosed with serious mental illness, promoting engagement

through peer support, use of 'Welcome Home Baskets' and social/recreational activities, and mentoring them through provision of shared decision-making strategies designed to help them connect with relevant services and supports. Services will be provided at a variety of sites to help identify where the best applicability is, including a primary focus on crisis residential facilities ('crisis houses'), with additional trials at a non-County-operated psychiatric hospital.

It will provide peer specialist support and active support for the person's role in discharge planning to persons at least three of the County's six crisis houses, utilizing specific strategies of shared decision-making and social/recreational outings and, unless we are able to establish a RCT at all six crisis houses, will compare outcomes with persons at the other three crisis houses where these Innovation services were not available. The PSC will work closely with the person and the crisis house-assigned discharge planner and participate with the client in the discharge planning team to promote use of shared decision-making and ensure that the person is actively involved in his/her discharge planning process. Tracking of readmission to the crisis houses and/or psychiatric hospitals is available through the County's Management Information System, and can provide clear information about such recidivism to determine if the peer services with focused shared decision-making strategies makes a significant difference in re-hospitalization rates and number of days in the community (versus in hospital or in crisis house).

The project proposes to initially include the same type of services to persons with Medi-Cal or no health insurance at least one private psychiatric hospital, as County Behavioral Health Services has not previously provided peer support services at such a site, and will participate and work closely with the person and the hospital-assigned discharge planner to promote shared decision-making in the discharge planning process. Connection of peer staff to the current 'Transition Team,' which works to connect hospitalized persons with relevant services and which has established connections with all private psychiatric hospitals serving persons with Medi-Cal will be explored. Consideration is also being made to provide the service at a locked long-term care facility to persons who have not previously effectively connected with the more formal support services available to them upon discharge.

Average length of service is expected to be three months, with active provision of and coaching about shared decision-making, linkage to relevant community services occurring during that time, and social/recreational outings. Caseloads will be low to ensure that the 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.

This project is informed in part by the following projects: *"The Welcome Basket Project: Consumers Reaching Out to Consumers"* (*Psychiatric Rehabilitation Journal*, Summer 2000, with phone follow-up with co-author Larry Davidson), SAMHSA's *"Shared Decision-Making in Mental Health"* (decision tools made available in 2012), *"Adding Consumer-Providers to Intensive Case Management Does It Improve Outcome"* (Rivera, *Psychiatric Services*, June 2007), *"Supported Socialization for People with Psychiatric Disabilities"* (Davidson, *Journal of Community Psychology*, May 2004), and *"Effectiveness of Peer Support in Reducing Readmissions of Persons with Multiple Psychiatric Hospitalizations"* (*Psychiatric Services*, May 2011).

This work plan is consistent with the General Standards identified in the MHSR and Title 9, CCR, section 3320.

**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. There has been major interest and support to expand peer-delivered services in our system, and this project is designed to expand provision of such services while also closely examining the possible different outcomes that may occur when peer-delivered services are made much more available to people diagnosed with serious mental illness during acute periods of need.

**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 therefore increase the cultural competence of delivered services. Staff hired shall be linguistically and culturally competent for the population served. Per CCR 3200.100 and in order to support the wide variety of persons who come to the crisis houses, expected orientation of staff will include a focus on increasing understanding of diverse belief systems concerning mental illness and mental wellness, the impact historical bias has had upon many different groups, the possible effects of trauma and the importance of trauma-informed care, and strategies to provide forms of support that are most relevant to a person's specific background and world view.

**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.

**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.

**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.

**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.

The project will serve approximately 480 persons each year. Approximate staffing will include one full-time equivalent (FTE) Program Manager (licensed or license-eligible), 1.5 FTE office support staff, 2 FTE Senior PSCs (Masters or Bachelor's degree level, who will have significantly smaller caseloads and provide additional support to the PSCs), and 7 FTE PSCs.

**Number of Clients to be Served:** At a minimum up to 120 unduplicated clients from Crisis Residential Treatment Programs (CRTP) on an annual basis and up to 120 clients annually from one or more hospitals (with efforts to match hospitals if more than one is used).

**Total Funding**

**Note: The 2<sup>nd</sup> year of proposed Innovation funding will occur in FY 2017-18, and the 3<sup>rd</sup> year in FY 18-19, which is outside of the time frame for this Three Year Plan.**

Annual Program Cost	\$1,055,877	3 Year Program Cost	\$3,167,631
Evaluation Cost (5% of Total)	\$55,572	3 Year Evaluation Cost	\$166,716
Total Annual Innovation Funding	\$1,111,449	3 Year Grand Total	\$3,334,347
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

In our review of outcomes related to peer support for persons diagnosed with serious mental illness, we have identified little if any solid research that supports any increased efficacy or cost savings through use of peer support—but much of that appears to be due to the paucity of solid research in that area. If we are able to design and implement a randomized controlled trial, we have the opportunity to make a significant contribution to the field, as most of the previous RCTs have been small or had significant challenges. If we are unable to do this project as a formal RCT, we still will be able to evaluate and compare outcomes based on sample matching, comparison sites, and pre-post measures on key items such as hospitalization and recovery status. In addition, while there has been some limited use of specific shared decision-making tools and strategies in our system, specific tools and strategies has not regularly been a key element in most program delivery. We therefore hope to learn if 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), will result in improved outcomes in clients participating in this project versus clients in another acute setting. This will be a significant adaptation to the peer support program our County operated through an earlier Innovations program, and we believe this may be a key factor to increase such a program’s impact.

We also propose that this project’s focus on providing a peer coach/mentor support, ‘welcome home basket’, and experiences in social/recreational outings is a way to increase client engagement, improve well-being, level of functioning and promote the continuation of social activities after their involvement with this program ends. This strategy may promote engagement

for those who otherwise would not be interested in such, and is also a significant adaptation to the peer support program our County operated through an earlier Innovations program.

We will learn that by comparing and contrasting outcomes for the people using this Innovations service at the crisis houses and designated hospital compared to a similar sample of people who did not use this innovations service at crisis houses and hospitals, and plan to examine both aggregate and individual outcomes.

We have had elements of peer specialist coaching provided at our County-operated psychiatric hospital, but have not used it at a privately operated psychiatric hospital. This project builds on our earlier efforts and gives us an opportunity to pilot the service at such sites, with the addition of the shared decision-making and social/recreational components, to see if it can be effectively used at such non-County-operated settings.

## Timeline

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

**NOTE:** Program design to be developed from competitive process. The dates identified below are a projection of implementation, actual datelines to be determined by winning proposal.

**Implementation/ Completion Dates:** 7/1/2016-6/30/19

07/01- 08/15/2016	This project will be encompassed within a three year period commencing on 07/01/2016. As it is a new project, the contractor will be allowed the typical 6 week start-up time to recruit, hire, and train staff and to establish an office.
08/2016-12/30/2016	The provider will begin to work with identified community partners, which are expected to include agencies such as the County's crisis houses and the 'Transition Team.' Prior to establishment of this program, the County will have established protocol for the evaluation, which will include at least opportunities for comparison among different sites and/or pre-post comparison, and may be able to incorporate elements necessary to establish a randomized clinical trial. The program will be required to report on a number of data elements (detailed below in the project measurement section.
01/30/2017	The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year to date, analysis of the barriers and successes of the project and recommendations based on lessons learned thus far.
07/30/2017	The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first annual report but also include results of an initial evaluation, as well as any new data elements and/or additional analyses recommended by the first report. (This date may be adjusted earlier to allow for timely contractual changes to be incorporated for year two of the project.)

01/30/2018	Follows same format of 01/30/2017
07/30/2018	Follows same format of 07/30/2017
01/31/2019	An interim report encompassing the 2.5 years of the project to date will be requested in order for the project to be considered for continued funding, sustainability via other ongoing services, or termination.
07/30/2019	A final report will be due evaluating the successes and challenges faced by the project throughout its duration and lessons learned. [Note: The evaluation component may continue past this time in order to include relevant follow-up data for persons served during the last year of the program.]

## **Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

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 Council, Older Adult Council, and Transitional-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:

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

## **Monitoring, Data Collection, Outcomes and Evaluation**

- Explore obtaining expert consultation from specialist in trial design to test effectiveness of mental health services delivered at both the individual and institutional level and pursue possibility of establishing a RCT. If RCT is not possible, identify alternate best ways to obtain meaningful comparison data to analyze likely program effects on client outcomes and costs.
- Monthly/Quarterly Reports, including number of potential participants to whom engagement efforts were made, and number of persons enrolled in the program
- Yearly report beginning with year 1
- Evaluation of outcomes – Identify outcomes to be tracked per INN guidelines
- Determine role of QI

## **Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

We plan to work with our Crisis House contractor to ensure that the services can be provided at and integrated into at least three of their six Crisis Houses. Project staff will work closely with the Crisis House staff, particularly with the assigned discharge planner, to promote use of shared decision-making in treatment and discharge planning.

We also plan to negotiate with our Transition Team contractor and at least one private psychiatric hospital about best ways to provide these services to some of their clients, and plan to link these services with other related services such as hospital discharge planning.

The project will work closely with existing Clubhouses, as those are excellent resources to support some persons' interests in social and recreational activities.

We will work closely with existing or new programs that share some elements with this program to ensure that duplication does not occur.

**NOTE:** Actual budget to be determined by winning proposal from competitive process. The following are proposed guidelines:

<b>NEW ANNUAL PROGRAM BUDGET – Year 1</b>					
<b>A. EXPENDITURES</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/ CBO's</b>	<b>Total</b>
1.	Personnel			650,000	650,000
2.	Operating Expenditures			190,877	190,877
3.	Non-recurring Expenditures			50,000	50,000
4.	Contracts (Training Consultant Contracts)			55,572	55,572
5.	Work Plan Management			165,000	165,000
6.	Other Expenditures				
	<b>Total Proposed Expenditures</b>			1,111,449	1,111,449
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>			\$0	\$0
	<b>C. TOTAL FUNDING REQUESTED</b>			1,111,449	1,111,449

**BUDGET NARRATIVE**

Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.
1- Personnel: This includes estimated Salary and Benefits. Approximate staffing will include one full-time equivalent (FTE) Program Manager (licensed or license-eligible), 1.5 FTE office support staff, 2 FTE Senior PSCs (Masters or Bachelor's degree level, who will have significantly smaller caseloads and provide additional support to the PSCs), and 7 FTE PSCs.
2- Operating Expenses: This includes estimated expenses other than Salary and Benefits that are needed to run the program (e.g., rent, transportation, insurance, supplies, overhead).
3- Non-Reoccurring: office supplies, laptops/tablets for field work, computers cell phones, initial operations deposits, print materials, office equipment leases and furniture purchase.
4- Contracts (Training Consultant Contracts): \$55,572 for consultant to provide data analysis and dissemination for evaluation purposes.
5- Work Plan Management: This includes estimated overhead/indirect costs by the Contractor.

<b>NEW ANNUAL PROGRAM BUDGET – Year 2</b>					
<b>A. EXPENDITURES</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/ CBO's</b>	<b>Total</b>
1.	Personnel			690,000	690,000
2.	Operating Expenditures			200,877	200,877
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)			55,572	55,572
5.	Work Plan Management			165,000	165,000
6.	Other Expenditures				
	<b>Total Proposed Expenditures</b>			1,111,449	1,111,449
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>			\$0	\$0
	<b>C. TOTAL FUNDING REQUESTED</b>			1,111,449	1,111,449

### **BUDGET NARRATIVE**

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2- Operating Expenses: This includes estimated expenses other than Salary and Benefits that are needed to run the program (e.g., rent, transportation, insurance, supplies, overhead).
4- Contracts (Training Consultant Contracts): \$55,572 for consultant to provide data analysis and dissemination for evaluation purposes.
5- Work Plan Management: This includes estimated overhead/indirect costs by the Contractor.

<b>NEW ANNUAL PROGRAM BUDGET – Year 3</b>					
<b>A. EXPENDITURES</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/ CBO's</b>	<b>Total</b>
1.	Personnel			690,000	690,000
2.	Operating Expenditures			200,877	200,877
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)			55,572	55,572
5.	Work Plan Management			165,000	165,000
6.	Other Expenditures				
	<b>Total Proposed Expenditures</b>			1,111,449	1,111,449
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>			\$0	\$0
	<b>C. TOTAL FUNDING REQUESTED</b>			1,111,449	1,111,449

**BUDGET NARRATIVE**

Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.
1- Personnel: This includes estimated Salary and Benefits. Approximate staffing will include one full-time equivalent (FTE) Program Manager (licensed or license-eligible), 1.5 FTE office support staff, 2 FTE Senior PSCs (Masters or Bachelor's degree level, who will have significantly smaller caseloads and provide additional support to the PSCs), and 7 FTE PSCs.
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5- Work Plan Management: This includes estimated overhead/indirect costs by the Contractor.