Delivery System Reform Incentive Payment (DSRIP)

Project Recommendations for Meaningful Transformation of the Chronic Illness Sector

December 2014

Table of Contents

Acknowledgements

Amida Care (AC) would like to thank all of the Project Advisory Committee (PAC) members for their immense contribution in the development of this report. The steering committee was instrumental in their direction and guidance throughout the process. Members of the four subcommittees lent their insight, expertise and time to develop project recommendations that have great potential to transform the chronic illness sector.

Steering Committee Chairs:
Pat Goldstein, The Coalition of Behavioral Health Agencies
Charles King, Housing Works

End of AIDS Subcommittee Chairs:
Charles King, Housing Works
Freddy Molano, Community Healthcare Network

Integrated Care Subcommittee Chairs:
Thomas Del Rio, Acacia Network
Paul Vitale, HELP/PSI

Consumer Workforce Development Subcommittee Chairs:
Sharen Duke, ASCNYC
Naomi Weinstein, The Coalition of Behavioral Health Agencies

Crisis Bed Diversion and Transitional Housing Subcommittee Chairs:
Michael Erhard, CAMBA
Jacquelyn Kilmer, Harlem United

Organizations Represented on the PAC:
Acacia Network
ASCNYC
Bronx-Lebanon Hospital Center
Callen-Lorde Community Health Center
CAMBA
Comunilife
Community Healthcare Network
Dominican Sisters Family Health Services
Harlem United Community AIDS Center
HELP/PSI
Housing Works
Institute for Family Health
Mount Sinai Medical Center
NYC Dept. of Health & Mental Hygiene
NYC Health and Hospital Corporation
Primary Care Development Corporation
Project Hospitality
Project Renewal
SUNY Downstate Medical Center
The Coalition of Behavioral Health Agencies
Village Care
VIP Community Services
Wyckoff Heights Medical Center

A dedicated team supported the committees including staff and representatives from the Amida Care Member Advisory Council and five external organizations. Amida Care staff included: Doug Wirth, President/Chief Executive Officer; Dr. Jerome Ernst, Chief Medical Officer; Stephane Howze, Ombudsman; Jason Lippman, Director of Public Policy and Government Relations; and Paula Ricca, Executive Assistant to the CEO. Member Advisory Council members included Eugene Wedgeworth and Romano Johnson. Consulting organizations included: Bannon Consulting Services, The Coalition of Behavioral Health Agencies, The Menges Group, The Primary Care Development Corporation and Shubert Botein Policy Associates.

I. Executive Summary

On April 14, 2014 Governor Cuomo announced a groundbreaking waiver that allows New York State to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The waiver amendment dollars are intended to address critical issues throughout the state and allow for comprehensive reform through the Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP will promote community-level collaborations and focus on system reform, specifically with a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will collaborate to implement innovative projects that focus on system transformation, clinical improvement and population health improvement.

Amida Care (AC) is a community-sponsored, non-profit Medicaid Special Needs Plan (SNP) designed to improve access to and retention in care for high-cost, high-need individuals living with multiple chronic medical and behavioral health conditions. Since its inception in 2003, AC has successfully coordinated medical and behavioral health care through its vast network of providers—while addressing psychosocial needs such as stable housing and food security as well as other social determinants of health—to achieve positive health outcomes and high retention in care for its members.

Since the Governor's announcement, AC has been working closely with New York State (NYS) and with providers throughout New York to maximize the impact of the DSRIP program for its members and other Medicaid beneficiaries with complex chronic conditions. AC applied for and received a planning grant that supported efforts to develop recommendations for community-based projects aimed at meaningful transformation of the chronic illness sector. Initially there was some exploration as to whether AC could become a lead Performing Provider System (PPS), a designated lead provider for a group of providers that form partnerships and collaborate in a DSRIP Project Plan. However, through consultation with the Department of Health, it was determined that instead of moving forward as a PPS, AC would develop recommendations that can be incorporated by emerging PPSs in New York City (NYC).

AC established a Project Advisory Committee (PAC) to support its planning process, which included a steering committee and four subcommittees. The steering committee served as an integral group that shaped the overall direction and strategic approach. AC identified key individuals among the safety net primary care, behavioral health, hospital, housing and care management communities in NYC to form a representative committee to guide the development of recommendations. The PAC actively collaborated with other PPSs during the planning process, especially to develop initiatives that will achieve the goals of the Governor's *Bending the Curve* campaign to end the AIDS epidemic in NYS by the year 2020.

AC focused its efforts on the five boroughs of NYC, targeting high-need, high-cost Medicaid beneficiaries with chronic medical (e.g., HIV/AIDS) and behavioral health conditions—specifically, adults meeting the serious mental illness (SMI) and substance use disorder (SUD) target criteria and risk factors.

Delivery system reform provides a crucial opportunity to address stark health disparities experienced by low-income New Yorkers living with complex, chronic health conditions through interventions that target social drivers of heightened health risks and poor disease management. The needs assessment findings demonstrate that changes in health delivery alone will not achieve the DSRIP goals. As one member of the AC Member Advisory Council observed in discussing integrated care: *"If you're gonna put everything in the same building I hope you'll have someone there to make sure it's effective. Cause you can always have a bunch of different things in the same building and people still might not get the help they need. They're not getting what they should be getting. It might be convenient, but the important part is if it's effective."*

AC believes that addressing the social determinants of health is fundamental to designing a collaborative system that all safety net providers will endorse—one that will enable and empower individuals to live healthier lives and stay out of the hospital, secure and maintain housing and avoid preventable behavioral health crises. This includes ensuring that services provided are being responsive and respectful of consumers/clients in order to engage and retain them in care. Accordingly, proposed projects focus on ensuring access to a more proactive, integrated system of care that addresses the multi-faceted health and social service needs of its members, many of whom face significant health disparities, stigma, housing instability and food insecurity. Recommendations were developed in four areas or "pillars", described below.
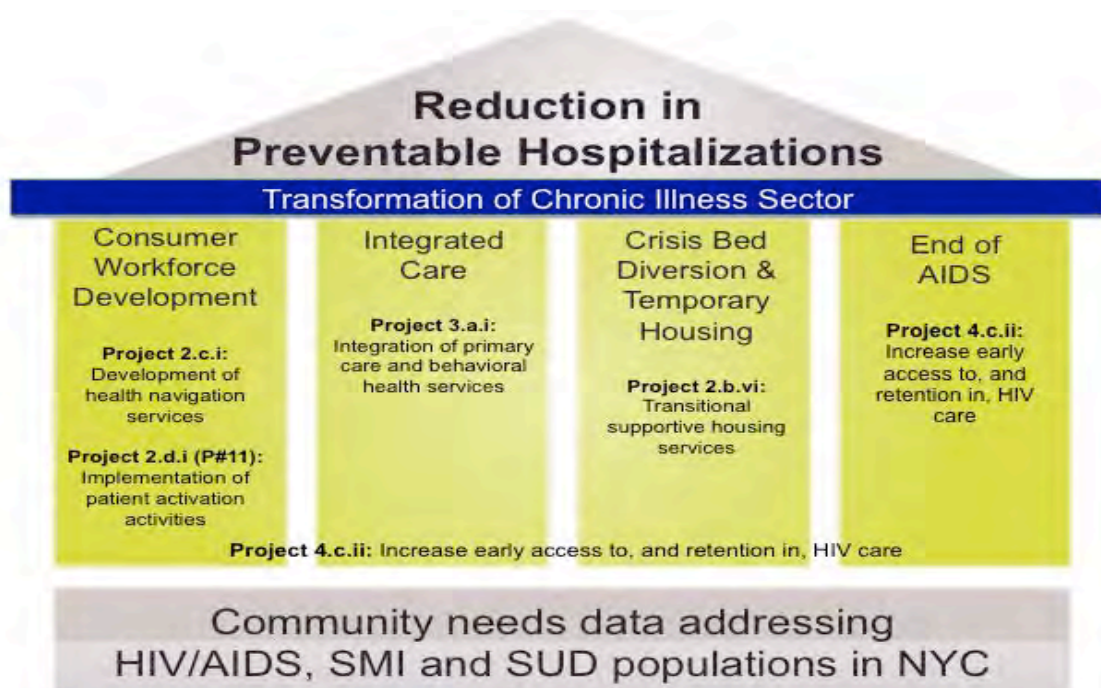
The recommendations include projects in each DSRIP Domain and emphasize cross-PPS and project collaboration. Each of the five project recommendations in this report includes a detailed project description, a summary of the evidence base for meaningful impact and a cost-benefit analysis.

Domain 2: System Transformation Projects

Stark health disparities, high rates of preventable emergency department (ED) use and inpatient admissions, and the high costs associated with complex overlapping medical conditions, SMI and SUD, in NYC support the need for Domain 2 projects. Specifically, Domain 2 projects can contribute to DSRIP goals by addressing the social barriers to chronic disease management, improve care coordination across systems, and increase access to culturally and linguistically appropriate supports for better disease self-management. Within Domain 2, AC planning focused on: consumer workforce opportunities that will both enhance quality of life and independence for consumers, and eventually lead to an improved and modernized workforce, which will support health navigation, care coordination, outreach, and health education at lower costs than professional case management; and crisis beds for hospital diversion and step-down for homeless and unstably housed persons at risk of avoidable inpatient admission or readmission.

Domain 3: Clinical Improvement Projects

The AC target population of persons with complex chronic medical and behavioral health conditions account for a disproportionate percentage of avoidable Medicaid spending and present the greatest opportunity for reducing acute care costs and improving health outcomes. AC planning focused on efforts to develop service delivery systems that provide integrated, community-based mental health and substance use treatment within primary care settings, a critical need for individuals with multiple medical and behavioral health conditions who have difficulty accessing care in a fragmented system.

Domain 4: Population Health Projects

The NYC Department of Health and Mental Hygiene (DOHMH) reports that there were 117,618 persons with diagnosed HIV/AIDS (PWH) living in NYC at December 31, 2013, and estimates that an additional 18,864 persons (14% of all PWH in NYC) are HIV infected but remain undiagnosed.[1] NYC recorded 2,832 new HIV diagnoses during 2013, reflecting a decease of over 40% in annual new HIV diagnoses in the City over the last decade, while nationally there has been no decline in the number of new HIV infections diagnosed each year. Yet 20% of persons newly diagnosed with HIV infection in NYC in 2013 were diagnosed concurrently with AIDS, which means poorer health outcomes for them and higher health care costs for all. While citywide HIV infection rates have declined, HIV morbidity is increasing alarmingly among young black and Hispanic men who have sex with men (MSM) and HIV is increasingly concentrated among people of color and in low-income neighborhoods. Although we now have the means to promote optimal health for PWH and to dramatically reduce new infections via antiretroviral (ARV) medications taken as treatment or as pre- or post-exposure prophylaxis (PEP or PrEP), at the end of 2012 only

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[1] NYC DOHMH HIV Epidemiology and Field Services Program. *HIV Surveillance Annual Report, 2013*. New York, NY. Accessed December 2014. Unless otherwise indicated, all HIV/AIDS statistics included in this report are based on NYC DOHMH surveillance data retrieved from: http://www.nyc.gov/html/doh/html/data/epi-reports.shtml.

41% of PWH in NYC were receiving effective ARV treatment that reduced viral load to an undetectable level and access to PEP and PrEP is extremely limited. AC's planning focused on strategies to improve access to and retention in HIV care, using DSRIP as a means to advance the work of the State's Ending the Epidemic (EtE) Task Force appointed to develop a blueprint for the Governor's *Bending the Curve* initiative. AC also drew on its experience and that of its sponsor agencies to develop innovative strategies to support self-management of HIV disease through peer support and by empowering PWH to take an active role in managing their health with adherence supports including incentives for maintaining a suppressed viral load.

In addition to developing the recommendations, citywide and statewide advocacy was a critical component of AC's DSRIP process. Throughout the entire process, AC worked to advance its priorities and recommendations. These multifaceted efforts focused on statewide inclusion of HIV/AIDS projects in DSRIP applications and specifically acting as a community liaison between DSRIP and EtE Task Force.

This report is the culmination of AC's DSRIP planning process and includes the following sections:

1. PAC Structure, Planning Process and Timeline: Provides an overview of AC's process leading up to the development of the report.
2. Community Needs Assessment: Identifies critical health priorities in local communities and identifies existing gaps in care and the resources available to advance innovative projects designed to transform the safety net health care delivery system, improve population health and reduce avoidable hospitalizations.
3. Project Recommendations: Includes five DSRIP project recommendations.
4. Advocacy Efforts: Describes AC's statewide and city-based advocacy efforts and collaboration with the State's EtE Task Force.
5. Appendix: Provides additional materials relevant to AC's planning process and final recommendations.

AC welcomes the opportunity to work with NYS, PPS Leads and other stakeholders to adapt and implement the ideas presented in this report. We are confident that we can bring significant savings to Medicaid and achieve improvements in individual and population-wide health outcomes. AC will also work with private foundations such as the New York State Health Foundation and the New York Community Trust to advance recommendations included in this report that cannot be supported through DSRIP.

## II. Amida Care DSRIP Structure, Planning Process and Timeline

AC's Project Advisory Committee (PAC) was responsible for coordinating and overseeing AC efforts to ensure that the wide range of interests and needs of the AC partners and stakeholders were fully represented during the DSRIP planning process, in advocacy efforts and in the development of recommendations. PAC members were recruited from AC's existing network of partnering providers (a variety of primary care, mental health and substance use providers; community health centers; hospitals; homeless providers; Health Homes; and Designated AIDS Centers) that are representative of different geographic communities throughout NYC and have specialized expertise in a range of medical, behavioral health and social services. These partners are well integrated into the communities they serve and have established linkages with a wide range of organizations—from hospitals to soup kitchens to community centers—to meet their clients' needs. As a collective network of providers dedicated to serving a subset of the most marginalized individuals in NYC, AC and its DSRIP planning participants drew on an extraordinary capacity to meet the complex needs of hard-to-reach Medicaid beneficiaries through an approach to care that emphasizes treating the whole person and overcoming barriers to access, retention, and treatment adherence.

The PAC originally met in August 2014 and continued to meet through December 2014 to guide all stages of developing the recommendations. As described below, the PAC structure included a steering committee and four subcommittees (Consumer Workforce Development Subcommittee; End of AIDS Subcommittee; Crisis Bed and Transitional Housing Subcommittee and Integrated Care Subcommittee). All subcommittees consisted of organizational and worker representatives from the AC providers, some of whom are participating in PPSs throughout NYC, as well as consumers identified to represent the diverse geographic and population needs of the service area. Each subcommittee oversaw the drafting of recommendations pertaining to specific projects within their applicable domain. The subcommittees discussed project implications, anticipated outcomes, financial and cultural considerations, implementation barriers, workforce structures, and health information technology issues. The PAC then incorporated feedback and information from each subcommittee into this report.

Each subcommittee held an initial planning meeting in September, followed by four additional meetings between October and December. Follow-up emails and calls exchanging information between the meeting dates allowed committee members to stay up-to-date on DSRIP developments and AC's PAC progress across all subcommittees. Additionally specific subcommittees held "sub-sub" committee meetings and conference calls between the scheduled full subcommittee meeting dates to discuss specific issues. Overall, the subcommittees played an integral role in all phases of the development of the final recommendations by offering guidance on the identification and prioritization of PPS initiatives. These committees ensured effective coordination among the PPS members by regularly soliciting feedback, facilitating discussions and working toward consensus among PPS partnering agencies. It should also be noted that the vast majority of AC's committee members were cross representative and actively involved on other city-based PPSs,

affording the PAC an opportunity to "cross pollinate" ideas between the city-based PPSs and AC's PAC. These subcommittee members assisted with AC's advocacy efforts up to the final Steering Committee meeting on December 16, 2014, and will continue to assist PPSs with implementing AC's recommendations.
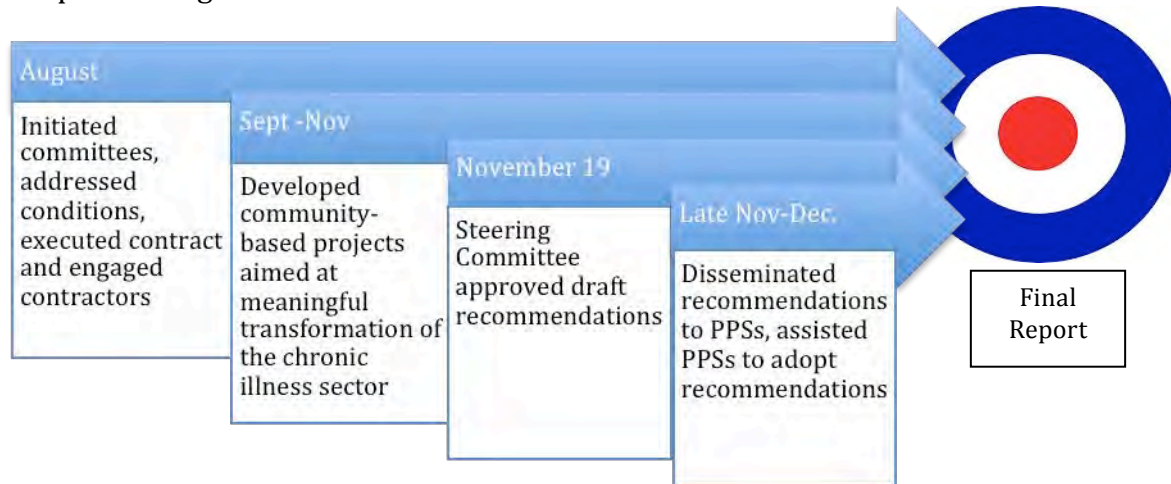
As part of AC's robust planning process, consultants were hired to support the committees' work. The project manager and needs assessment and finance consultants supported the work of all the subcommittees while the Learning Collaborative consultants assisted with the specific development of the Integrated Care Subcommittee recommendations.
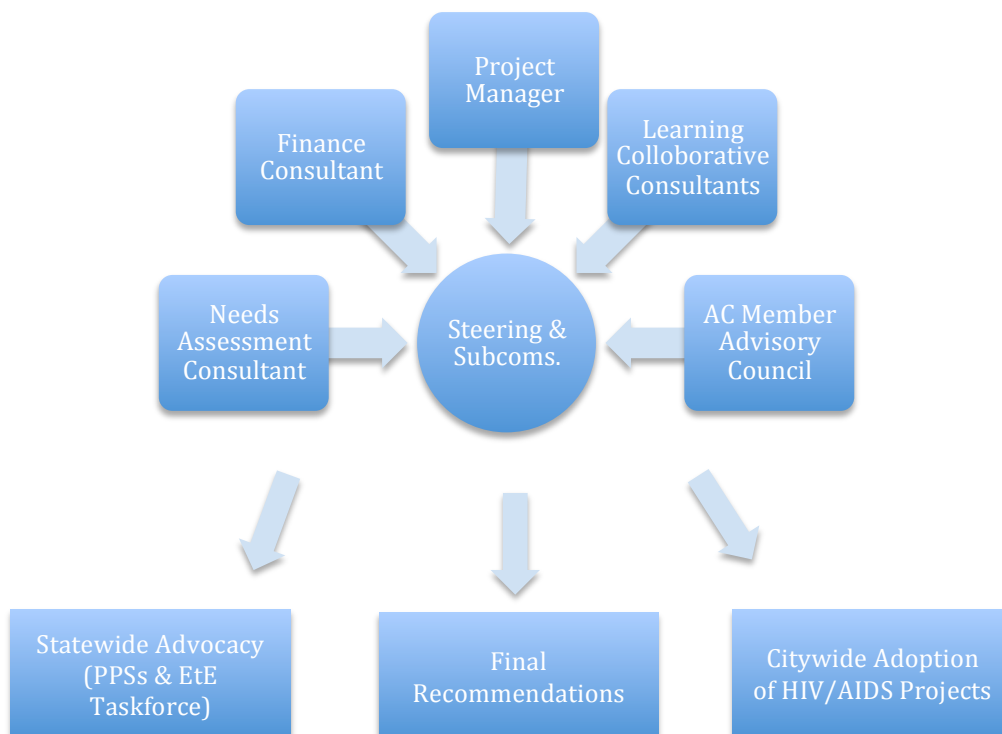
Community Needs Assessment (CNA) Consultant:
Ginny Shubert is a principal of *Shubert Botein Policy Associates*, a public policy consulting group that supports the development and implementation of public policies and programs that impact low-income people and communities. Ms. Shubert has 27 years' experience as an advocate, service provider and consultant working on poverty and health issues including homelessness and access to housing, HIV/AIDS, tuberculosis, and drug and alcohol dependence. Ms. Shubert founded the AIDS Project of the Coalition for the Homeless in 1988 and was a co-founder of Housing Works. For the last 20 years Ms. Shubert has worked as a consultant on housing, health, and economic justice issues.

Finance Consultant:
The Menges Group (TMG) provides nationwide consulting services that promote and develop effective and efficient care coordination and other related business strategies. TMG supports clients in the design and development of strategies designed to optimize operations focused on high-risk populations. TMG's mission is to promote the highest quality, cost-effective strategies to delivering care to high-risk, high-need populations. To that end, all projects aim to improve client/member coordinated care strategies and services and to reduce costs for high-need and vulnerable subgroups of all ages. Mr. Joel Menges, Chief Executive Officer and the lead on this project, has led hundreds of consulting engagements that involve the design, development, improvement or evaluation of coordinated care programs, including Medicaid initiatives in more than 30 states.

Project Management Consultant:
Bannon Consulting Services works with organizations to maximize the impact of community-based health, housing and human services programs. It provides expertise in complex programmatic, financial and regulatory aspects of program development. Projects primarily address overlapping chronic health conditions (such as HIV/AIDS, Hepatitis C, mental illness and substance use disorders) and socioeconomic barriers (such as homelessness, unemployment and involvement in the criminal justice system). Its ultimate aim is to improve the health and well-being of underserved individuals through effective programs that reduce the economic and societal burdens placed on the broader community.

Learning Collaborative Consultants:
Two organizations were engaged to assist in developing the Integrated Care's Learning Collaborative proposal for small, community-based providers.

The Coalition of Behavioral Health Agencies is the umbrella advocacy organization of New York's behavioral health community, representing over 130 non-profit community-based behavioral health agencies that serve more than 350,000 clients in the five boroughs of NYC and its environs. Founded in 1972, The Coalition is membership supported along with foundation and government funding for special purpose advocacy training and technical assistance projects.

Primary Care Development Corporation (PCDC) is a nonprofit dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs, and reduce disparities. PCDC provides the expertise to renovate and expand community-based health facilities so that providers can deliver the best care to their patients; consulting, training and coaching to help practices deliver a patient-centered model of care that maximizes patient access, meaningful use of health IT, care coordination and patient experience; and support to successfully develop policy initiatives that increase access to quality primary care, improve the health of communities, and lower health system costs.

The Coalition partnered with PCDC to design a learning collaborative recommendation to assist PPSs with integrating primary and behavioral health care. The Coalition served as the behavioral health expert and PCDC as the primary care lead, and both worked together to provide guidance, resources and technical assistance to AC in its DSRIP planning efforts.

Member Advisory Council (MAC):
The Member Advisory Council (MAC) is a group of Member representatives, elected by their peers from many of AC's primary care/owner sites. These representatives attend quarterly meetings where they discuss their perceptions and evaluations of how the Plan is working for its Members. The MAC also recommends two of its Members to the Board of Directors. These 'consumer' Board Members attend monthly Board meetings and present the MAC. They participate fully in Board discussions and help the other Board Members to see issues from the Members' point of view. The MAC is an important part of how AC works. By providing a constant source of information from the Members, AC staff can work to improve the services of the Plan. The MAC has helped to improve existing programs, create new programs, identify new providers, suggest health education topics and events that members will attend.

The following chart provides an overview of AC's DSRIP PAC timeline including major milestones in the planning process. Each subcommittee meeting marked a critical point in AC's PPS planning process.

Date	Meeting	Agenda
August	Steering Committee #1	• Overview of AC's DSRIP goals • Review and approve AC's timeline and planning process
September	Subcommittee Meetings #1	• Overview of AC's DSRIP goals • Review and brainstorm projects applicable to each subcommittee • Identify data needed to advance recommendations
Early October	Subcommittee Meetings #2	• Choose projects to advance • Receive general DSRIP updates along with CNA updates • Start outlining recommendations • Engage in city and statewide advocacy & collaborate with EtE Task Force

Date	Meeting	Agenda
October	Steering Committee #2	• Update on AC's planning process and the subcommittees' projects • Review and plan AC's continued advocacy • Review CNA and financial analysis progress
Late October	Subcommittee Meeting #3	• Review draft recommendations & provide feedback • Receive general DSRIP updates • Review revised AC timeline, planning process and advocacy efforts • Review CNA and financial analysis progress
November	Subcommittee Meetings #4	• Review draft recommendations • Feedback specifically focused on strengthening the drafts so they could be easily picked up and adapted into PPS project applications
November	Steering Committee #3	• Vote and approve the subcommittees' recommendations • Disseminate recommendations to all PPSs in the metropolitan area • Discuss advocacy efforts
December	Subcommittee Meetings #5 & Final Steering Committee	• Review cost savings analysis data for each recommendation. • Review final report to the State • Discuss how AC and its partners can help PPSs implement the recommendations in 2015

Overall during the four-month period, 20 full subcommittee meetings, 6 "sub-sub" committee meetings and 5 Steering Committee meetings were held with additional, smaller working groups and conference calls focused on particular issues. In total over 75 PAC members met for more than 65 working hours to ensure that the perspective of community members and stakeholders were incorporated and reflected in AC's proposed projects and final report.

AC facilitated committee engagement between the formal meetings. These included scheduling "sub-sub" meetings – for example, specific members of the Consumer Workforce Development Subcommittee met as a working group to discuss eligibility requirements and the training curriculum for the peer health navigation recommendation. Additionally, the project manager also met with external stakeholders such as state agencies, DOHMH, organizations outside of the PAC to brief them on AC's progress, collaborate and solicit feedback.

Throughout the process AC also sought consumer representation and input. Consumers attended some steering committee and subcommittee meetings. AC also called a special MAC meeting, to present the recommendations and solicit client feedback. Similar to the Steering Committee, the MAC voted unanimously to approve the recommendations.

III. Community Needs Assessment

Introduction

AC employed its DSRIP planning grant to focus attention on innovative strategies to address health disparities, improve outcomes and reduce avoidable costs among Medicaid beneficiaries with chronic medical and behavioral health conditions. Specifically, AC planning targeted the group of Medicaid beneficiaries across the five boroughs of NYC— including New York, Kings, Queens, Bronx and Richmond counties—with HIV/AIDS and adults meeting SMI and SUD target criteria and risk factors. The NYS Department of Health (DOH) estimates that there are 975,000 high-cost Medicaid enrollees statewide with multiple chronic illnesses utilizing Medicaid services at an average cost $2,338 per person per month. Of these, 168,000 are living with HIV/AIDS, 408,529 have mental health and/or substance use disorders and 306,087 have two or more chronic conditions.[2] These individuals require complex, cross-sector health care that involves coordination across multiple providers and agencies. As outlined below, many of these Medicaid beneficiaries also confront social drivers of poor health outcomes prevalent in NYC, such as homelessness, poverty, racism, stigma, language barriers, unemployment, inadequate social supports and incarceration. These "social determinants" of health outcomes contribute to problems with accessing or remaining engaged in care, making chronic illnesses particularly difficult to manage.

Social determinants of health have been defined as the circumstances in which people are born, grow up, work and age, and the systems put in place to deal with illness. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels, and often determine the risk of illness and the actions taken to prevent people from becoming ill or to treat illness when it occurs. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status between groups of people. Drivers of health inequities include: income, education, employment opportunities, gender, race/ethnicity and other factors.[3]

For example, in the United States people with SMI die, on average, 25 years earlier than the general population, with a majority of this excess mortality due to medical conditions such as cardiovascular, pulmonary and infectious diseases, which result from modifiable medical risk factors.[4] Schizophrenia, Bipolar Disorder and Major Depressive Disorder have

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[2] NYSDOH. Medicaid Health Homes, High Cost Population Characteristics. *State of Medicaid Spending: High Cost Enrollees*. 2011. Retrieved from:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/bucket_slide.pdf
[3] WHO. What are the social determinants of health? Accessed December 2014 at
http://www.who.int/social_determinants/sdh_definition/en/
[4] SAMHSA. (2011). *SAMSHA Strategic Initiatives.* HHS Publication No. (SMA) 11-4666. Retrieved from:
https://store.samhsa.gov/shin/content/SMA11-4666/SMA11-4666.pdf

all been associated with medical causes of death that are often 2 to 3 times that of the general population.[5]

HIV/AIDS risk and health outcomes reflect stark disparities rooted in the social determinants of health. As depicted in the charts below, an increasing body of research evidence documents the impact of poverty, housing insecurity, lack of insurance and other social factors on the risk of acquiring HIV infection and on outcomes along the continuum, or cascade, of steps necessary to benefit from HIV treatment.[6]

HIV Infection Among Heterosexuals in Urban Areas, by Socio-Economic Indicators, 2006-2007, N=14,837- Structural/Environmental

*CDC. Characteristics Associated with HIV Infection Among Heterosexuals in Urban Areas with High AIDS Prevalence --- 24 Cities, United States, 2006--2007. MMWR 2011:60:1045-1049.

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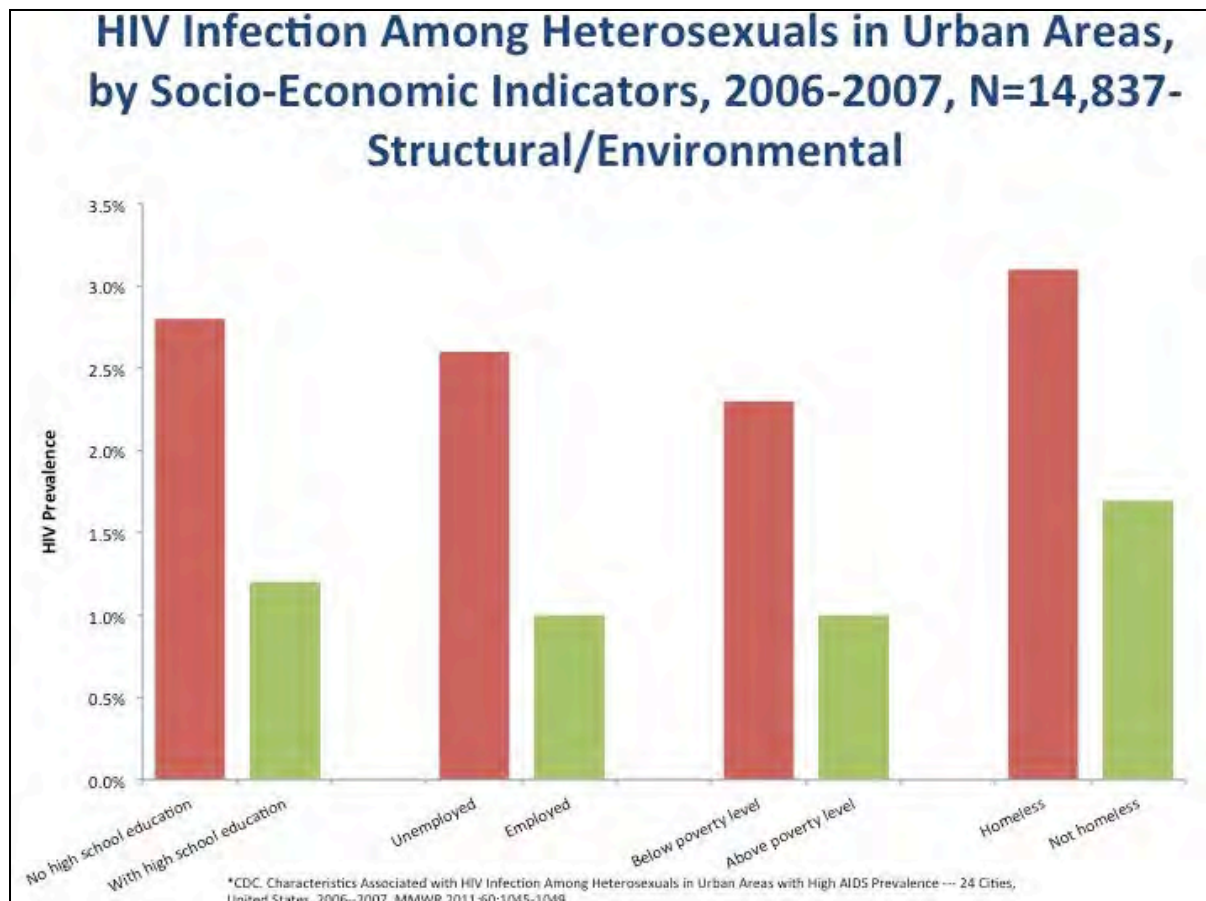
[5] National Association of State Mental Health Directors, Medical Directors Council. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. Technical Report. Retrieved from: http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

[6] Millett, G. (2014). *Structural Factors and the HIV Continuum of Care*. Presentation at The Housing Determinant: Integrating Housing into the Continuum of HIV Services Meeting. UCLA, October 21, 2014. Retrieved from: http://chipts.ucla.edu/2014/11/14/covel/

Disparities by Structural Factors Across Treatment Cascade

(Sources: Muthulingam, 2013; Hannah, 2013; CDC, 2012; Hall, 2012; Traeger, 2012; Torian, 2011; Knowlton, 2010; Meade, 2009; Mugavero, 2009; Weiser, 2009; Kidder, 2007; Bell, 1999)
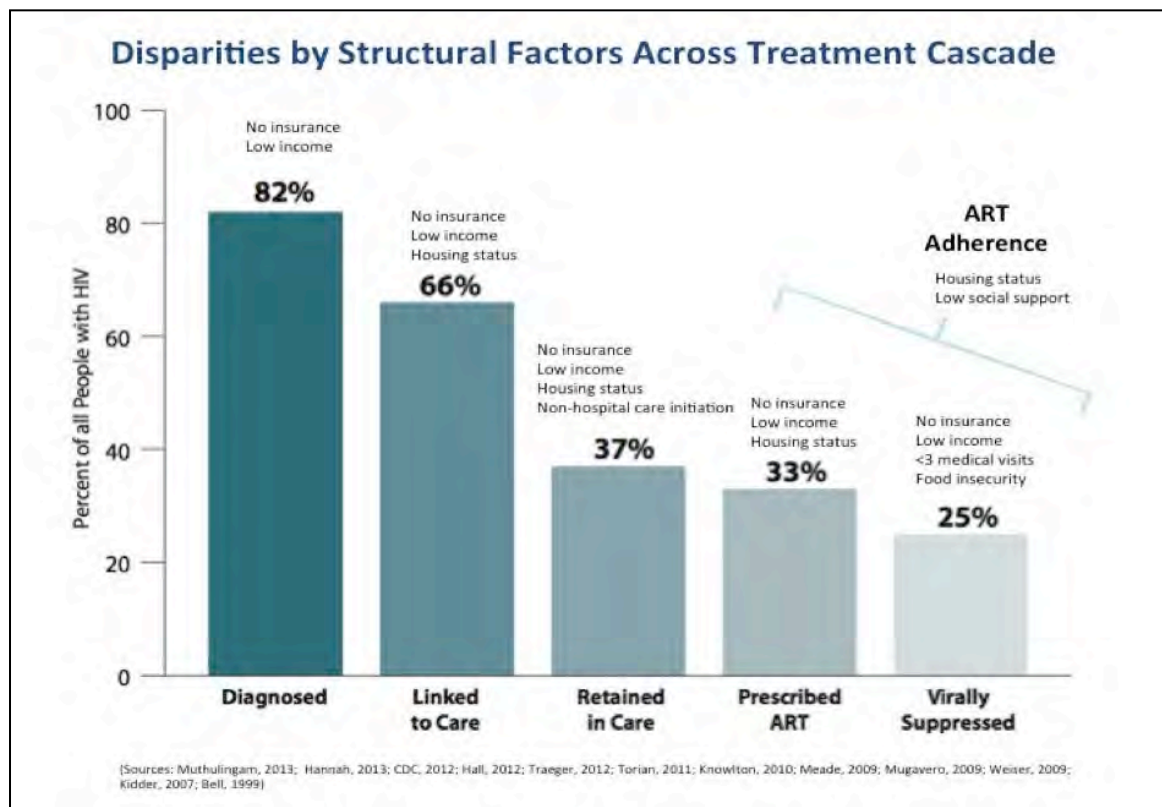
AC sponsor agencies and provider partners have used the CNA process to deepen their understanding of the multi-faceted health care and psychosocial needs of this subset of individuals with complex chronic and behavioral health issues, and to examine the evidence base for innovative strategies to: 1) enhance integration of medical and behavioral health care services to better address complex needs; 2) address structural determinants of health; 3) strengthen culturally competent community-based services; and 4) support the goals of Governor Cuomo's historic *Bending the Curve* plan to end AIDS as an epidemic in New York by the year 2020. The goal of this CNA is to add value in these areas to the overall DSRIP process towards achieving the 'triple aims' of health care reform articulated by Donald Berwick, former director of the Center of Medicaid and Medicare Services: namely, to improve population health, increase quality of care, and reduce costs.[7]

The AC Community Needs Assessment includes the following:
- Community needs assessment process and methods
- Description of target population health disparities and challenges
- Social barriers to health improvement for the AC target population
- Evaluation of community assets and resources
- Evidence base for proposed AC projects (see Section IV Project Recommendations)

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[7] Berwick, D.M., et al. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs*, 27(3): 759-769.

Community Needs Assessment Process and Methods

The CNA findings reported here are based on review and analyses of secondary data sources, a search of the research literature on health outcomes and interventions for members of the AC DSRIP target population, and extensive work in collaboration with members of the AC DSRIP Project Advisory Committee (PAC) and the four AC DSRIP subcommittees focused on Integrated Care, Crisis Bed Diversion and Temporary Housing, Consumer Workforce Development and End of AIDS. AC identified key individuals among the safety net primary care, behavioral health, hospital, housing and health home communities in NYC, as well as consumers of these services, to form representative committees to guide the CNA and the development of recommended projects.[8]

The CNA consultant, Shubert Botein Policy Associates, did an extensive review of the published and grey literature on unmet needs of the target population and evidence-based interventions, and engaged in an iterative process with PAC steering and subcommittee members to refine the CNA to focus specifically on the need for and evidence base supporting proposed projects. In addition, CNA findings and recommendations were presented to the AC Member Advisory Council (MAC) for review and comment.

The AC CNA was also informed by and drew from the extensive NYC Health Provider Partnership Community Needs Assessments for Brooklyn, the Bronx, Manhattan and Queens that were prepared by the New York Academy of Medicine, Tripp Umbach, and the New York City Health and Hospitals Corporation (HHC).[9] The goal of the AC CNA was to build upon rather than duplicate findings from these needs assessments and to supplement and add value to reported findings rather than collect additional primary data.

Finally, AC, a number of its sponsor and provider agencies, and Shubert Botein Policy Associates have actively participated in the work of the EtE Task Force appointed to develop a blueprint for achieving the goals of the Governor's *Bending the Curve* initiative. Several AC DSRIP PAC members sit on the Task Force. AC representatives and Shubert Botein Policy Associates have attended Task Force meetings and community listening sessions, and have been actively involved in the development of the EtE recommendations currently under consideration by Task Force members. A number of recommendations are synergistic with DSRIP and would advance both DRSIP and EtE goals.

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[8] See Section II above for a description of community engagement in the AC DSRIP planning process, including the selection, expertise and work of the AC Project Advisory Committee, AC DSRIP Steering and Subcommittee members.

[9] Available on the HHC website at:
Bronx: www.nyc.gov/html/hhc/downloads/pdf/community-needs-2014/bronxcommunityneedsassessment.pdf;
Brooklyn: www.nyc.gov/html/hhc/downloads/pdf/community-needs-2014/brooklyncommunityneedsassessment.pdf;
Manhattan: www.nyc.gov/html/hhc/downloads/pdf/communityneeds2014/manhattancommunityneedsassessment.pdf
Queens: www.nyc.gov/html/hhc/downloads/pdf/community-needs-2014/queenscommunityneedsassessment.pdf

Description of Target Population Health Disparities and Challenges

Overview
In 2012, 11% all NYC Medicaid and dually-eligible Medicaid/Medicare beneficiaries had at least one hospital admission and 23% had at least one ED visit. The rate per 100,000 of potentially avoidable inpatient discharges during 2012 ranged from 2,482/100,000 for the Bronx (1.38% of the expected rate) to 1,318/100,000 in Queens (.80% the expected rate). In 2012 there were 345,073 potentially preventable hospital readmissions and 1,191,549 potentially preventable ED visits among NYC Medicaid beneficiaries.[10]

Health outcomes in NYC reflect marked disparities. During the 2010-2012 period, black and Hispanic NYC residents were twice as likely to die prematurely than white residents, with the top five causes of premature death being cancer, heart disease, unintentional injury, diabetes and AIDS.[11] Black and Hispanic NYC Medicaid beneficiaries were 2.27 times and 1.58 times more likely, respectively, than white beneficiaries to experience a preventable hospitalization.[12]

This section of the CNA report includes: an overall description of the population targeted by AC DSRIP planning activities; overviews of the health status (including health disparities) and Medicaid utilization of persons in NYC living with SMI, SUD and/or people with HIV (PWH); and data on certain social barriers to improved health outcomes that were the particular focus of AC DSRIP planning activities.

AC Target Population
As noted above, the NYSDOH estimates that there are 975,000 high-need, high-cost Medicaid enrollees with chronic medical and behavioral illnesses. Improving outcomes and reducing costs for this group with complex needs will require coordinated management and an integrated approach that addresses medical, behavioral and social factors. For example, costs for Medicaid beneficiaries with mental health conditions are twice as high as for beneficiaries without mental health conditions, and nearly three-quarters of total spending for this group is related to co-occurring physical health conditions.[13] AC DSRIP planning focused in particular on NYC Medicaid beneficiaries in this high-need, high-cost group who are living with HIV/AIDS, SMI[14] and/or SUD.

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[10] Source: NYSDOH Office of Quality and Patient Safety Bureau of Health Informatics. *Medicaid Claims Extract, 2012*.

[11] Source: NYSDOH Bureau of Biometrics and Health Statistics. *Premature deaths (< age 75) for the three years 2010-2012*. Vital Statistics Data as of March 2014.

[12] NYS Prevention Agenda 2013-2017 State and County Dashboard. 2012 Reported Data. Accessed December 2014.

[13] SAMHSA-HRSA Center for Integrated Health Solutions. Integrating Addiction and Primary Care Services. Accessed December 2014 at http://www.integration.samhsa.gov/about-us/esolutions-newsletter/integrating-substance-abuse-and-primary-care-services

[14] The term "serious mental illness" is defined by the U.S. Department of Health and Human Services to include adults (18 or older) who have diagnosable mental, behavioral, or emotional disorder that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. There

Persons with SMI and/or SUD

Health Status
In any given year, one in four adults in NYS has a diagnosable mental disorder, and one in 17 has a diagnosis of SMI. In many cases, individuals living with SMI also experience a range of chronic and disabling medical conditions, such as diabetes, asthma, obesity, and heart disease.[15] Data emerging from Medicaid Health Homes show a correlation between behavioral health conditions and chronic physical illness, with each condition typically treated in a silo with little service integration or communication among providers. The data indicate that of Health Home eligible individuals age 21 or older with SMI, there is a high prevalence of chronic health conditions[16] Among adult who use NYS Office of Mental Health (OMH) licensed behavioral health services in NYC, 57% have been diagnosed with at least one chronic medical condition and 34% use tobacco.[17]

Like persons with SMI, Medicaid beneficiaries with SUD also experience high rates of medical co-morbidities. An evaluation of NYS Medicaid fee-for-service spending over a 12-month period found that 55.5 percent of beneficiaries treated for SUD had mental illness, 32.5 percent had heart disease, and 22.0 percent had HIV/AIDS. The prevalence of SUD was almost twice as high among beneficiaries who received mental health treatment compared to those who did not (22.2% versus 11.5%).[18]

People with SMI die, on average, 25 years earlier than the general population, with a majority of this excess mortality due to medical conditions.[19] Almost half of tobacco-related premature deaths occur among people with mental health and SUDs.[20] Trauma, including intimate partner violence, is also strongly associated with mental health and SUDs, and more than half of all prison and jail inmates (people in state and Federal prisons and in local jails) meet criteria for having mental health problems, 6 in 10 meet criteria for a

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is an analogous definition of "serious emotional disturbance" (SED) for children. *Federal Register,* 58(9): 29422-29425. Published Thursday May 20, 1993.

[15] NYS OMH. *Statewide Comprehensive Plan Interim Report, July 2014*. Retrieved from: https://www.omh.ny.gov/omhweb/planning/statewide_plan/2013_to_2017/2014-interim-report/report.pdf

[16] NYSDOH MRT Behavioral Health Reform Work Group. *Final Recommendations*. Retrieved from: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

[17] NYS OMH. Patient Characteristics Survey DataPortal, NYC Region, 2013. Accessed December 2014 at https://www.omh.ny.gov/omhweb/statistics/pcs-message.htm

[18] Coughlin, T.A. & Shang, B. (2011). *New York Medicaid Beneficiaries with Mental Health and Substance Abuse Conditions.* Report prepared for the Medicaid Institute at the United Hospital Fund, NYC. Retrieved from: http://www.integration.samhsa.gov/pbhci-learning-community/NHSA_-_New_York_Medicaid_Costs_Report.pdf

[19] SAMHSA. (2011). *SAMSHA Strategic Initiatives.* HHS Publication No. (SMA) 11-4666. Retrieved from: https://store.samhsa.gov/shin/content/SMA11-4666/SMA11-4666.pdf

[20] Ibid.

substance use problem, and more than a third meet criteria for having both a substance use problem and a mental health problem.[21]

Medicaid Utilization
In 2012 there were 702,585 Medicaid beneficiaries in NYC with behavioral health conditions (SUD and/or SMI), 19.58 per 100,000, compared to 17.09 per 100,000 for NYS as a whole. In 2012, 32.34% of these persons with a behavioral health condition had at least one inpatient admission (with an average of 2.43 admissions) and 42.33% had at least one ED visit (with an average of 2.98 ED visits).[22]

NYC Medicaid beneficiaries with a mental health diagnosis had an average of 2.43 inpatient admissions for the year, and an average of 2.98 ED visits. The rate of readmissions for persons with mental health diagnosis is also high, with 23.3% being readmitted within 30 days (compared to 20.9% statewide).[23]

Among the 222,198 Medicaid beneficiaries in NYC with SUD (6.19 per 100,000 compared to 6.36 statewide), 65.03% had at least one admission and 58.37% had at least one ED visit. This group has high overall average numbers of hospital admissions and ED visits. In NYC, the average number of admissions was 3.58 (3.13 for the state as a whole) for 2012 and the average number of ED visits was 4.34 (4.18 for the state). And in certain parts of NYC, such as the Lower Manhattan service area, the average number of admissions is higher still, at 4.44 per person.[24]

One reason for the high admission rates, high number of ED visits, and frequent readmissions is noncompliance with aftercare instructions following discharge. Prescription refill rates, an indicator of compliance, are low for patients relying on behavioral health medications. The 30-day fill rate for psychotropic meds is 57.6% in NYC (64% at the state level); for antipsychotic medications, the 30-day fill is lower at 54.3%, and the 30-day fill rate for mood stabilizers is just 47.0%. Given the gravity of the conditions for which these medicines are prescribed, and the readmissions likely caused by noncompliance, the need for post-discharge care management is compelling.[25]

Evidence also indicates that a small number of persons with SMI and/or SUD account for a disproportionate percentage of total inpatient behavioral health costs. A 2007 NYS study of potentially preventable acute care hospitalizations found that Medicaid beneficiaries with both mental health and substance abuse conditions experienced potentially preventable hospital readmissions over 3.5 times more frequently than recipients with neither of these

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[21] Ibid.

[22] NYSDOH Office of Quality and Patient Safety Bureau of Health Informatics. *Medicaid Claims Extract, 2012*.

[23] Ibid.

[24] Ibid.

[25] NYS OMH DSRIP Dashboard. *Behavioral Health Organization Performance Metrics, 2012.* Accessed December 2014.

health conditions.[26] In 2012, among all individuals hospitalized in NYC for mental illness, 2,811 persons had three or more hospital stays, which accounted for 9% of all users and 24.8% of all psychiatric hospitalizations. Of these persons, 654 had five or more hospital stays (2% of all users), accounting for 9.1% of all psychiatric hospitalizations. Sixty-six percent of individuals with multiple hospitalizations had a secondary diagnosis of SUD. Among 1,500 people discharged from inpatient detox in NYC during the month of December 2013, nearly 800 had multiple visits within the subsequent year, including 100 people with 10 or more readmissions to detox within the year.[27]

According to the NYS Behavioral Health Organizations Summary, inpatient readmission rates dropped throughout 2012 for persons with behavioral health conditions, suggesting positive impact by Health Homes and other efforts. But the data indicate that rates of hospital provider communication and coordination of post-discharge behavioral health services are low and that rates of coordination with physical health providers are even lower, and that homelessness remains a significant barrier to care coordination, even when over 90% of individuals are discharged to stable housing.[28]

People Living with HIV/AIDS

Health Status
During 2013, NYC recorded 2,832 new HIV diagnoses and 1,784 new AIDS diagnoses, historical lows that represent a more than 40% decrease in new HIV diagnoses and 67% decrease in new AIDS diagnoses in the last decade.[29]

As depicted in the chart below, NYC has also realized a dramatic decrease in premature deaths among people diagnosed with HIV, with a corresponding increase in the number of persons living with HIV/AIDS. At the end of 2013, there were 117,618 persons diagnosed HIV/AIDS living in NYC, and an additional 18,864 persons (estimated by DOHMH as 14% of all PWH) who were HIV infected but remained undiagnosed.

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[26] Lindsey, M., et al. (2007). *Potentially Preventable Hospital Readmissions Among Medicaid Recipients with Mental Health and/or Substance Abuse Health Conditions Compared with All Others: New York State.* Statistical Brief No. 3, NYSDOH. Retrieved from:
https://www.health.ny.gov/health_care/managed_care/reports/statistics_data/3hospital_readmissions_mentahealth.pdf

[27] Kunins, H., Marsik, T., & Tom, L. *DSRIP and Behavioral Health*. NYC DOHMH presentation on August 6, 2014.

[28] NYS OMH & OASAS. (2013). New York State Behavioral Health Organizations 2012 Summary. Accessed December 2014 at https://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-05-01_mrt_bh1_slides_resubmitted_5-7.pdf

[29] NYC DOHMH HIV Epidemiology and Field Services Program. *HIV Surveillance Annual Report, 2013*. New York, NY. Accessed December 2014.

FIGURE 1.1: History of the HIV/AIDS epidemic, New York City 1981-2012
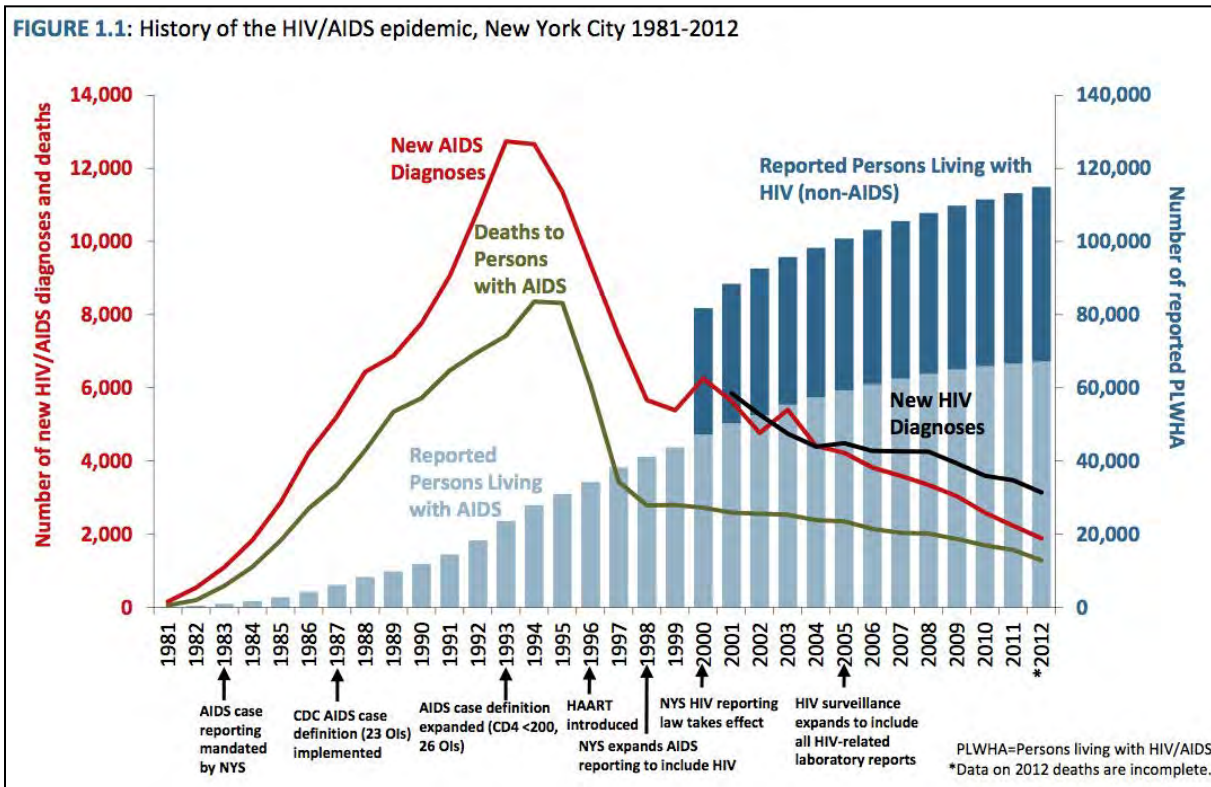
Yet despite these gains, HIV/AIDS still causes significant morbidity and mortality in NYC, particularly in minority communities. HIV is the fifth overall leading cause of premature death among NYC residents under 65 years of age, the third leading cause of premature death for non-Hispanic blacks, and fourth for Puerto Rican New Yorkers.[30]

DOHMH also report continued improvements in the proportion of PWH in NYC who are linked to care after diagnosis and the proportion of those retained in care who achieve viral suppression, with both over 75% in 2013; however, rates of linkage and viral suppression vary widely by demographics, risk group and age. Rates of viral suppression for persons in care are lower among females than males, lower for blacks compared to other racial groups, lower for IDUs and lowest (57%) for young persons (17 to 24 years).

Federal guidelines now recommend antiretroviral medication (ARVs) for all adults and adolescents living with HIV.[31] Effective ARV therapy that suppresses HIV viral load to an undetectable level (typically measured as ≤200 copies/ml) optimizes the health of people

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[30] NYC DOHMH. (2013). *Summary of Vital Statistics 2012: The City of New York*. New York, NY. Accessed December 2014.

[31] U.S. DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents. (2014). *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents.* Accessed December 2014 at http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf

living with HIV and dramatically reduces their risk of transmitting the virus to others.[32] As depicted in the overall 2012 NYC HIV continuum (or cascade) of care below, significant percentages of PWH in NYC remain undiagnosed (14%), are out of care (45%), and are not receiving effective ARV therapy that suppresses viral load to an undetectable level (59%).

Number and proportion of persons with HIV in New York City engaged in selected stages of the continuum of care at the end of 2012

Of all persons estimated to be infected with HIV in NYC, 41% have a suppressed viral load.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2013. For definitions of the stages of the continuum of care, see Appendix.
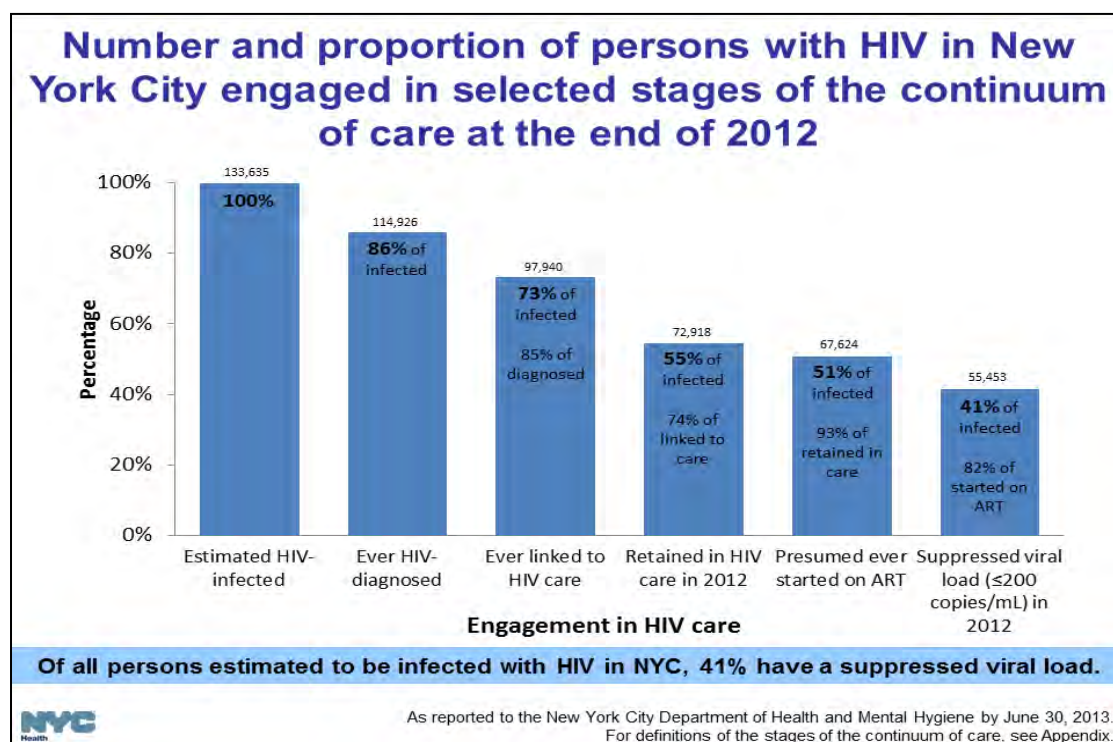
A significant number of persons were newly diagnosed with HIV in 2013, and 20.3%, were diagnosed concurrently with AIDS, which is too late in the course of HIV infection to fully benefit from life-extending ARV therapy. PWH who enter medical care late in their HIV disease have substantially higher direct medical treatment expenditures than those who enter at earlier stages, including significantly higher inpatient costs.[33] Failure to timely diagnose HIV means poorer health outcomes, an increased risk of spreading HIV to others and increased costs for all.

HIV in NYC is increasingly concentrated in low-income communities of color, where many individuals experience multiple challenges that severely impact health in addition to HIV, such as substance use, mental illness, hepatitis C virus (HCV), and homelessness. Of 2,547 persons newly diagnosed with HIV in 2013 and for whom NYC zip code data was available, 1,524, or 60%, resided in high poverty (807 new diagnoses) or very high poverty (717 new

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[32] Cohen, M.S., et al. (2011). Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med.*, 365(6): 493-505

[33] Fleishman, J.A., et al. (2010). The Economic Burden of Late Entry Into Medical Care for Patients With HIV Infection. *Med Care*, 48(12): 1071–1079.

diagnoses) zip codes. NYC neighborhoods with the highest proportion of PWH include the South Bronx, Upper and Lower Manhattan, Central Brooklyn and East New York/New Lots.

As stated in the recently released 2013 DOHMH HIV Surveillance Report, "disparities by sex, race/ethnicity, HIV transmission risk, geography and poverty level contribute powerfully to the distribution of HIV and AIDS diagnoses, prevalence, HIV care outcomes, survival and mortality rates."[34] People newly diagnosed with HIV infection in NYC in 2013 were predominately black or Hispanic, young, men who have sex with men (MSM), or people living in high-poverty neighborhoods. Black and Hispanic women represent an overwhelming majority of new HIV diagnoses among women (88.2%). MSM continue to represent a disproportionate share of new HIV diagnoses (56.8%), and 37.4% of all living HIV cases are MSM. The number of new HIV infections annually among young MSM, most notably young men of color, is alarmingly high; 35.5% of New Yorkers newly diagnosed with HIV in 2013 were under the age of 30. As described in more detail below, transgender people of all ages, immigrants or foreign-born people, homeless persons and persons involved with the criminal justice system also experience HIV health disparities in NYC.

Black and Hispanic New Yorkers accounted for more than three-quarters of new HIV diagnoses in 2013. The HIV diagnosis rate among black males is 1.5 times higher than the rate among Hispanic males and over 2 times higher than the rate among white males; the HIV diagnosis rate among black females was over 2 times higher than the rate among Hispanic females and over 9 times higher than the rate among white females. Blacks having the poorest short-term survival after an HIV diagnosis, and in 2012, black PWH had an age-adjusted death rate almost twice as high as that of whites. Blacks are also among the populations most likely to be diagnosed late in the course of infection, and once in care, blacks are more likely than other PWH to have persistently high viral load.[35]

The NYC DOHMH reports that there were 220 new HIV diagnoses among transgender persons between 2008-2012, of whom 92% were black or Hispanic and 20% were foreign-born.[36] Although overall HIV prevalence among transgender New Yorkers is unknown, one study documented HIV infection rates in NYC of 49.6% among transgender women of Latin American origin and 48.1% among transgender women of African descent, compared to HIV prevalence of 3.5% white, non-Hispanic transgender women.[37] Foreign-born PWH in NYC are more likely to be diagnosed late—27% of foreign-born NYC HIV cases were concurrently diagnosed with AIDS in 2012-2013, compared to 18% of non-foreign-born concurrently diagnosed HIV/AIDS cases. People who are foreign-born, especially the

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[34] NYC DOHMH HIV Epidemiology and Field Services Program. *HIV Surveillance Annual Report, 2013*. York, NY. December 2014.

[35] Ibid.

[36] NYC DOHMH. (2014). *HIV/AIDS Among Transgender Persons in New York City, 2008-2012*. New York City HIV/AIDS Surveillance Slide Sets, Accessed December 2014 at: http://www.nyc.gov/html/doh/html/data/epi-surveillance.shtml

[37] Nuttbrock, L., et al. (2009). Lifetime risk Factors for HIV/STI infections among male-to-female transgender persons. *J Acquir Immune Defic Syndr*, 52(3): 417-421.

undocumented, may delay seeking HIV testing and care services due to stigma associated with HIV, isolation, cultural and language differences, and fear of exposure and potential deportation. Single, homeless adults are significantly more likely to be newly diagnosed with HIV than other New Yorkers; a 2005 report on the health of the homeless in NYC found that the rate of new HIV infections among adult NYC shelter users was 16 times the rate in the general NYC population.[38] DOHMH estimates that HIV prevalence among inmates in NYC jails is at least three to four times higher than in the general population, and that 4,500 correctional inmates diagnosed with HIV are released to the NYC area annually from city and state facilities.[39]

For many PWH in NYC, HIV infection is complicated by other chronic behavioral and health conditions. People aged 50 and older account for 49% of PWH in NYC, underscoring the importance of addressing the complex service needs of older PWH. Yet across age groups, many PWH in NYC experience multiple chronic co-morbidities. Among AC members, 47% are diagnosed with SUD and 39% with mental health issues, and other common chronic conditions include kidney disease (56% of members), hepatitis C virus (HCV) infection (40%), asthma (34%), diabetes (28%) and hypertension (28%).[40] Over 80% of PWH in the Community Health Advisory and Information Network (CHAIN) study[41] cohort report at least two other diagnosed chronic conditions and about 25% report five or more.[42] Among CHAIN participants, 51% report a need for professional mental health services, and 46% report a need for SUD treatment.[43] Based on the MOS SF-36 standardized scale, 49% of the 2010 CHAIN cohort had a low mental health score, 27% had a very low mental health score, and 14% had a dual diagnosis of low mental health and problem drug use in the past 12 months; 48% of those with low mental health scores reported no mental health services in past 6 months.[44] DOHMH estimates the prevalence of HCV/HIV co-infection in NYC at 5.6 times the rate in the general population (13,339/100,000 versus 2,370/100,000). Lifetime

[38] Kerker, B., et al. (2005). *The health of homeless adults in New York City: A report from the New York City Departments of Health and Mental Hygiene and Homeless Services.* Retrieved from: http://www.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf

[39] New York, NY Eligible Metropolitan Area HIV Emergency Relief Grant Program FY 2015 Part A Grant Application. (Unpublished data provided by DOHMH).

[40] Personal communication with Dr. Jerome Ernst, Chief Medical Officer, Amida Care.

[41] The Community Health Advisory and Information Network (CHAIN) study is an ongoing prospective study of the characteristics, health and social service needs and utilization, and wellbeing of large representative samples of PWH in NYC. Initiated in 1994, CHAIN is conducted by researchers from Mailman School of Public Health at Columbia University in collaboration with DOHMH. CHAIN information and reports are available at: http://www.nyhiv.org/data_chain.html#reports.

[42] Messeri, P. et al. (2007). *Prevalence of Chronic Diseases & Comorbid Conditions in the CHAIN Cohort of PLWHA*. CHAIN 2007-4 Report. Retrieved from: http://www.nyhiv.org/data_chain.html#reports

[43] Yomogida, M., et al. (2011). *Service Needs and Utilization New York City Round 6 Interviews: 2009-2011.* CHAIN 2011-1a Report. Retrieved from: http://www.nyhiv.org/data_chain.html#reports

[44] Aidala, A. (2011). Mental Health Needs of Persons Living with HIV/AIDS and Pathways to Mental Health Care. Presentation to the HIV Health and Human Services Planning Council of New York Integration of Care Committee, March 11, 2011. Accessed at: http://www.nyhiv.com/pdfs/committees/Mental%20Health%20Angela%20Aidala.pdf

and current smoking prevalence is also extremely high among PWH, with 52% of CHAIN respondents reporting current smoking – twice the prevalence of the general population.[45]

Medicaid Utilization

According to a Kaiser Family Foundation analysis of 2010 Medicaid Statistical Information System (MSIS) data, NYS had the highest number of Medicaid enrollees with HIV/AIDS in the U.S. (58,005) and the highest total annual Medicaid spending on enrollees with HIV/AIDS ($2.32 billion); and an average annual Medicaid payment per enrollee of $40,034 (compared to $26,067 for the U.S. overall).[46] The NYSDOH AIDS Institute (AI) estimates that there are currently an estimated 52,000 Medicaid recipients with diagnosed HIV infection living in NYC, about 30,000 of who are enrolled in Medicaid Managed Care, Approximately 16,400 PWH in HIV Special Needs Medicaid Managed Cares Plans as of December 31, 2013 (SNPs).[47]

Despite medical advances and reductions in HIV-related deaths, PWH have a high rate of hospital admissions and ED visits. In NYC during 2012, over one-third (35.44%) of Medicaid beneficiaries with HIV/AIDS had at least one ED visit and 25.12% had one or more inpatient admissions. This group averaged 2.22 inpatient admissions and 2.43 ED admissions.[48]

A 2007 review of NYS Medicaid spending found that excess costs are concentrated among PWH with high rates of co-occurring medical and behavioral health issues. In 2007, 9.4% of New York State's Medicaid recipients with HIV disease accounted for 44.9% of total HIV/AIDS-related Medicaid costs. Median annual expenditure for this group was $157,209, compared to $18,242 for the remainder of NYS Medicaid beneficiaries with HIV. Almost all (94%) high-cost Medicaid recipients had co-occurring chronic health and mental health issues, most prevalent being substance abuse (53%), mental illness (54%), hypertension (50%) and HCV (37%). The most expensive service category for the high-cost group was hospital inpatient (50.2% of total costs) followed by institutional LTC (27.6%).[49]

Lack of effective ARV therapy and sustained viral suppression increases HIV morbidity, mortality and health care costs. Research findings indicate that PWH on ARVs cost as much as $7,000 less per year than PWH not taking the drugs, due to the increased medical costs

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[45] Messeri, P. & Vardy, Y. (2012). *Tobacco use, cessation and medical provider intervention*. CHAIN 2012-9 Report. Retrieved from: http://www.nyhiv.org/data_chain.html#reports

[46] The Kaiser Family Foundation. *State Health Facts*. Data Source: FY 2010 MSIS and CMS-64 reports. Accessed December 2014 at: http://kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/?state=ny

[47] NYSDOH. *2014 Managed Care Plan Enrollment Report*. Retrieved from: https://www.health.ny.gov/health_care/managed_care/report/2014/docs/complete_plan_enrollment.pdf

[48] NYSDOH Office of Quality and Patient Safety Bureau of Health Informatics. *Medicaid Claims Data, 2012*. New York, NY. Accessed December 2014.

[49] Chesnut, T.J., et al. (2011). An Expenditure Analysis of High-Cost Medicaid Recipients with HIV Disease in New York State. *Journal of Health Care for the Poor and Underserved*, 22: 329–344.

incurred and shorter life expectancies.[50] Research shows that expenditures for non-ARV medications and hospitalization contribute significantly to increased costs for the sickest patients with HIV.[51] CHAIN findings show that self-reported inpatient days, ED visits and outpatient visits all rise with increases in the number of comorbid conditions, and the CHAIN investigators estimate that in NYC, the management of these other chronic disease conditions accounts for 35% of inpatient days and 25% of ED visits among PWH.[52]

Social Barriers to Health Improvement for the AC Target Population

Poverty and Unemployment
Rates of employment are extremely low among members of the AC DSRIP target population. In NYC, only 12% of persons served by OMH licensed mental health providers have any kind of paid employment, the lowest rate of employment for this group of any region in NYS, and compared to 14% statewide.[53] 64,000 users of OHM licensed mental health services in NYC rely on public benefits, with 68% of these persons receiving SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance) and 18% receiving public assistance.[54] A 2007 CHAIN analysis of employment among PWH in NYC showed that only 16% of CHAIN participants reported any current employment at the most recent interview (only 6% full-time), although 29% reported an interest in work; lack of educational attainment and prior work experience, coupled with impaired health were major obstacles to participants returning to paid work.[55] NYC's Human Resources Administration (HRA) HIV/AIDS Services Administration (HASA) currently provides assistance with public benefits and housing for 32,418 persons with diagnoses of AIDS or advanced HIV disease in NYC, about 28% of all diagnosed PWH, including 14,450 who receive SSI, SSDI or Veterans Disability Benefits.[56] The number of asymptomatic PWH who receive public assistance is not known.

U.S. Centers for Disease Control and Prevention (CDC) surveillance data point to poverty – not race – as the most significant factor contributing to HIV risk in low-income communities in the U.S., with other social determinants including homelessness,

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[50] Hutchinson A.B., et al. (2006). The economic burden of HIV in the United States in the era of highly active antiretroviral therapy: evidence of continuing racial and ethnic differences. *J Acquir Immune Defic Syndr*, 43(4): 451–7.
[51] Chen, R.Y., et al. (2006). Distribution of health care expenditures for HIV-infected patients. *Clin Infect Dis*, 42(7): 1003–10.
[52] Messeri ,P., et al. (2007). *Prevalence of Chronic Diseases & Comorbid Conditions in the CHAIN Cohort of PLWHA*. CHAIN 2007-4 Report. Retrieved from: http://www.nyhiv.org/data_chain.html#reports
[53] NYS OMH. Patient Characteristics Survey DataPortal, NYC Region, 2013. Accessed December 2014 at https://www.omh.ny.gov/omhweb/statistics/pcs-message.htm
[54] Ibid.
[55] Messeri, P. & Hart, B. (2007). *Employment & Economic Wellbeing*. CHAIN 2006-6 Report. Retrieved from: http://www.nyhiv.org/data_chain.html#reports
[56] NYC HRA. *HASA Facts, August 2014*. Accessed December 2014 at: http://www.nyc.gov/html/hra/downloads/pdf/facts/hasa/hasa_facts.pdf

unemployment and low education level also independently associated with HIV infection.[57]
The proportion of PWH living in poverty in NYC is unknown, but 60% of persons newly
diagnosed with HIV in 2013 lived in high or very high poverty zip codes;[58] among CHAIN
participants, 61% live below the Federal Poverty Level (FPL).[59] Data from the U.S. Medical
Monitoring Project (MMP) show that lower income itself is associated with poorer HIV
treatment adherence and higher rates of advanced HIV disease,[60] and two of NYC's highest-
prevalence boroughs rank nationally as the poorest urban county (the Bronx) and the
county with the greatest income disparity (Manhattan).[61] For example, according to
Community Health Survey data, in the Highbridge/Morrisania neighborhood of the South
Bronx (where 42% of residents live below the FPL) individuals are 4.5 times more likely
than residents of other NYC neighborhoods to be hospitalized for HIV/AIDS.[62]

Unmet Subsistence Needs
Housing and food insecurity are significant barriers to health maintenance and
management of chronic disease.

On December 10, 2013, the reported daily census for the NYC homeless shelter system was
58,945,[63] and the NYC Department of Homeless Services (DHS) estimates that an additional
3,000 persons are homeless on the streets of NYC. In addition, the NYC HRA administers
2,500 domestic violence units throughout the City. The homeless population includes single
adults and families with and without children. HASA currently provides about 5,300
permanent supportive housing units and 2,300 non-shelter emergency placements
(including 1,500 in often unsafe commercial single room occupancy hotels) for homeless or
unstably housed PWA in NYC, and administers an HIV enhanced rental assistance program
that served 26,748 households living with HIV as of August 2014.[64] Because eligibility for
HASA housing services is limited to persons with a diagnosis of AIDS or advance HIV
disease, thousands of PWH in NYC are unable to access HIV housing assistance, including
an estimated 1,000 adults with HIV infection in NYC shelters on any given night.[65]

[57] CDC. (2011). Characteristics associated with HIV infection among heterosexuals in urban areas with high
AIDS prevalence – 24 cities, United States, 2006-2007. *MMWR*, 60(31); 1045-49.
[58] NYC DOHMH HIV Epidemiology and Field Services Program. *HIV Surveillance Annual Report, 2013*. New
York, NY. December 2014.
[59] Aidala, A. & Yomogida, M. (2009). *Poverty, homelessness, incarceration in the NYC CHAIN cohort*. C.H.A.I.N
2009-5 Brief Report. Retrieved from: http://www.nyhiv.org/data_chain.html#reports
[60] Quinn, K., and Skarbinski, J. (2013). *Health Insurance Coverage and Type Predict Durable Viral Suppression
among HIV-Infected Adults Receiving Medical Care in the United States Medical Monitoring Project (MMP),*
2009. Conference on Retroviruses and Opportunistic Infections (CROI). Atlanta, GA.
[61] U.S. Census Bureau. (2012). *Poverty 2010 and 2011*. American Community Service Briefs
[62] NYC DOHMH. *NYC Community Health Survey, 2012.* New York, NY. Accessed December 2014.
[63] NYC Department of Homeless Services. *Daily Report, December 11, 2013*. Accessed December 2014 at:
http://www.nyc.gov/html/dhs/downloads/pdf/dailyreport.pdf
[64] NYC. *HRA HASA Facts, August 2014*. Accessed December 2014 at:
http://www.nyc.gov/html/hra/downloads/pdf/facts/hasa/hasa_facts.pdf
[65] Estimate based on data reported in: Kerker, B., et al. (2005). *The health of homeless adults in New York City:
A report from the New York City Departments of Health and Mental Hygiene and Homeless Services.* Retrieved
from: http://www.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf

Homelessness exacerbates health problems, complicates treatment, and disrupts the continuity of care. People experiencing homelessness deal with high rates of physical and behavioral health problems, increased mortality, and frequent hospitalizations. Homeless persons experience high rates of hospitalization and prolonged length of stay relative to housed persons.[66] Homeless persons are three to four times more likely to die prematurely than their housed counterparts.[67]

A 2005 DOHMH and DHS study of the health of NYC shelter users found that the death rate among those who used the single adult shelter system was twice as high as that of the general NYC adult population. Cancer and heart disease were the leading causes of death, but among those who used the single adult shelter system, substance use and HIV/AIDS accounted for nearly one-third of all deaths, compared with less than 5% in the NYC adult population. Homeless adults were disproportionately hospitalized, and on average stayed in the hospital longer than non-homeless adults. The prevalence of HIV/AIDS among adults who used the single adult shelter system was more than twice as high as the prevalence in the NYC adult population, and the average rates of TB and new HIV diagnoses were 11 and 16 times higher, respectively, among those who used the single adult shelter system than among the NYC adult population.[68]

A New York study aimed at establishing a methodology to identify persons at the highest risk for continued, frequent hospital admissions found that patients who were homeless or precariously housed were more than six times more likely to name the ED as their usual source of care or to say they had no usual source of care than patients who had stable housing. Patients who were homeless or unstably housed were also far more likely to have a hospital admission associated with substance use or related illness. Seventy-three percent of the patients who were homeless or precariously housed were admitted with mental health or substance use-related diagnoses, compared to only five percent of housed patients.[69]

For PWH, lack of stable housing poses a significant barrier to engagement in care and treatment success at each point in the HIV care continuum: compared to PWH in stable housing, homeless and unstably housed PWH are: more likely to delay HIV testing and entry into care following diagnosis; are more likely to experience discontinuous care – dropping in and out of care and/or changing providers often; are less likely to be receiving

[66] Levy BD & O'Connell JJ. (2004). Health care for homeless persons. *New England Journal of Medicine*, 350(23): 2329–2332.

[67] O'Connell, J.J. (2005). Premature Mortality in Homeless Populations: A Review of the Literature. *National Health Care for the Homeless Council.*

[68] Kerker, B., et al. (2005). *The health of homeless adults in New York City: A report from the New York City Departments of Health and Mental Hygiene and Homeless Services.* Retrieved from: http://www.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf

[69] Raven, M. C., et al. (2009). Medicaid Patients at High Risk for Frequent Hospital Admission: Real-Time Identification and Remediable Risks. *Journal of Urban Health,* 86(2): 230–241.

medical care that meets minimal clinical practice guidelines; are less likely to be on ARV therapy; are less likely achieve sustained viral suppression; rate their mental, physical and overall health worse; are more likely to be uninsured, use an emergency room, and be admitted to a hospital; and have significantly higher rates of all-cause mortality.[70] CHAIN data also show that food insecurity is a barrier to engagement in effective ARV therapy and is associated with missed HIV primary care appointments, ED use and detectable viral loads.[71]

Data from the CHAIN study show that over time, receipt of housing assistance exerts a stronger impact on retaining PWH in NYC in appropriate medical care than client demographics, health status, insurance coverage, co-occurring mental illness, problem drug use, or the receipt of supportive services to address co-occurring conditions.[72] Findings from the "NY/NY III" initiative show that placement in supportive housing can reduce hospital admissions, length of inpatient stays and ED use for homeless persons with chronic behavioral and medical health conditions.[73] These findings are consistent with a substantial evidence base, including seven randomized controlled trials, demonstrating that permanent supportive housing models reduce homelessness, increase housing tenure, and decrease emergency room visits and hospitalization, prompting the study's authors to recommend that policy makers consider including supportive housing as a covered medical service for individuals with mental illness and substance use disorders.[74]

Lack of Insurance
A 2013 estimate put the number of NYC residents who remain uninsured post-implementation of the Affordable Care Act at 927,000, of whom 63% are black and Hispanic and 67% are between the ages of 19 and 44.[75] A more recent estimate puts the number at approximately 450,000 persons.[76] Uninsured adults are more likely than insured adults to report being in fair or poor health, to not have a regular care provider and

[70] U.S. Department of Housing & Urban Development, Office of HIV/AIDS Housing. (2014). *The Connection Between Housing And Improved Outcomes Along The HIV Care Continuum.* Retrieved from: https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf

[71] CHAIN. *Fact Sheet: HIV/AIDS, Food and Nutrition Service Needs.* Retrieved from: http://www.nyhiv.org/pdfs/chain/CHAIN%202011-5%20Brief%20Report_HIVAIDS,%20Food%20&%20Nutrition%20Service%20Needs%20Factsheet.pdf

[72] Aidala, et al. (2007). Housing need, housing assistance, and connection to medical care. *AIDS & Behavior*, 11(6)/Supp 2: S101-S115.

[73] Levanon-Seligson A, et al. (2014). *New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis.* A report from the NYC DOHMH in collaboration with the NYC HRA and the NYS OMH. Retrieved from: http://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf

[74] Rog, D. J., et al. (2014). Permanent Supportive Housing: Assessing the Evidence. *Psychiatric Services*, 65(3): 287-294.

[75] Urban Institute. (2013). *Uninsured New Yorkers After Full Implementation of the ACA: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area.* Retrieved from: http://info.nystateofhealth.ny.gov/sites/default/files/Uninsured%20New%20Yorkers%20Substate%20Regions%20Report%2C%20May%202013_1.pdf

[76] Goldberg, D. (2014). *Mapping Obamacare by New York City ZIP code.* Capital New York, October 20, 2014.

to have foregone needed medical care at some point in the past year.[77] An estimated 18% of PWH in NYC remain uninsured in 2014.[78] Many uninsured PWH have access to HIV medications through the AIDS Drug Assistance Program (ADAP) and to ambulatory care through the ADAP Plus program,[79] however these programs do not cover inpatient care. [80]

The 2012 NYC Community Health Survey indicates that 28.1% of foreign-born New Yorkers are uninsured compared to 10.9% of New Yorkers born in the U.S.[81] NYS offers public insurance to individuals with a broad range of immigration statuses, but eligible immigrants are often deterred from enrolling themselves and their children in affordable insurance due to lack of awareness of eligibility, the complexity of the enrollment process, and perceptions about immigrant specific consequences of using public insurance. Recommendations include proactively addressing immigrants' concerns, offering linguistically and culturally appropriate information and assistance, and increasing resources for community-based health advocates who help immigrants navigate the health insurance and health care system.[82]

Evaluation of Community Assets and Resources

NYC's health and human services infrastructure provides a solid base for launching collaborative programs to reduce the over utilization of acute care services and support public health interventions. The City has an extensive array of public and private hospitals, hospital outpatient extension clinics, Federally Qualified Health Centers (FQHCs), community health centers, independent community based primary care providers, and community-based organizations that are coming together to establish targeted care coordination, health prevention, and disease management strategies through initiatives such as DSRIP, Regional Health Information Exchange Organizations (RHIOS), SNPs, Medicaid Health Homes, Health and Recovery Plans (HARPs), and other initiatives.[83]

NYC has in place numerous programs and offices to assist its citizens in obtaining essential services. For example, NYC has a website, *Access NYC,* which assists users in completing screening questionnaires for over 30 support programs.[84] The NYC HRA has a number of

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[77] NYC DOHMH. Uninsured Adults in New York City. *Epi Data Brief 43, March 2014.* Retrieved from: http://www.nyc.gov/html/doh/downloads/pdf/epi/databrief43.pdf

[78] NYSDOH. *Salient Data, 2014.* New York, NY.

[79] For example, 98% of PWH in the CHAIN study cohort report have access to ARV medications through some form of coverage including ADAP. Messeri P & Sorgi A. (2011). *CHAIN 2011-4 Brief Report: Determinants of HAART Use and Adherence*

[80] NYSDOH. *HIV Uninsured Care Programs – Summary.* Retrieved from https://www.health.ny.gov/diseases/aids/general/resources/adap/

[81] NYC DOHMH. NYC Community Health Survey, 2012. New York, NY. Accessed December 2014.

[82] Freij, M., et al. (2010). *"Mutual Responsibility": A Study of Uninsured Immigrants' Perspectives on Health Insurance in New York City.* New York Immigration Council, February 2010. Retrieved from http://www.nclej.org/documents/uninsuredimmigrantshealthinsurance.pdf

[83] Detailed, by borough, descriptions of health care and community resources are included in New York City Health Provider Partnership Community Needs Assessments for Brooklyn, the Bronx, Manhattan and Queens.

[84] Access NYC. *Programs.* Accessed at https://a858-ihss.nyc.gov/ihss1/en_US/IHSS_S054_programsPagePage.do?sequenceNumber=4&

satellite offices throughout the City to meet the needs of local residents, including specific services targeted to PWH.[85] The HHC makes health care services affordable for all New Yorkers through a financial screening system called *HHC Options*.[86] And there are other programs and care available to uninsured New Yorkers.[87]

There are numerous HIV/AIDS related services located in NYC. Non-profit community-based organizations provide housing support, substance abuse and mental health counseling, legal assistance, health education, benefits assistance and case management services. Many of the organizations focus on specific populations based on racial or ethnic identity or sexual orientation. Large-scale Ryan White and CDC Prevention-funded HIV programs in the City include HIV prevention and outreach efforts such as sexual and behavioral health for HIV prevention, condom distribution, harm reduction, testing and linkage to care, and syringe exchange. Additionally there are programs to support HIV positive patients such as supportive counseling, home care, housing services, food and nutrition support, and care coordination.

On June 29, 2014, Governor Cuomo announced a three-point "Bending the Curve" plan to end AIDS as an epidemic in New York State. The goal of the initiative is to decrease new HIV infections to the point where, by 2020, the number of persons living with HIV in New York State will be reduced for the first time. The NYSDOH AI is leading the work of the Ending the Epidemic Task Force established in support of the Governor's plan, made up of key stakeholders representing public and private industry, and community leaders who are expert in the field of HIV/AIDS. The Task Force is responsible for developing and issuing an executive blueprint for NYS to achieve the stated goals of: identifying persons with HIV who remain undiagnosed and linking them to health care; linking and retaining persons diagnosed with HIV to health care and getting them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission; and facilitating access to ARV chemoprophylaxis (Pre Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (PEP) for high-risk persons to keep them HIV negative.[88]

AC believes that the success of all of these programs and efforts for its target population of Medicaid beneficiaries with complex chronic conditions will require the continued viability and engagement of NYC's rich network of community-based providers, and that one measure of PPS performance should be how well the system works to preserve existing critical community-based services.

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[85] NYC HRA. *HIV/AIDS Service Administration*. Accessed at
http://www.nyc.gov/html/hra/html/services/hasa.shtml
[86] HHC. *HHC Options*. Accessed at http://www.nyc.gov/html/hhc/html/patients/ForPatients-Paying-Options.shtml
[87] NYC DOHMH. NYC Insurance Link. Accessed at
http://www.nyc.gov/html/hia/html/healthcare_resources_uninsured/free_low_cost.shtml
[88] NYSDOH. Ending the Epidemic Task Force. Accessed at
https://www.health.ny.gov/diseases/aids/ending_the_epidemic/index.htm

People living with chronic conditions need more than medical treatment from their health care providers – they need support in mastering and sustaining the complex self-care behaviors that are necessary to enable them to live as healthy as possible. For example, CHAIN study results show that the best outcomes for PWH with mental health needs result from receipt of professional mental health treatment followed by ongoing supportive services such as counseling or peer group participation.[89] Studies show that without sustained support, many adults will not succeed in managing their conditions well, leading to worse health outcomes, including expensive hospitalizations and avoidable complications.[90]

For example, NYC providers identify three types of key barriers to HIV testing and linkage to care: (1) health care system factors (e.g., long wait for provider appointments; requirement of a positive confirmatory test before scheduling an appointment; system navigation; disrespect to patients); (2) social factors (e.g., stigma related to HIV, behavioral health issues, sexual orientation, immigrant status and other factors); and (3) characteristics of risk populations (e.g., mental illness, homelessness, substance use, immigrant status and primary language other than English). The most commonly suggested solution was system navigation provided by peers whose life experience helps overcome patient reluctance to enter care. The authors also noted the importance of community-based providers that offer innovative approaches not found in hospitals and community health centers.[91]

New York's Health Home experience has demonstrated that effective outreach to high-need, high-cost Medicaid beneficiaries must also be strongly rooted in the community. Outreach staff should be intimately familiar with the community's cultures, needs, geography, and resources. This has led many Health Homes to hire community health workers and peers who currently live, or have lived, within communities targeted for outreach. These non-professional staff members are able to connect with eligible members based on shared experiences and mutual understanding.[92]

Cultural and linguistic competence is increasingly important to efforts to reform health care delivery in NYS. According to the 2010 Census, about 18% of the NYS population is Hispanic/Latino, 16% African American, 7% Asian American, and 11% other or two or more races; these groups together comprise 52% of the State's population, and the foreign-

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[89] Abramson D, et al. (2000). *Comorbid Conditions: Intersecting Needs among the CHAIN Cohort.* CHAIN Update Report #24.

[90] DiMatteo, M.R., et al. (2002). Patient adherence and medical treatment outcomes: a meta-analysis. *Med Care*, 40:794-811.

[91] Bauman, L.J., et al. (2013). Barriers and facilitators of linkage to HIV primary care in New York City. *J Acquir Immune Defic Syndr*, 64(1): S20–S26.

[92] Hamblin, A. et al. (2014). Outreach to High-Need, High-Cost Individuals: Best Practices for New York Health Homes. Prepared for the NYS Health Foundation.

born population grew from 16% in 1990 to 22% in 2010.[93] Linguistic and cultural complexity can be a particular challenge to effective health care delivery in NYC, where approximately 48.7% of the population reports speaking a language other than English at home.[94]

Small behavioral health, substance use and primary care organizations serving Medicaid and uninsured consumers with SMI, SUD and physical health services/primary care, housing providers, and other CBOs that target key sub-populations with linguistically and culturally appropriate services are essential community-based assets that are crucial to building the capacity of effective NYS DSRIP PPSs. Many of these smaller, not-for-profit, organizations will require additional support to become effective participants in fully integrated delivery systems. These organizations often face two significant challenges: a lack of experience integrating services and a struggle for financial stability. At the same time, these organizations currently serve the health care needs of some of the most frequent and costliest users of service and they add essential capacity to the Medicaid "safety net," often due to their innovative models of care, patient populations served, as well as their linguistic and cultural competence.

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[93] NYS OMH Bureau of Cultural Competence (2012). *Ensuring Cultural Competency in New York State Health Care Reform.* Retrieved from: https://www.omh.ny.gov/omhweb/cultural_competence/resources.html
[94] U.S. Census Bureau. *State and County QuickFacts, 2013 Estimate.*

IV. Project Recommendations

Following are detailed descriptions of five project recommendations with supporting justification of need, evidence base and cost savings analysis. The recommendations focus on ensuring access to a more proactive, integrated system of care that addresses the multi-faceted health and social service needs of people living with chronic illnesses, many of whom face significant health disparities, stigma, housing instability and food insecurity:

1. Peer Health Navigation
2. Viral Load Suppression
3. Crisis Bed Diversion
4. Hospital Step-Down
5. Integrated Care Learning Collaboratives

1. Peer Health Navigation Services

PPSs can implement an education, certification/credentialing and employment program for peers to provide health navigation services. Peer health navigators will draw on their lived experiences with HIV, serious mental illness (SMI) and substance use disorder (SUD), working as part of a care team, to support early access to and retention in health and behavioral health care. This recommendation surpasses the traditional boundaries of peer-based programs, as the end goal is to create uniform pathway for individuals to utilize their lived experience and enter the workforce as full-time employees. While traditional peer-based programs employ peer workers as stipend support staff, peer health navigators will receive a living wage and benefits and be integral member of the care coordination team. The project will decrease avoidable hospitalizations and the use of inappropriate detox and rehabilitation services by improving access to community-based health services.

> *Supports the following DSRIP Projects:*
> *2.c.i Development of community-based health navigation services;*
> *2.d.i (Project 11) Implementation of Patient Activation Activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community-based care; and,*
> *4.c.ii Increase early access to, and retention in, HIV care.*

Justification of Need

Currently, the New York State Office of Mental Health (OMH) and the Office of Alcohol & Substance Abuse Services (OASAS) have training and certification mechanisms for peers to work in OMH and OASAS facilities. OASAS outpatient clinic treatment programs are able to bill Medicaid for these services but the payment is deemed to be too low to support implementation of a program that can support living wages for peers. Medicaid Health and Recovery Plans' (HARPs) Home and Community Based Services will reimburse for peer services at a level that is anticipated to support a living wage. However, these services will be limited to individuals with behavioral health conditions. For those individuals whose

primary diagnosis is not related to behavioral health, there are limited resources (grants or general operating funding) to support peer health navigation services.

According to data from the Health Home Program, there is a large population that could be served by the project. There are 976,356 individuals in the State with complex medical conditions utilizing Medicaid services at an average cost $2,338 per person per month (PMPM). Of these, 168,000 are living with HIV/AIDS, 408,529 have mental health and/or substance use disorders and 306,087 have two or more chronic conditions. Further, only 12.5% of persons receiving public mental health services in New York City (NYC) have any type of paid employment, indicating a need to provide opportunities for individuals to engage in meaningful employment.

Project Description

Uniform Training and Certification/Credentialing Program: To be eligible to become peer health navigators, participants must be 18 years or older and publicly self identify as a person with direct personal experience overcoming the challenges resulting from a diagnosis of HIV, SMI and/or SUD. All peers will receive skills training focused on strengthening clients' connection to care, overcoming barriers to accessing care and advocating on behalf of clients. The PPSs may elect to offer training in languages other than English to meet the needs of their client population. The NYSDOH AI, OASAS and OMH will be consulted in the design of the training in order to ensure that the proposed peer health navigation services can become eligible for Medicaid reimbursement. The project will draw on the OMH Academy of Peer Service, the OASAS Recovery Coach Program and peer training programs developed by community-based organizations. The education and training component is expected to last approximately 10-12 weeks and will utilize a diverse curriculum that may include:

- World of Work Skills: An introductory course that prepares applicants to successfully complete the education component. Topics will include class prep, taking notes, daily living skills, resume writing and interview skills, managing expectations and interacting with classmates and colleagues. (This course will be completed prior to start of the training curriculum, and will support the training, internship, and employment components.)
- History and Introduction to Peer Services: Participants learn about the history of peers helping peers and what it means to be part of the peer workforce in the healthcare system.
- Crisis Management: Participants learn the role of peers in dealing with patient crisis, with a focus on positive and negative coping strategies.
- Motivational Interviewing: Participants learn the theory and techniques of Motivational Interviewing (MI) and increase their understanding of how MI techniques can be applied to management of chronic conditions.
- Essential Communication Skills: Participants learn engagement and communication strategies including active listening, and personalized and reflective responding.
- Trauma-Informed Peer Support: Participants identify ways to counter the impact of secondary trauma on people in recovery. The course will explore examples of traumatic

events peers may encounter and how they should respond.

- Overview of Harm Reduction: Participants learn the basic principles of harm reduction and examples of how to incorporate harm reduction into their work supporting clients. Participants will analyze harm reduction examples and learn to use these techniques with clients who exhibit risky behaviors impacting their treatment plan or recovery.
- Stigma, Self-Disclosure and Self Care: Participants learn how stigma and self-disclosure impacts their relationship with clients, colleagues and supervisors. Since peers will be called upon to be open about their experiences, this course will help them navigate the process of self-disclosure. They will also learn techniques to stay healthy while working and how to seek help if needed.
- Patient Rights and Confidentiality: Participants learn about state and federal laws protecting patient privacy and information. Participants will analyze likely scenarios to learn how to properly work with patients and handle their information. Specific training will be provided about HIPAA, 4CFR Part 2, and the State's HIV Privacy Laws.
- Cultural Competency: Participants learn techniques to provide culturally relevant assistance to clients based on likely scenarios they will encounter in various healthcare environments.
- Overview of Medical, Mental Illnesses and Substance Use: Since participants may work in diverse healthcare settings and with co-morbid clients, participants learn basic understanding of common medical, mental illnesses and substance use disorders.

This list is not meant to be exhaustive, but meant to show some of the core training components for all peer health navigators. Specific topics, in addition to the core topics, and particularly related to specific peer services or job functions, can be included by the PPS.

Internship & Full-time Employment: Upon completing the training and passing an exam, peers will be placed in a paid internship at a hospital, clinic, Health Home or other community-based setting within the PPS provider network to gain real life job experience. Once the education and internship components are completed, peers will become credentialed/certified and placed in a part-time or full-time position within the PPS provider network. Salaries of peers will initially be paid by the PPS (through implementation grants) but will become a billable service paid by Medicaid. PPSs may submit regulatory waivers as needed, to ensure the continuation of the peer health navigators' benefits when employed. Potential services provided by peers may include:

- Conducting outreach at "hot spot" areas, which may include emergency departments, health centers or community locations such as food pantries, soup kitchens, social welfare offices, etc.
- Assisting clients in connecting with a care team and assisting them to navigate various health care environments, ensuring that patients understand their treatment options and assisting with a "warm handoff" to providers.
- Providing health education or coaching focused on assisting clients to sustain healthy behavior, improving their health and well-being, staying connected to their care team, and accomplishing their health care and recovery goals.
- Supporting clients to overcome treatment obstacles and empowering clients to take

charge of their health.
- Re-engaging clients who have fallen out care and acting as a bridge between the client and their care team.

This list of peer health navigation services can be tailored or expanded by the PPS to fit the needs of its partners and patient populations. Peer health navigation services may be short-term or sustained, long-term engagement with clients over the course of months to provide broad-based support. The inherent strength of this recommendation is its flexibility that allows PPSs to tailor the education and training curriculum, peer responsibilities and work placement locations to meet the needs of their patient populations.

Technical Assistance for Providers: Providers will receive resources, funding and comprehensive training to integrate peer health navigators into their organizations. The training component will utilize a team approach that collectively trains the management and administrative team supervising the peer health navigation workforce. Topics include boundaries, mutual expectations, and peers' proper roles and responsibilities within the organizations. Once peer health navigators have started working within the PPS network, continued training for both the peer health navigation workforce and the supervising staff will be offered throughout the integration process.

Comprehensive Support for Peers: Beyond the education and internship period, peers will continue to receive skills development assistance, including employment coaching, peer support groups, and other mechanisms to support peers.

General Implementation Framework
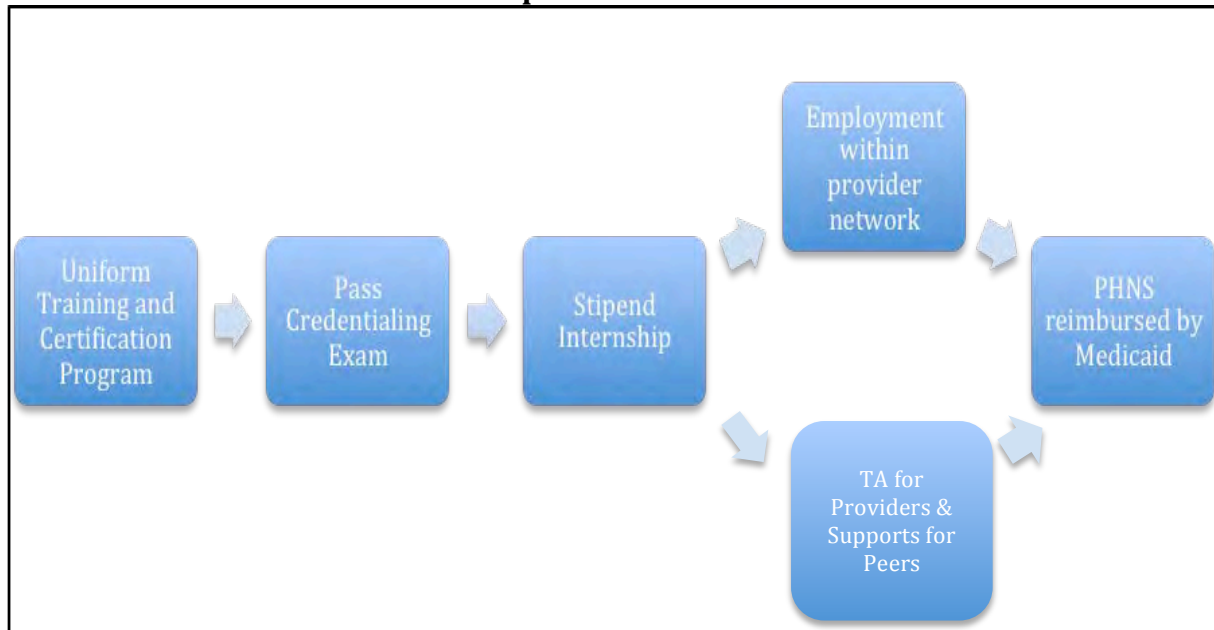
Evidence Base/Meaningful Impact

In 2007, Medicaid deemed peer support services an evidence-based model of care for SMI and SUD, reimbursable in states that choose to build these services into their state plans.[95] There is a strong evidence base for peer services in the context of SMI. A systematic review of the literature concluded that evidence for the effectiveness of peers added to traditional services for persons with SMI showed improvements that include: reduced inpatient service use; improved relationship with providers; better engagement with care; higher levels of patient activation; and higher levels of hopefulness for recovery.[96]

Many studies have identified health care cost-savings associated with community health workers (CWH), including peers, who contribute to overall health system savings through their impact on (1) improved prevention and chronic disease management, which reduces costly inpatient and urgent care costs; (2) cost-shifting, with increased utilization of lower cost health services; and (3) indirect savings associated with reallocation of expenditures within the health care system.[97] Increasing attention is directed to peer support models as especially promising for safety-net providers and for public health systems facing severe resource constraints in the face of great needs among patients living with chronic conditions.[98]

Examination of 6-month pre- and post-outcomes showed that New York City patients with SMI who enrolled in a peer-based program experienced: a 47.9% decrease in use of inpatient services (92.6% to 48.2%); a 62.5% decrease in number of inpatient days (11.2 days to 4.2); a 28% increase in outpatient visits (8.5 visits to 11.8); and a 47.1% decrease in behavioral health costs (from $9,998.69 to $5,291.59).[99]

A recent evaluation of a peer mentor program for patients with a history of multiple inpatient psychiatric hospitalization found that a group of patients who received peer mentor services upon discharge from an inpatient stay had statistically significant fewer

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[95] Baltimore Centers for Medicare and Medicaid Services. (August 2007). *State Medicaid Director Letter on Peer Support Services*. SMDL 07-011. Retrieved from: www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf

[96] Chinman, M., et al. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, 65(4): 429 – 441. See also, Pfeiffer, P.N., et al. (2011). Efficacy of peer support interventions for depression: a meta-analysis, *General Hospital Psychiatry,* 33: 29–36.

[97] Viswanathan, M., et al. (2009). Outcomes and costs of community health worker interventions: a systematic review. *Med Care*, 48(9): 792-808; Rosenthal, E.L., et al. (2010). Community health workers: Part of the solution. *Health Affairs*, 29(7): 1338-1342.

[98] Heisler, M. (2006). *Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success.* Prepared for the California HealthCare Foundation. Retrieved from: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingPeerSupportPrograms.pdf

[99] Results reported by Dr. Rebecca Cate, Research Scientist, Behavioral Health Sciences Department, Optum Health. Presentation available upon request from Optum Health, https://www.optum.com. See also, Bergeson, S. (2012). *Cost effectiveness of using peers as providers*. Available on the New York Association of Psychiatric Rehabilitation Services website: http://www.nyaprs.org/e-news-bulletins/2011/2011-02-02-Bergeson-Cost-Effectiveness-of-Using-Peers-as-Providers.cfm

admissions (42%) than a control group over a 9-month follow up period and significantly fewer total hospital days of service (48%).[100]

There is mounting evidence that peer services can also be highly effective in promoting engagement, retention, and care coordination as part of physical health services. Over a 12-month period of care coordination, a CHW program in NYC reduced asthma-related ER visits and hospitalization rates by more than 50% and shortened hospital lengths of stay.[101] Peer services have also been found to improve adherence to HIV medical care and therapies.[102]

Peer positions also provide meaningful work that enables transition back into the workforce. Nationally, only 2.1% of people served by state mental health authorities receive supported employment services (79% are unemployed), despite evidence that supported employment programs for persons with SMI place more than 50 percent of their clients into paid employment and that participation can reduce health costs for high users of mental health services.[103] Over the past 20 years, the Community Access Howie the Harp Advocacy Center (HTH), a peer-run program that provides employment resources to people with mental health conditions, has helped over 1,000 graduates gain the skills and knowledge they need to find meaningful employment at over 400 agencies, including many who pursue higher education opportunities.[104] The Housing Works Second Life job training program for formerly homeless PWH has trained and employed over 300 graduates in the past 23 years, moving them from public assistance into the economic mainstream at jobs that pay a living wage and include health insurance and other employment benefits.[105] Research findings show that employment is strongly related to better physical and mental health quality of life for PWH after controlling for factors.[106]

NYS has a rich history of grant-funded peer services. AC's *Retention in Care Unit* utilizes peers to reach its most complex clients and re-connect them with their health care providers. In 2014, Community Health Outreach Workers (CHOWs), AC members working

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[100] Sledge, et al (2011) Effectiveness of Peer Support in Reducing Readmissions of Persons With Multiple Psychiatric Hospitalizations. *Psychiatric Services,* 62(5): 541–544. Retrieved from: http://ps.psychiatryonline.org/doi/abs/10.1176/ps.62.5.pss6205_0541

[101] Peretz, P., et al. (2012). Community health workers as drivers of a successful community-based disease management initiative. *Am J Pub Health*, 102(8): 1443-1446.

[102] Broadhead, et al. (2002). Increasing drug users' adherence to HIV treatment: results of a peer-driven intervention feasibility study. *Social Sciences & Medicine*, 55(2): 235-246).

[103] SAMSHA, 2011, citing Cook, J. A., et al. (2005). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. *Archives of General Psychiatry*, 62: 505–512.

[104] Community Access. *What We Do*. Accessed at http://www.communityaccess.org/what-we-do/hth-peer-advocacy-ctr

[105] Personal communication with Linney Smith, Senior Vice President for Prevention & Services, Housing Works.

[106] Rueda, S., et al. (2011). Employment status is associated with both physical and mental health quality of life in people living with HIV. *AIDS Care*, 23(4): 435-443.

as peers, completed 158 new member orientations, 138 case management reassessments and 370 Social Innovation Fund (SIF) surveys, all of which serve as tools to assist AC in determining short and long-term needs of members and potential barriers to medical and behavioral health care. This vital peer work allows the AC Integrated Care Teams to develop care plans to help link members to and stay retained in care. In addition, AC CHOWS also provide support by escorting members to primary care and social service appointments. In 2014, 284 members worked closely with AC peer staff to assist with reengagement in care. AC recently piloted the Peer Training Institute (PTI) in partnership with Housing Works, a 6-week job training program. To date, 2 classes of AC members have graduated and been placed in part-time peer positions. The PTI is designed to afford clients an opportunity to develop marketable vocational and soft skills in preparation for re-entering the workforce.[107]

In addition to the activities outlined above, community-based Health Home and AIDS Adult Day Health Care (ADHC) providers such as Housing Works, Harlem United, VIP Community Services and AIDS Service Center also train and integrate peers into their outreach and treatment programs. However, resources (grant or general operating funding) to support peer health navigation services are extremely limited and insufficient to provide a living wage.

OMH and OASAS are currently implementing training and certification mechanisms to enable peers to provide Medicaid-reimbursable services in OMH and OASAS facilities, and once implemented, Medicaid HARP's Home and Community Based Services will reimburse for these peer services at a level that is anticipated to support a living wage. However, these services will be limited to individuals with behavioral health conditions.

The NYSDOH Medicaid Redesign Team (MRT) Social Determinants of Health Work Group recently recommended steps to establish a similar program of Medicaid-reimbursable peer specialist certification and to promote creation of peer positions for management of other chronic conditions (in addition to SMI and SUD) as part of its recent recommendations for employment-related strategies to decrease disparities in health access, utilization, and outcomes.[108] Medicaid reimbursable peer specialist services would establish a funding mechanism to support opportunity for full-time, sustainable employment as peer health workers. Facilitating the training and credentialing of health care consumers as peer specialists addresses multiple social determinants of health (including homelessness, poverty, unemployment and inadequate social supports) to reduce health disparities both for peer workers and the persons they serve. Such programs have the potential to enhance quality of life and independence for consumers while promoting innovative peer-provided services that have been demonstrated to support retention in care and improved health outcomes.

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[107] Personal communication with Wendy L. Carlson, Supervisor of Retention in Care Unit, Amida Care.
[108] NYSDOH MRT Social Determinants of Health Work Group. (October 2014). *Final Recommendations.*

Resource Availability

PPSs can draw upon diverse organizations and rich resources to design and implement its peer health navigator program. Community-based Health Home and ADHC providers like Housing Works, Harlem United, VIP Community Services and AIDS Service Center already train and integrate peers into their outreach and treatment programs. Their expertise can be used to design the peer health navigator curriculum, provide technical assistance at the management and organization level, and provide behavioral, job placement and skills development assistance directly to peers who are working part- or full-time. Further, OMH and OASAS curricula and grantees' experience can be drawn upon to inform program development. Other peer training programs such as HTH have over 20 years of experience training and placing peers in health service positions.

AC, a Medicaid Managed Care Organization, can also provide expertise and technical assistance to PPSs based on its Retention to Care and Peer Training Institute. Through these provider network-wide programs, AC coordinates peer-based training programs for its clients. Its Retention to Care Unit utilizes peers to reach its most complex clients and re-connect the clients to their providers. Both these programs provide AC with the technical expertise of coordinating peer health navigation workforce programs among a network of providers similar to a PPS.

Both OMH and OASAS's peer credentialing systems can act as models for peer health navigator in NYSDOH-certified health facilities. The PPS can also integrate lessons and training modules from the state agencies' peer programs to ensure that the peer health navigators can work with co-morbid SMI or SUD clients in NYSDOH facilities.

The NYSDOH AIDS Institute (AI) can be a critical partner in developing peer health navigation services to support people with HIV.

Cost/Benefit Analysis

Estimates suggest that this initiative will yield a net annual operational savings of approximately $300 per person, comparing the costs of the outreach program with the midpoint of the expected range of inpatient cost savings that will occur due to improved health status.

Development Costs: All cost components identified below are presumed to be one-time investments that will be made using DSRIP funds to support the implementation of this initiative. We estimate these up-front fixed costs to be approximately $330,000.

One key development task involves creating the program structure and related materials for credentialing and training the peer health navigators. The staffing costs estimate three months of initial "onboarding" for the navigators, their supervisor, and their service coordinators. These costs also project six months of salary and benefits for the credentialer to help put the program in place and conduct the training of the peer health navigators.

Fixed Cost Estimates

Costs of Developing the Program	One-Time Cost
Create materials and processes for identification/recruitment of navigator candidates	$25,000
Create credentialing program for peer health navigators – application materials, candidate evaluation/verification process, training and testing materials, training process, field work requirement prior to "licensure," etc.	$75,000
Initial salary/benefits for new staff (6 months for trainer/credentialer; 3 months for others)	$229,433
Total Development Cost	**$329,433**

Cost and Savings per Person: The ongoing operational impacts of the program will include a combination of medical and non-medical components. These items and their projected costs are listed below.

The estimated program scale is that it will operate at caseload ratio of 25 patients per peer health navigator. For an "average" PPS it is estimated that there will be 600 patient participants and thus 24 FTE peer health navigator staff. To preserve the peer health navigators' eligibility for public income support and health coverage programs, it is envisioned that the peer health navigators will work only half time, thus, 48 individuals will be employed to yield a labor effort of 24 FTEs. (The end goal is that peer health navigators will eventually transition to full-time employment as they build their skills and/or changes in regulations allow them to work full-time and maintain benefits.) The average caseload per part-time navigator will therefore be approximately 12.5 per week. Peer navigators' projected pay is the "minimum living wage" which has been estimated to be $12.75 per hour.

One-half (.5) FTE is budgeted for training and credentialing of peer navigators, one (1) FTE is budgeted for ongoing management of a PPS's peer health navigator team, and an additional (1) FTE is budgeted for a person to coordinate the efforts/activities of the peer health navigators within the PPS. It is assumed that these individuals will receive benefits and a full salary. By dividing the overall shown cost by 1.25, the assumed salary levels shown below can be derived. Minor costs are projected for MetroCards for the peer health navigators to meet with beneficiaries. This is envisioned to be a "high-touch" model, as suggested by the average caseload of only 25 patients.

Collectively, the operational costs for the program, at a scale of 600 patient participants, are estimated to be approximately $890,000.

Annual Operating Costs

Costs	Cost Per Person	Annual Cost
Trainer/Credentialer for Peer Health Navigators	$62,500	$31,250

Costs	Cost Per Person	Annual Cost
Peer Health Navigator	$26,520	$636,480
Program Manager/Supervisor	$62,500	$62,500
Program Coordinator	$46,875	$93,750
Outreach Costs (local transportation, etc.)		$64,512
Total Annual Operating Costs		**$888,492**

The projected impacts on medical costs for the involved beneficiaries are presented below. The initiative's savings component is the inpatient cost reductions spurred by health status improvements attributable to the peer health navigator team's efforts.

While this is an extremely challenging estimate to make in advance, the program's impacts can be quantified retrospectively via a thorough and objective evaluation effort once it is operational. The projections for inpatient cost impact are driven by an assumption that the peer health navigator outreach program can only be beneficial to the targeted beneficiaries' health status and thus only have a favorable (lowering) impact on medical costs. The overall average baseline inpatient cost is projected to $6,000 per beneficiary, which approximately represents one hospitalization every two years. This is below the inpatient usage occurring for PWH in New York, as the target population also includes persons with SMI and SUDs.

Medical cost reductions of 25%, 30%, and 35% are shown. These inpatient cost reduction percentages are higher than the range projected for the viral load incentive program, as this initiative entails a more intensive community-based outreach model, with substantial face-to-face interactions envisioned between the peer health navigators and the targeted patients.

Projected Per Person Medical Cost Impact

Inpatient Cost Impacts	Number of Persons	Inpatient Cost Per Person Per Year	Total Dollar Cost (Savings)
Baseline Annual Cost	600	$6,000	
at 25% Reduction	600	$1,200	-$720,000
at 30% Reduction	600	$1,800	-$1,080,000
at 35% Reduction	600	$2,100	-$1,260,000

Overall Projected Impacts: The overall program impacts are summarized below at different levels of PMPM inpatient cost reduction across the participating beneficiaries. Impacts are shown on a per-participant basis and across the projected scale of 600 participants per PPS.

The program is projected to achieve a net operational savings throughout the range of financial outcomes we believe are most likely to occur. A net cost of approximately $300 per participant is projected at the lower end of the range (where a 25% inpatient cost

reduction is projected). At the high end of the range (35% inpatient case reduction), annual net savings of approximately $600 per participant are projected to occur.

Net Savings Projections

Projected Annual Operational Cost (Savings)	Net Cost (Savings) Per Person	Total Dollar Cost (Savings)
At 25% PMPM Inpatient Reduction	-$281	-$168,492
At 30% PMPM Inpatient Reduction	-$319	-$191,508
At 35% PMPM Inpatient Reduction	-$619	-$371,508

While the range of estimates above demonstrates our concern that medical cost impacts are elusive to project in advance, the range used also indicates our expectation that this initiative will likely yield a net savings. Our mid-point estimate is that an annual savings of approximately $190,000 would occur at a participant scale of 600 beneficiaries. This would result in the initiative recouping its one-time investment costs in less than two years.

Potential Distorting Factors: Given the innovative nature of this project, experience data does not exist. We have identified the assumptions made, and it is a straightforward exercise to adjust any assumptions in order to better understand the sensitivity of the estimates to these assumptions.

We encourage that as part of program implementation, data be continually collected to support an objective and thorough program evaluation effort. Notwithstanding these limitations, we believe the cost-benefit framework we have developed in this analysis provides an important starting point for discussions and evaluations of the potential impact of this important project.

We also want to emphasize that this innovation has benefits external to the target patient population. For the peer health navigators, this initiative creates the option for full-time employment, which can have significant positive ramifications for their own health and quality of life. For the State, the employment likely moves peer health navigators from Medicaid to private insurance (initially or over time as they move into full-time employment with benefits), and the peer health navigator salaries also create a positive contribution to the tax base.

A further element of conservatism with regard to the cost savings estimates for this initiative is that per person costs for deploying peer navigators are well below the costs of utilizing clinically licensed personnel (e.g., RN case managers, CSWs, etc.). Our projections assume that the navigator costs will be additive when in many instances they may turn out to be a substitution for costlier care management time. To the extent that the model proves as effective as envisioned, peer navigators may be hired, trained and credentialed to provide support to high-need persons that would reduce the amount of time clinically licensed staff are used/needed.

It is quite possible that these dynamics will lead to greater overall governmental financial gains – both through increased tax revenues and decreased reliance on Medicaid – than the program participant savings estimates projected herein.

2. Viral Load Suppression Initiative

PPSs can implement a viral load suppression initiative that employs a tiered set of evidence-based HIV treatment adherence supports including financial incentives, integrated case conferencing and linkage to wrap-around behavioral and social supports as needed to achieve and sustain suppression of HIV viral load to an undetectable level.

Supports the following DSRIP Project:
Project 4.c.ii. Increase early access to, and retention in, HIV care

Justification of Need
New Yorkers living with HIV face a number of demonstrated barriers to antiretroviral (ARV) adherence, including high rates of co-occurring behavioral health issues and socioeconomic factors such as housing instability and food insecurity. The HIV epidemic in New York disproportionately impacts the poorest and most vulnerable communities, particularly racial and ethnic minorities (including women and young men who have sex with men (MSM) of color). Other heavily impacted populations are MSM and transgender people of all ages, immigrants or foreign-born people, and people aged 50 and over. Lower income itself is associated with poorer HIV treatment adherence and higher rates of advanced HIV disease; and two of New York City's (NYC) highest-prevalence boroughs rank nationally as the poorest urban county (the Bronx) and the county with the greatest income disparity (Manhattan). For example, according to Community Health Survey data, in the Highbridge/Morrisania neighborhood of the South Bronx (where 42% of residents live below the federal poverty line) individuals are 4.5 times more likely than residents of other NYC neighborhoods to be hospitalized for HIV/AIDS.

NYC surveillance data indicate that only 41% of all persons infected with HIV and 62% of those diagnosed with HIV are receiving effective ARV therapy that suppresses viral load to an undetectable level. Persons with HIV (PWH) who do not receive effective ARV therapy drive increased Medicaid expenditures and hospitalization rates due to advanced HIV disease and related behavioral health issues. In 2007, 9.4% of New York State's Medicaid recipients with HIV disease accounted for 44.9% of total HIV/AIDS-related Medicaid costs. Almost all (94%) high-cost Medicaid recipients (median annual expenditure = $157,209) had co-occurring health and mental health issues, and the most expensive service category for the high-cost group was hospital inpatient stays (50.2% of total costs) followed by institutional long-term care (27.6%).[109]

Project Description
The proposed Viral Load Suppression Initiative (VLS) is based on *The Undetectables* program at Housing Works – an individualized, stepped approach to ARV adherence support that moves from the least intensive tools (adherence planning, case management

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[109] Chesnut, T.J., et al. (2011). An Expenditure Analysis of High-Cost Medicaid Recipients with HIV Disease in New York State. *Journal of Health Care for the Poor and Underserved*, 22: 329–344.

support, harm reduction recovery readiness and financial incentives for viral suppression) to the most intensive (directly observed therapy [DOT]). This approach is based on the assumption that a certain percentage of clients will require a higher level of support to achieve or maintain viral suppression, and that a stepped system will ensure the most efficient and cost-effective use of available resources.[110] Participating providers in the PPS will pair eligible clients with a case manager or care coordinator who will work with the primary care provider and the client to create and implement an individualized adherence plan and coordinate behavioral health services and other adherence supports, or "tools" as needed.

Key components of the intervention include motivational interviewing (MI), cognitive behavioral therapy (CBT) groups and financial incentives. Other intervention components are as follows:

- Incentives for Achieving and Maintaining Viral Suppression: Clients will receive a quarterly financial incentive for each lab report demonstrating an undetectable viral load.
- ARV Adherence Plan: Clients will be connected with a case manager or care coordinator who will coordinate integrated case conferencing with the medical provider and client to create an individualized ARV adherence plan and make appropriate referrals. As part of this process, the client will be screened for possible barriers to adherence, such as behavioral health conditions.
- Other Evidence-Based Adherence Supports: Clients will have access a range of adherence tools, including adherence-based MI, assistance to meet basic subsistence needs, referral to behavioral health specialists, CBT adherence groups, adherence devices such as pill-boxing or text reminders, and DOT (traditional and mobile-based).
- Peer Supports: The care coordination and support team will include peers. These peers will be clients who have already achieved viral load suppression. Peers will co-facilitate adherence support groups, assist with education and outreach, and act as escorts to appointments. Peers may include credentialed/certified peer health navigators (Project 2.c.i) whose services are Medicaid reimbursable.
- Retention to Care Unit: Outreach teams comprised of peer workers will coordinate with case managers to identify and reach participating clients who have not achieved or maintained viral suppression.
- Broad-based Education Campaigns: Marketing campaigns explaining the program and the positive impact of viral load suppression will be implemented at the individual and community level.
- Training: Ongoing training in adherence-focused MI and CBT for case managers, care coordinators, group facilitators and peers.

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[110] Personal communication with Michael Clarke, Senior Vice President, Health Homes, ADHC and Community Partnerships, Housing Works.

Stepped Approach to ARV Adherence Support

Most Intensive Services

DOT, pill boxes & adherence devices

Behavioral health interventions & retention to care unit

Harm reduction & recovery readiness, peer support groups, and/or peer navigation

Integrated case conferencing & care management

Least Intensive Services
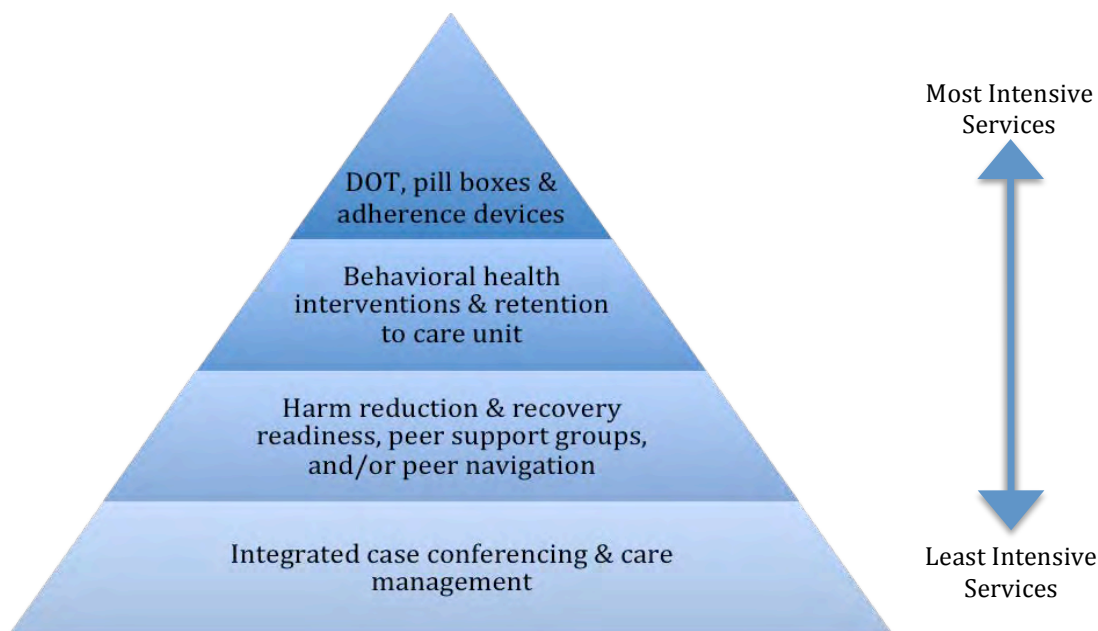
Note: Adherence support tools can be utilized interchangeably and simultaneously. Least intensive services are used by a larger percentage of clients enrolled in VLS.

The project addresses the following 4.c.ii sector projects:

4.c.ii Sector Project Components	Connection to VLS
Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care	Specifically targets high-risk populations who are already linked to services with PPS provider. Viral load suppression in high-risk populations would decrease morbidity and disparities.
Increase peer-led interventions around HIV care navigation, testing, and other services	Peer-led interventions are proven tools to link and retain clients in care. Peer workers with undetectable viral loads will support the VLS program.
Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration and mental health	VLS will use a tiered intervention model to address the needs of clients with co-behavioral or substance use morbidities and who have difficulty adhering to their treatment plan.
Assure cultural competency training for providers, including gender identify and disability issues	The PPS lead organization will coordinate efforts to train PPS network staff.
Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care	Individualized ARV treatment plans are created and approved by the client and his/her case manager or care coordinator. The plan can be modified as needed based

4.c.ii Sector Project Components	Connection to VLS
	on the needs of the client. Virally suppressed peer workers will also serve as the chief advocate and support system for clients.
Promote interventions directed at high-risk individuals patient, such as therapy for depression	All co-factors impacting adherence will be addressed and any additional services will be offered in the PPS network.
Promote group or behavioral change strategies in conjunction with HIV/STD efforts	Clients and peers in the VLS program are urged to educate and recruit their peers, creating a movement around the *Undetectables* initiative.

Evidence Base/Meaningful Impact

Durable VL suppression, achieved by initiation of highly active ARV therapy and engagement in regular HIV-medical care, is necessary to restore immune status, increase survival, and reduce risk of transmission to HIV-uninfected partners. In a study comparing PWH in NYC with durably suppressed VL (DSVL) to those with sustained high VL (SHVL), PWH with SHVL were more likely to be younger, black and have a history of injection drug use (IDU), and were significantly more likely to die prematurely.[111]

As described above, PWH in NYC face a number of demonstrated barriers to ARV adherence, including high rates of co-occurring behavioral health issues and socioeconomic factors such as housing instability and food insecurity. Among CHAIN participants ARV non-adherence is associated with poor mental health, recent substance use and homelessness, and the lowest rates of ARV adherence are reported among with recent homelessness (38%), recent substance use (38%), and no comprehensive primary care (46%).[112]

Increasing attention is focused on interventions to improve ARV access and overcome barriers to adherence in order to improve the health of PWH and reduce new HIV infections. There is growing evidence that comprehensive care coordination can improve engagement in care and viral load suppression for vulnerable populations with HIV, including recently released results from a 2-year NYC Ryan White Part A HIV Care Coordination initiative that included patient navigation and ARV adherence supports.[113] Encouraging research evidence shows that financial incentives of sufficient value can be

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[111] Terzian, A.S., et al. (2012). Novel Use of Surveillance Data to Detect HIV-Infected Persons with Sustained High Viral Load and Durable Virologic Suppression in New York City. *PLoS ONE* 7(1): e29679.

[112] Messeri P & Sorgi A. (2011). *Determinants of HAART Use and Adherence.* CHAIN 2011-4 Brief Report.

[113] Irvine, M.K., et al. (2014). Improvements in HIV Care Engagement and Viral Load Suppression Following Enrollment in a Comprehensive HIV Care Coordination Program. *Clin Infect Dis.*, doi: 10.1093/cid/ciu783, published online: October 9, 2014.

extremely effective as a support for medication adherence.[114] Findings from an ongoing Veterans Administrative study indicate that it is feasible to use financial incentives to reward ARV adherence, and that a $100 quarterly incentive is likely cost-neutral, with intervention costs offset by downstream savings from averted infections.[115] Qualitative findings from the HIV Prevention Trials Network (HTPN) O65 study of financial incentives for VL suppression included unexpected program benefits such as better engagement in care, improved patient-provider relationships and a real financial benefit to low-income participants who used the $70 quarterly incentive to pay for basic necessities including medication co-payments.[116, 117] Cognitive behavioral therapy is also a proven ARV adherence strategy for patients managing multiple challenges including HIV, depression and substance dependence.[118]

ARV adherence interventions with moderate efficacy costing ≤$100/month have been estimated to meet a cost-effectiveness threshold that is generally accepted in the US.[119] Even intensive ARV adherence supports have been associated with significant decreases in hospital days and found to be cost saving when adherence program costs were compared to savings in health care utilization.[120]

The *Undetectables* VLS initiative launched by Housing Works in March 2014 employs a tiered set of such evidence-based adherence interventions that include a quarterly financial incentive to reward clients for viral suppression. The project is designed to incentivize both achieving and maintaining viral suppression over time, since rates of virologic failure or rebound are quite high among persons who face significant barriers to ongoing adherence (27% over 2 years in one study).[121] The project employs an individualized, stepped approach to ARV adherence support that moves from the least intensive tools to more intensive interventions, as described previously. This approach is the most efficient and cost-effective use of resources.[122] A rigorous evaluation of the *Undetectables* intervention by Housing Works' academic partners at the University of Pennsylvania is examining the

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[114] DeFulioa, A. & Silvermana, K. (2012). The use of incentives to reinforce medication adherence. *Preventive Med*, 55(Suppl): S86–S94.

[115] Farber, et al. (2013). A Study of Financial Incentives to Reduce Plasma HIV RNA Among Patients in Care. *AIDS & Behavior*, 17: 2293–2300.

[116] Pack, A., et al. (2014). *Unanticipated Impact of Financial Incentives on HIV Patients and Providers: Findings from a Qualitative Sub-study (HPTN 065).* Poster presentation at the HIV Research for Prevention conference, Cape Town, October, 2014. Available at: http://www.epostersonline.com/hivr4p2014/node/930

[117] HPTN 065 outcomes, including the impact of financial incentives on linkage to care and viral load suppression, are expected in 2015.

[118] Safren, S.A., et al. (2012). Cognitive behavioral therapy for adherence and depression (CBT-AD) in HIV-infected injection drug users: a randomized controlled trial. *J Consult Clin Psychol.*, 80(3): 404-15.

[119] Schackman, B.R., et al. (2005). The cost of HIV medication adherence support interventions: results of a cross-site evaluation. *AIDS Care*, 17(8): 927-37.

[120] Sansom, S.L., et al. (2008). The costs of HIV antiretroviral therapy adherence programs and impact on health care utilization. *AIDS Patient Care STDS*, 22(2): 131-38.

[121] Robbins, G.K., et al. (2010). Predicting Virologic Failure in an HIV Clinic, *Clin Infect Dis*, 50 (5): 779-786.

[122] Personal communication with Michael Clarke, Senior Vice President, Health Homes, ADHC and Community Partnerships, Housing Works.

impact and cost-effectiveness of the program. Preliminary results at 6 months indicate a statistically significant increase pre- to post-enrollment in the proportion of participants virally suppressed at all time points.[123]

Resource Availability

The project will leverage Housing Works' knowledge in developing the model; and Housing Works staff can be utilized to develop and expand the program. The program can be easily implemented in other parts of the well-established NYC HIV/AIDS infrastructure. It will also build on the tremendous energy created by the Governor's EtE Task Force, which is looking towards PPSs' leadership to advance ending the AIDS epidemic in New York by the year 2020. The NYC Department of Health and Mental Hygiene offers medical provider training to improve provider cultural competency and technical assistance, which can be utilized in the implementation of the project.

Cost/Benefit Analysis

Our estimates suggest that this initiative will yield a net annual operational savings of approximately $700-$1,400 per person, comparing the incentive payment outlays and the administrative costs of the initiative with the expected range of inpatient hospital cost savings that will occur due to improved health status (and due to maintaining a favorable health status).

Development Costs: All cost components identified below are presumed to be one-time investments that will be made using DSRIP funds to support the implementation of this HIV-focused initiative. We estimate these up-front fixed costs to be approximately $120,000.

One key development task involves setting up a data structure to track participants' viral load and incentive payment trajectories, as well as to track the outreach activities that have occurred. This data set can then facilitate a sound evaluation of the program's impacts in relation to the intervention and education activities the PPS has implemented.

The initiative's design also anticipates hiring one (1) FTE Program Coordinator at each participating PPS. This individual will be responsible for ensuring that existing case management services and clinical providers' efforts are well-coordinated across the PPS to optimally serve the program participants. The Program Coordinator is not expected to interact with the participating beneficiaries. An Administrative Assistant is also budgeted to support the Program Coordinator. The staffing costs estimate three months of initial training for these personnel.

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[123] King, C., et al. (2014). The Undetectables Project. Presentation at the U.S. Conference on AIDS, October 4, 2014, San Diego, CA.

Fixed Cost Estimates

Cost of Developing the Intervention	One-Time Cost
Create criteria for PPS to identify persons eligible for program	$5,000
Create protocols for PPS to appropriately notify persons about incentive program	$5,000
Establish process and tools for assessing persons' ARV adherence and creating individualized ARV adherence plan	$30,000
Recruit Program Coordinator and Administrative Assistant	$25,000
Initial salary/benefits for new staff (3 months)	$37,500
Create educational materials about program	$15,000
Total Fixed Costs	**$117,500**

Costs and Savings per Person: The ongoing operational impacts of the program will include a combination of medical and non-medical components. The non-medical components, which include but are not limited to providing the incentive payments, are listed in below.

The estimated program scale is that, at an "average PPS," 1,500 patients will participate in the program. Minor costs are projected for the dissemination of pill boxes to support medication adherence.

Seventy-five percent (75%) of the program participants (1,125) are projected to earn the $100 quarterly incentive payment. An annual cost of $50,000 is projected for general administration of the incentive payments – tracking persons' viral load progression, processing the incentive payments, etc.

Collectively, the operational costs for the program, at a scale of 1,500 patient participants, are estimated to be approximately $660,000.

Non-Medical Variable Costs Per Beneficiary

Annual Operation Costs	# Persons	Annual Cost Per Person	Total Cost
Program Coordinator	1	$100,000	$100,000
Administrative Assistant	1	$50,000	$50,000
Adherence Devises (e.g. pill boxes)	1,500	$5	$7,500
Persons Qualifying for Incentive per Quarter	1,125	$400	$450,000
General Administration (maintain registry of program participants and contact information, administer incentive payments, etc.)			$50,000
Annual Operating Costs and Incentive Payments			**$657,500**

Projected medical cost impacts for the involved beneficiaries are presented in the chart below. The initiative's savings component is the medical cost reductions spurred by health status improvements attributable to the financial incentive program and the HIV Care Team's efforts.

While this is an extremely challenging estimate to make in advance, the program's impacts can be quantified through a thorough and objective evaluation effort once it is operational. The medical cost impact projections below are driven by an assumption that the incentive program can only be beneficial to an HIV-positive individual's health status and thus only have a favorable (lowering) impact on medical costs. Annual Medicaid inpatient costs for PWH currently average approximately $6,000 in a well-managed setting. A baseline annual cost of $7,500 is assumed with medical cost reductions of 15%, 20% and 25% shown.

Projected Per Person Medical Cost Impacts

Medical Cost Impacts	Type of Unit	Number of Persons	Medical Cost Per Person Per Year	Total Dollar Cost (Savings)
Baseline Annual Cost	Inpatient PMPY Cost	1,500	$7,500	
15% Reduction		1,500	$1,125	-$1,687,500
20% Reduction		1,500	$1,500	-$2,250,000
25% Reduction		1,500	$1,875	-$2,812,500

Overall Projected Impacts: The overall program impacts are summarized at different levels of inpatient hospital cost reduction across the participating beneficiaries. Impacts are shown on a per-participant basis and across the projected scale of 1,500 participants per PPS.

The program is projected to achieve a modest net operational savings of approximately $690 per participant per year if a 15% inpatient cost reduction occurs across the participating beneficiaries. Higher levels of inpatient cost reductions would thus yield considerable net savings. On a per participant basis, a 20% inpatient cost reduction is projected to yield a net annual savings of approximately $1,060 per participant; a 25% inpatient cost reduction would yield a net annual savings of approximately $1,440 per participant.

Net Saving Projections

Projected Annual Operational Cost (Savings)	Net Costs (Savings) Per Person	Total Dollar Cost (Savings)
At 15% PMPM Inpatient Reduction	-$687	-$1,030,000
At 20% PMPM Inpatient Reduction	-$1,062	-$1,592,500
At 25% PMPM Inpatient Reduction	-$1,437	-$2,155,000

The program's expected savings are also expected to quickly offset the initial one-time set-up costs (projected at $117,500 per PPS).

Potential Distorting Factors: Given the innovative nature of this project, experience data does not exist. We have identified the assumptions made regarding the volume and price of each cost (or savings) component of the projection. It is a straightforward exercise to adjust any assumptions in order to better understand the sensitivity of the estimates to these assumptions. We would strongly suggest that as part of program implementation, data be continually collected to support an objective and thorough program evaluation effort. We further encourage that the evaluation be designed not only to assess overall financial savings impacts, but to assess component impacts (e.g., which types of persons are benefiting from the program in terms of achieving health status improvements).

Notwithstanding these limitations, we believe the cost-benefit framework used in this analysis provides an important starting point for discussions and evaluations of the potential impact of this important project.

Three key issues that can create different savings levels relative to the above projections include:

- First, some persons who receive the incentive payment for securing/maintaining an undetectable viral load would have achieved the improved viral load outcome anyway (without the incentive program and/or without the HIV Care Team's involvement), due to the effectiveness of the health care services they receive and their own behavior and decision-making. For these persons, the initiative will entail a cost with no corresponding benefit.

- Second, some persons will improve clinically and behaviorally due to the HIV Care Team's involvement and the motivation of the financial incentives, but they will nonetheless not achieve an undetectable viral load. These persons' improvements should lead to lower medical costs, although the program will not make any incentive payments for this subgroup.

- Third, when persons transition from having a detectable viral load to an undetectable level, the risk of transmitting HIV to others is reduced/eliminated. Considerable cost savings occur for *each* averted HIV infection—the CDC projects that the lifetime treatment costs associated with HIV infection are nearly $400,000. For every one percent of the persons earning the incentive payment who, as a result of this initiative avoid infecting one other individual, 11 new infections would be averted. This would create a lifetime savings of approximately $4.5 million. If 10% of the incentive earners avoid infecting one additional person, the lifetime savings impact would be roughly $45 million.

The fact that the first potential distorting factor would lower the program's savings potential, and the second and third factors would increase the program's savings, is encouraging. It is possible that these dynamics will essentially offset one another, and not cause actual savings outcomes to significantly vary from those projected herein.

3. Crisis Diversion

PPSs can contract with community-based supportive housing providers to develop a pool of temporary crisis housing units. The units will be staffed with experienced clinical professionals, providing intensive crisis residential services, and will be available 24 hours a day, 7 days a week, for a maximum of 28 days.

> *Supports the following DSRIP Project:*
> *Project 2.b.vi Transitional Supportive Housing Services*

Justification of Need

Currently over 58,000 persons use New York City (NYC) shelters each night; and users of NYC shelters have higher rates of hospitalization, prolonged length of stay and substantially higher death rates relative to the general population. From 2001-2003, homeless adults made up less than 1% of adult New Yorkers but accounted for 1.6% of adult hospitalizations. There currently exists a lack of residential crisis services in the community for high utilizers of Medicaid services who experience reoccurring behavioral, emotional, substance use or psychiatric crises. Only two medical respite programs serve homeless persons in NYC, providing 10 beds (Comunilife) for persons leaving hospitalization and 24 beds (BRC) as an alternative to inpatient care.

At the same time, a significant number of individuals with severe behavioral health conditions undergo crisis trigger events and present themselves at emergency departments (EDs). They are often admitted for inpatient care in the hospital, when, such crisis events could have been stabilized with short-term, recovery-based care in community residences.

There is a critical need to develop safe, transitional housing for individuals experiencing an emotional crisis, who are at-risk of an escalation of symptoms that cannot be managed without intensive onsite supports. Developing short-term crisis residences will not only provide for more appropriate care, but will help to prevent future crisis episodes that would result in high-use of EDs and hospital admissions/ readmissions if no interventions are implemented.

Project Description

The units will create pathways for hospital diversion and avert unnecessary use of ED services for acute behavioral health conditions that result in preventable hospital admissions. The short-term residences will provide a safe place for up to 28 days, and will provide crisis intervention, assessment, supportive counseling, clinical monitoring, and connection or reconnection to other behavioral health services, peer support, wellness education and skill building. Upon stabilization, consumers will be connected to the community-based treatment programs and supports that they need to maintain long-term recovery and rehabilitation. This will include referrals to more long-term transitional and permanent supportive housing programs funded through the New York State (NYS) Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health (DOH), and the NYC Department of Health & Mental Hygiene

(DOHMH) and HIV/AIDS Services Administration (HASA), among others.

Project activities include:

- Contracts with Community-based Supportive Housing Providers: Providers will develop and operate short-term residential units specifically designed for crisis diversion services. For example, a community provider may have existing or unused space in a congregate setting that can be utilized for this purpose. Memoranda of Understanding and other service agreements will be established to ensure that units are funded and made available 24 hours, 7 days a week.
- Identify High-utilizers of ED and Inpatient Services: PPSs will partner with hospitals and housing providers to identify individuals in need of services, incurred from crisis episodes, which will begin the process of forming long-term relationships with service providers in the community.
- Referrals: Clients who are experiencing a behavioral health crisis will be assessed in EDs, and if deemed clinically appropriate, referred for intensive crisis treatment in short-term community-based residences. Referrals may also come from community-based providers that identify people in crisis and wish to avoid the ED.
- Protocols: Protocols for diversion from emergency room to community-based treatment will be established, and will include: staffing procedures, consent forms, timely sharing of medical records and patient information, benefits screening, safe transportation, etc.
- Staffing & Service Planning: A robust staffing and service plan will be designed to treat individuals experiencing a crisis in temporary community-based residences. The staffing plan should include licensed professionals, such as medical doctors, nurse practitioners, and social workers, as well as certified peers.
- Behavioral Health Services: Clients will receive person-centered, intensive behavioral health services to stabilize and reduce crisis situations including, but not limited to crisis intervention, supportive counseling, clinical monitoring, ambulatory detox, harm reduction, case management, and peer services. Critical Time Intervention (CTI) services should be used to further stabilize people in the transition process.
- Community Partnerships: Temporary residence staff will collaborate with community-based providers, including Health Home care coordinators and managed care companies to ensure that clients are able to receive recovery-based services and ensure that these services are covered.
- Transitional Services: Temporary residence staff will work with clients and their next housing provider during their stay in the temporary residence, and then for a 15-day follow-up period to facilitate transition to the new residence.
- Strengthen Long-Term Supports: Clients will receive support to develop and strengthen their long-term support structures, including social, family and community supports. Clients will be connected or reconnected to health and behavioral health services in the community.
- Relapse Prevention: Clients will be provided services to build their skills and identify tools needed to avoid future crisis episodes. A relapse prevention plan will

be developed as part of wellness self-management program, and will include informal caregivers.

Evidence Base/Meaningful Impact

Emergency psychiatric services are often costly and distressing to individuals and families affected by a serious mental illness. Alternative services, however, such as crisis respites, hospital diversion, and step-down programs can prevent or lessen the length of time spent in the ED and hospital. Such models of enriched crisis and transitional housing offer voluntary, time-limited, intensive residential support services to those experiencing a psychiatric crisis. Development of crisis respite centers that offer an alternative to hospitalization is a priority for NYC.[124]

Research shows that even brief stays in behavioral respite decrease hospitalization, reduce readmission and reduce overall medical costs. This program will improve the diversion process to more appropriate community settings, and decrease the use of inappropriate ED services and hospital admissions/readmissions and associated costs. Connection of individuals with long-term community supports to foster long-term rehabilitation and recovery, and break the cycle of emergency department use and hospital readmissions. Overall quality of care and health outcomes will be improved by reintegrating people back into their communities.

Parachute NYC, a new DOHMH project, provides a community-based alternative to emergency hospitalization for individuals aged 18 to 65 who are experiencing psychiatric crises, including four new crisis respite centers. The NYC DOHMH reports that Parachute NYC results to date show that, compared to a control group, every night in respite saves $650 in avoided Medicaid costs. However, respite center guests must have stable housing to return to after their respite stay.[125]

In 2012-2013, the NYS Medicaid Redesign Team (MRT) recognized the importance of supportive housing services and set aside $75 million to expand access to supportive housing initiatives for high-need and high-cost Medicaid recipients. The amount of funds set aside in budget year 2013-2014 increased to $86 million.[126] In 2013, on the recommendation of the MRT Affordable Housing Workgroup, the MRT transferred $4 million of the Medicaid budget to the OMH to fund an enriched Crisis and Transitional Housing Pilot Initiative. The Initiative will include up to 36 units statewide to fill a critical gap in New York State's service delivery system by providing enriched housing as an alternative to psychiatric EDs and hospitals, by diverting individuals in crisis from use of

[124] NYS OHM. *Statewide Comprehensive Plan Interim Report, July 2014*. Retrieved from: https://www.omh.ny.gov/omhweb/planning/statewide_plan/2013_to_2017/2014-interim-report/report.pdf
[125] Kunins, H., Marsik, T., & Tom, L. *DSRIP and Behavioral Health*. Presentation on August 6, 2014.
[126]NYS Medicaid Redesign Team Affordable Housing Work Group. Accessed at http://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm

such services, and by providing a transitional step-down program following psychiatric hospitalization.[127]

Cost/Benefit Analysis
Our estimates suggest that this initiative would save a PPS approximately $1,500 per person, comparing the operational costs of its implementation with the cost savings of reduced hospital usage. These per person savings will need to be balanced against the up-front costs of securing additional housing capacity and developing program tools, to determine the patient volume needed for the initiative to achieve overall financial break-even (and ongoing net savings thereafter).

Development Costs: Several cost components identified are presumed to be one-time investments that will be made using DSRIP funds to support the implementation of this crisis housing initiative. We estimate these up-front fixed costs to be approximately $150,000.

Fixed Cost Estimates

Costs of Developing the Intervention	Cost
Develop contracts between PPS and housing providers	$15,000
Establish protocols for diversion – staffing procedures, consent forms, etc.	$15,000
Prepare training materials for ED staff	$20,000
Periodic presentations to ED staff	$10,000
Identify persons with low acuity admissions and/or housing insufficiency (working with each hospital's data) and create system flag when they present in ED (work with each facility's data)	$20,000
Initial housing cost per unit (3 months of pre-program set-up cost assumed for 5 units)	$35,000
Initial salary/benefits for new staff (3 months)	$32,500
Total Fixed Cost	**$147,500**

The table below estimates the unit costs of renovating the acquired housing capacity to support the crisis housing program. We estimate that on average five units of housing would be acquired to support a given PPS' early discharge program. A unit cost of $28,000 is used for renovating housing capacity, based on information in a recent RFP prepared by the Office of Mental Health and the Medicaid Redesign Team. There may be opportunities to share these costs across other initiatives within the PPS or with other PPSs developing similar programs. For example, the housing capacity and staffing costs are assumed to be

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[127] NYS OMH Request for Proposals. (March 7, 2014). *MRT Enriched Crisis and Transitional Housing Services Pilot Initiative for Adults with Serious Mental Illness.* Retrieved from: http://www.omh.ny.gov/omhweb/rfp/2014/enriched-crisis/

allocated in full to this Crisis Housing Support Initiative, but there are potential economies of scale if these costs were shared with the Early Discharge Initiative.

Per Unit Cost of New Housing Capacity & Staff

Cost of New Housing Capacity & Staff	Type of Unit	Number of Units	Cost Per Unit
Reconfiguration of Additional Housing Capacity	One Person Living Unit	5	$28,000

Cost and Savings Per Person: The ongoing operational impacts of the program will include a combination of medical and non-medical components. The non-medical components, which include but are not limited to providing the housing support, are listed below. Staff time at the ED will be needed to evaluate the presenting patient's housing stability (as part of the intake assessment), and when the admission can be averted, work to line up appropriate crisis housing support.

An average of 21 days of housing support is projected. The initiative is structured to provide up to 28 days of housing. The projections anticipate that the average amount of housing support for program participants will be substantial, but that many participants will require far less than the maximum 28 day allotment.

Substantial transition support is also budgeted during the crisis housing stay, to help the individual remain stable, safely housed, and connected to community resources. The model also budgets for follow-up with the patient after being transitioned from crisis housing, to check in on the individual's well-being and re-establish linkages to community and medical resources as needed. Note that if a patient is hospitalized, some transition support will be provided at the point of discharge. However, the transition support delivered through the crisis housing initiative is projected to be considerably more extensive than the inpatient discharge transition process. The costs projected below are estimated to be additive to what would occur as part of a hospital discharge transition.

Non-Medical Variable Costs Per Beneficiary

Non-Medical Costs Per Person	Type of Unit	Number of Units	Cost Per Unit	Total Dollar
Conduct housing assessment when a flagged person presents at ED	ED Intake Staff time (hours)	0.2	$75	$15
Line up housing support	ED Intake Staff time (hours)	1	$75	$75
Crisis Housing Support				
Amortization of licensed staff on-site	Day of FTE/5 residents	21	$49	$1,023
Housing rental costs/ amortization of purchase	Per diem housing cost	21	$85	$1,790
Food	Cost/day for 3 meals	21	$9	$184

Non-Medical Costs Per Person	Type of Unit	Number of Units	Cost Per Unit	Total Dollar
Other misc. crisis housing support costs	Cost/day	21	$7	$153
Transportation from ED to housing location	Taxi fare	1	$20	$20
Transition support for return to community	Clinical Social Worker hour	6	$150	$900
Follow-up support upon return to community	Clinical Social Worker hour	6	$150	$900
Total Non-Medical Costs				**$5,060**

Projected medical cost impacts for the involved beneficiaries are presented below. The initiative's savings component is the inpatient admission that is averted. The dollar value of this admission is estimated at 80% of a NYC Medicaid health plan's average payment for medical/surgical admissions (reflecting the expectation that if the admission is "avoidable" the patient's clinical acuity is likely tied to a below-average DRG payment rate). At the same time, if the patient was on the verge of being admitted there are clearly significant clinical concerns that remain in need of attention during the crisis housing stay. The model assumes multiple home, physical and behavioral health visits during the crisis housing stay, as well as some diagnostic tests, medications, and transportation to and from care. Taken together, medical cost impacts are projected to be a savings of roughly $6,600 per beneficiary.

Projected Per Person Medical Cost Impacts

Medical Cost Impacts Per Person	Type of Unit	# of Units	Cost Per Unit	Total Dollar
Inpatient Costs (reduction)	Admission	1	($8,867)	($8,867)
Home Health Visits	House Visit	10.5	$125	$1,313
Physician/Clinic Services (increase)	Outpatient Visit	2	$130	$260
Behavioral Health Counseling (increase)	Outpatient Visit	4	$70	$280
Diagnostic Services (increase)	Procedure	4	$30	$120
Pharmacy (increase)	Script	2	$45	$90
Transportation to/from outpatient care	Taxi Fare	10	$20	$200
Total Medical Cost Impacts				**-$6,605**

Overall Projected Impacts: The overall per person impacts are summarized below, along with savings estimates at different levels of beneficiary participation. A net savings of

approximately $1,500 per person is projected. These savings are "per event" figures (rather than per year figures—a person could receive crisis housing support more than once in a given 12 month period).

Net Savings Projections

Annual Cost Impacts, Crisis Housing Support	Per Person	Per 200 Persons	Per 500 Persons
Total Variable Costs	$5,060	$1,012,000	$2,530,000
Per Case Costs (Savings)	-$6,605	-$1,320,940	-$3,302,350
Net Costs (Savings) From Initiative	-$1,545	-$308,940	-$772,350

Potential Distorting Factors: Given the innovative nature of this project, experience data does not exist. We have identified the assumptions made regarding the volume and price of each cost (or savings) component of the projection. It is a straightforward exercise to adjust any assumptions in order to better understand the sensitivity of the estimates to these assumptions. We would strongly suggest that as part of program implementation, data be continually collected to support an objective and thorough program evaluation effort. Notwithstanding these limitations, we believe the cost-benefit framework we have developed in this analysis provides an important starting point for discussions and evaluations of the potential impact of this important project.

Two key issues that can distort the projections in this initiative are as follows:

- First, the potential exists that persons presenting in the hospital ED will be referred into the crisis housing program, but would not have been hospitalized in the absence of this program. For these persons, the introduction of the housing supports would constitute a cost that has little offsetting medical savings benefits (since no hospitalization would have occurred). It will be important for the program to predominantly refer persons into the crisis housing who would in fact be admitted to the hospital, for this initiative to yield a net savings.

- Second, the ancillary support provided during the crisis housing stay—the linkages to behavioral health therapy, education regarding adherence to medication regimens, connections with community resources, and the transition supports—all create a meaningful potential for the person to achieve and maintain more stable health status than if he/she were simply stabilized and discharged through an inpatient hospital stay. No longer-term medical savings have been built into the model, but it seems likely that the program will have a favorable impact on reducing future use of inpatient and outpatient hospital services.

The fact that the first potential distorting factor would lower the program's savings potential, and the second factor would increase the program's savings, is encouraging. It is possible that these two dynamics will roughly offset one another, and not cause actual savings outcomes to significantly vary from those projected herein.

4. Hospital Step-Down Services

PPSs can contract with community-based supportive housing providers to develop a pool of transitional housing units to safely discharge high-risk individuals from hospitals to community settings. These transitional housing units will be available 24 hours a day, 7 days a week, for a maximum of 28 days; and will be staffed with experienced clinical professionals and intensive residential services to create pathways for step-down services and respite care.

> *Supports the following DSRIP Project:*
> *Project 2.b.vi Transitional Supportive Housing Services*

Justification of Need
A significant number of people with chronic health and behavioral health conditions use a high volume of hospital inpatient services. These populations could be transitioned out of the hospital and prevented from returning if they had an appropriate level of care and services in place at discharge to manage their long-term issues. Behavioral health conditions make it difficult to manage primary health care needs. Further, the transitional period after a hospital discharge is often beset with challenges for high-risk individuals to establish secure housing arrangements. Currently over 58,000 persons use New York City (NYC) shelters each night; and users of NYC shelters have higher rates of hospitalization, prolonged length of stay and substantially higher death rates relative to the general population.

A critical need exists to develop safe, transitional and step-down housing services for people who are medically cleared for discharge but do not have the necessary level of health and behavioral health supports in place to fully return to the community. A published comparison with usual care found that temporary step down reduced hospital admissions by 49%, with the most significant reduction among people who are homeless. In a temporary supportive housing program based in NYC (Comunilife), only 23% of clients were readmitted for medical reasons within 30 days of discharge from temporary supportive housing. By utilizing resources allocated for existing hospital beds to develop time-limited, intensive residential units, hospitals, in partnership with community housing providers can meet the needs of people who have difficultly returning to the community. Together, they can prevent crisis and emergency incidents from reoccurring, which are often related to unstable or inappropriate housing, and result in emergency department (ED) visits and hospital admissions/readmissions.

Project Description
Hospitals and community-based providers will work together to provide for an intermediate housing option for individuals ready for discharge but lacking the appropriate support to reintegrate back into the community. The temporary, step-down residential units will be available to individuals who require a short-term period (up to 28 days) of intensive residential supports in the community to adequately address their mental health,

substance use and medical conditions, and connect them to the services that can meet their long-term recovery and rehabilitation needs.

Project activities include:
- Contracts with Community-based Supportive Housing Providers: Providers will develop and operate step-down and respite care units to ease transition back to the community. For example, a community provider may have existing or unused space in a congregate setting that can be utilized for this purpose. Memoranda of Understanding and other service agreements will be established to ensure that units are funded and made available 24 hours, 7 days a week.
- Identify High-utilizers of ED and Inpatient Services: PPSs will partner with hospitals and housing providers to identify individuals who could be cleared for discharge with appropriate community-based behavioral and medical supports in place. This will begin the process for forming long-term relationships with service providers in the community.
- Referrals: Clients who are deemed eligible for services will be assessed and discharge-planning requirements will be fulfilled. If deemed clinically appropriate, patients will be referred to step-down and respite care treatment in short-term community-based residences.
- Protocols: Protocols for diversion from emergency room to community-based treatment will be established, and will include: staffing procedures, consent forms, timely sharing of medical records and patient information, benefits screening, safe transportation, etc.
- Staffing & Service Planning: A robust staffing and service plan will be designed to support individuals ready to transition to care in temporary community-based residences. The staffing plan should include licensed professionals, such as medical doctors, nurse practitioners, social workers, as well as certified peers.
- Behavioral Health Services: Clients will receive person-centered, intensive behavioral health services to bridge the transition back to the community: attention to urgent health and behavioral health care needs, including psychiatric services, mental health and substance use assessments, intensive case management, medication management, supportive counseling, wellness self-management, transportation to and from appointments, etc. Critical Time Intervention (CTI) services should be used to further stabilize people transitioning back to the community.
- Community Partnerships: Temporary residence staff will collaborate with community-based providers, including Health Home care coordinators and managed care companies to ensure that clients are able to receive recovery-based services and ensure that these services are covered.
- Transitional Services: Temporary residence staff will work with clients and their next housing provider during their stay in the temporary residence, and then for a 15-day follow-up period to facilitate transition to the new residence.
- Strengthen Long-Term Supports: Clients will receive support to develop and strengthen their long-term support structures, including social, family and

community supports. Clients will be connected or reconnected to health and behavioral health services in the community.

- Relapse Prevention: Clients will be provided services to build their skills and identify tools needed to avoid future crisis episodes. A relapse prevention plan will be developed as part of wellness self-management program, and will include informal caregivers.
- Homeless Services: PPS will collaborate with homeless outreach teams in each borough for people who are homeless to ensure timely referral to transitional/permanent housing.
- Decommission Unused Hospital Beds: The PPS should decommission hospital beds, which will be freed-up as a result of this initiative.

Meaningful Impact/Evidence Base
As described above, homeless adults are hospitalized more frequently than those in the general population and often require longer inpatient stays; however, their lack of a stable home environment diminishes the long-term effectiveness of their hospital care. Living on the streets after hospital discharge creates competing priorities for homeless patients. Challenges such as obtaining healthy food, accessing transportation, and finding a safe and clean place to rest can compromise adherence to medications, other physician instructions, and follow-up appointments, thus increasing the probability of future hospitalizations.[128]

A growing body of research demonstrates that homeless patients who are discharged to medical respite programs have fewer hospitalizations and reduced hospital readmissions than homeless patients who are discharged to their own care. Even brief stays in a medical respite program have been found to decrease hospitalization, reduce readmissions, and reduce costs for hospitals and the health care system.[129] Data collected over three years in Boston compared 90-day hospital readmission among patients discharged to respite versus other settings, adjusting for differences in patient characteristics, including burden of illness, and found release to respite care significantly reduced the odds of hospital readmission.[130] A Chicago study found that homeless patients discharged from inpatient care to a respite center had 49% less hospital days in the following 12 months than similar patients discharged to usual care.[131]

According to the National Health Care for the Homeless Council, there are currently 72 medical respite care programs, also known as recuperative care, operating in the U.S., but only two medical respite programs serve homeless persons in NYC, providing 10 beds

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[128] Garcia P. (2006). The effects of respite care for homeless patients: A cohort study. *Am J Pub Health*, 96(7): 1278-1281.

[129] Zerger, S. (2006). *An evaluation of the respite pilot initiative: Final report, 2006*. Available at: http://www.nhchc.org/wp-content/uploads/2011/09/RespiteRpt0306.pdf

[130] Kertesz, et al. (2009). Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons. *J Prev Interv Community*, 37(2): 129–142.

[131] Buchanan D, et al. The effects of respite care for homeless patients: A cohort study. *Am J Pub Health*, 96(7): 1278–1281.

(established by Comunilife in 2011) for persons leaving hospitalization and 24 beds (operated since 2001 by Bowery Residence Committee (BRC)) as an alternative to inpatient care.[132]

The BRC Medical Respite program offers a primary care environment for homeless people who have severe chronic health problems but do not require an inpatient hospitalization stay. Co-located within BRC's Chemical Dependency Crisis Center (CDCC), participants must meet the CDCC admission criteria (active substance abuse or at-risk for relapse).[133]

Comunilife partners with Montefiore Hospital Care Management Organization and Bronx Lebanon Hospital on its Medical Respite program, developed in 2011 to provide safe, transitional housing available for patients who are medically cleared and do not require hospitalization but cannot be discharged to a stable home or shelter. The program aims to reduce the hospitals' financial burden by providing temporary residential care that enables clients to be medically discharged from the hospital into a safe, temporary environment where they can access medical care and other supportive services and housing.[134] Among the initial 52 clients discharged from inpatient stays to the program, Comunilife reports that only 23% of clients were readmitted to the hospital and only 13% visited an ED in the 30 days following discharge.[135]

Cost/Benefit Analysis

Our estimates suggest that this initiative would save a PPS approximately $400 per person, comparing the operational costs of its implementation with the cost savings of reduced hospital usage through reductions in future inpatient admissions. It is assumed that the savings associated with the early discharge on the original admission are unlikely to flow to the PPS under New York's underlying DRG payment structure for inpatient care.

Development Costs: Several of the cost components identified below are presumed to be one-time investments that will be made using DSRIP funds to support the implementation of this housing initiative. We estimate these up-front fixed costs to be approximately $150,000.

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[132] National Health Care for the Homeless Council (NHCHC). (2014). *2014 Medical Respite Program Directory: Descriptions of Medical Respite Programs in the United States*. Retrieved from http://www.nhchc.org/resources/clinical/medical-respite/tool-kit/medical-respite-programs-united-states/. NHCHC hosts the Respite Care Providers Network, whose mission is to improve the health status of individuals who are homeless by supporting programs that provide medical respite and related services. For more information about medical respite care, there is a wealth of information Retrieved from: www.nhchc.org/respite/

[133] Ibid.

[134] Ibid.

[135] Gill, R.M. *Medical Respite in New York City*. Presentation at the New York State Supportive Housing Conference, June 2014.

Fixed Cost Estimates

Costs of Developing Intervention	One-Time Cost
Develop contracts between PPS and housing providers	$15,000
Establish protocols for diversion–staffing procedures, consent forms, etc.	$15,000
Prepare materials for hospital staff educating them about earlier discharge opportunity	$20,000
Periodic presentations to hospital staff	$10,000
Data analyses in partnership with hospital to identify persons in prior years whose LOS was longer than necessary due to housing insufficiency	$20,000
Initial Housing Cost Per Unit (3 months of pre-program set-up cost assumed for 5 units)	$35,000
Initial Salary / Benefits for New Staff (3 months): Per PPS assumptions include 0.5 Project Manager at annual cost per FTE of $100,000 and 1 Case Manager at annual cost per FTE of $80,000	$32,500
Total Fixed Cost	**$147,500**

The table below estimates the unit costs of renovating the additional housing capacity and adding oversight staff to support the housing program. We estimate that on average five units of housing would be acquired to support a given PPS' early discharge program, with these units being acquired at least three months prior to program implementation.

Per Unit Cost of New Housing Capacity and Staff

Cost of New Housing Capacity and Staff	Type of Unit	Number of Units	Cost Per Unit	Total Dollar
Reconfiguration of Additional Housing Capacity	Living Unit for One Person	5	$28,000	$140,000

A unit cost of $28,000 is used for renovating housing capacity, based on information in a recent RFP prepared by the Office of Mental Health and the Medicaid Redesign Team. There may be opportunities to share these costs across other initiatives within the PPS or with other PPSs developing similar programs. For example, we assume that the housing capacity and staffing costs are allocated in full to this Crisis Housing Support Initiative, but there are potential economies of scale if these costs were shared with the Crisis Housing Support Initiative.

Costs and Savings Per Person: The ongoing operational impacts of the program will include a combination of medical and non-medical components. The non-medical components, which include but are not limited to providing the housing support, are listed below. Staff time during the hospital admission process will be needed to evaluate the patient's housing

stability (as part of the intake assessment), and to line up appropriate transitional housing support once the patient is medically ready for discharge.

An average of 15 days of housing support is projected. The initiative is structured to provide up to 28 days of housing. The projections anticipate that the average amount of housing support for program participants will be substantial, but that given the time already spent as an inpatient, many participants will require far less than the maximum 28-day allotment.

Substantial transition support is also budgeted during the housing stay, to help the individual remain stable, safely housed, and connected to community resources. The model also budgets for follow-up with the patient after being transitioned from the housing, to check in on the individual's well-being and re-establish linkages to community and medical resources as needed. Note that if a patient remains hospitalized, some transition support will be provided at the point of discharge. However, the transition support delivered through the housing initiative is projected to be considerably more extensive than the inpatient discharge transition process. The costs projected are estimated to be additive to what would occur as part of a hospital discharge transition.

Non-Medical Variable Costs Per Beneficiary

Non-Medical Costs Per Person	Type of Unit	Number of Units	Cost Per Unit	Total Dollar
Identify persons with housing insufficiency upon admission (include in assessment)	Intake staff time (hours)	0.2	$75	$15
Lining up housing support	Staff time (hours)	2	$75	$150
Crisis Housing Support				
Amortization of licensed staff on-site	Day of FTE/5 residents	15	$49	$731
Housing rental costs/amortization of purchase	Per diem housing cost	15	$85	$1,279
Food	Cost/day for 3 meals	15	$9	$131
Other misc. crisis housing support costs	Cost/day	15	$7	$110
Transportation from hospital to housing location	Taxi fare	1	$20	$20
Transition support for return to community	Clinical Social Worker hour	4	$150	$600
Follow-up support upon return to community	Clinical Social Worker hour	4	$150	$600
Total Non-Medical Costs				**$3,635**

Projected medical cost impacts for the involved beneficiaries are presented in the chart below. The initiative's two savings components both involve reductions in inpatient costs.

First, the initial early discharge may create a savings due to the inpatient hospital days that are averted. The dollar value of the decreased hospital days is estimated at $5,500, based on a 50% reduction in average length of stay and the average payment per day for a NYC Medicaid health plan. In weighing the ultimate cost/benefits of this initiative for an individual PPS, it will be important to consider which entity actually captures these hospital savings under a DRG payment system.

The second inpatient savings reduction involves an assumption that future hospital use will be reduced by 0.5 admissions, due to the efforts made to ensure a successful initial transition to the community (from the temporary housing) as well as ongoing efforts thereafter to support the individual in remaining safe and stable.

The model assumes multiple home, physical and behavioral health visits during the crisis housing stay, as well as some diagnostic tests, medications, and transportation to and from care. Taken together, medical cost impacts are projected to be a savings of roughly $9,600 per beneficiary. These medical savings would be reduced by over half—to approximately $4,000 per person—if the DRG payment model negates inpatient savings from the initial earlier discharge to the housing facility.

Projected Per Person Medical Cost Impacts

Medical Costs Per Person	Type of Unit	Number of Units	Cost Per Unit	Total Dollar
Immediate inpatient costs (reduction)	Day	2.67	($2,075)	-$5,540
Future inpatient admissions (reduction)	Admission	0.5	($11,084)	-$5,542
Home health visits	House visit	5	$125	$625
Physician/clinic services (increase)	Visit	2	$130	$260
Diagnostic services (increase)	Procedure	2	$30	$60
Behavioral health counseling (increase)	Visit	4	$70	$280
Pharmacy (increase)	Script	2	$45	$90
Transportation to/from outpatient care	Taxi fare	4	$20	$80
Total Medical Cost Impacts				**-$9,687**
Medical Cost Impacts if Initial Hospitalization LOS Reduction Yields No Savings Due to DRG Payment Model				**-$4,022**

Overall Projected Impacts: The overall per person impacts are summarized in the chart below, along with savings estimates at different levels of beneficiary participation. A net savings of approximately $6,000 is projected if the initial inpatient length-of-stay reduction yields lower hospital costs. If the DRG payment structure prevents this savings component

from occurring, a net savings of approximately $400 per case is projected to occur—a much smaller gain but still a net savings.

Net Savings Projections

Annual Cost Impacts, Early Discharge Housing	Per Person	Per 200 Persons	Per 500 Persons
Non-Medical Costs	$3,635	$727,000	$1,817,500
Medical Costs (Savings)	-$9,687	-$1,937,450	-$4,843,625
Net Costs (Savings) From Initiative	-$6,052	-$1,210,450	-$3,026,125
Net Costs (Savings) if no immediate reduction in inpatient costs due to DRG payment structure	-$512	-$102,400	-$256,000

Potential Distorting Factors: Given the innovative nature of this project, experience data does not exist. We have identified the assumptions made regarding the volume and price of each cost (or savings) component of the projection. It is a straightforward exercise to adjust any assumptions in order to better understand the sensitivity of the estimates to these assumptions. We would strongly suggest that as part of program implementation, data be continually collected to support an objective and thorough program evaluation effort. Notwithstanding these limitations we believe the cost-benefit framework we have developed in this analysis provides an important starting point for discussions and evaluations of the potential impact of this important project.

One concern is that some persons, who would not have been kept in the hospital in the absence of this program, may be discharged to the transitional housing program. For these persons, the introduction of the housing supports would constitute a cost that has little immediate offsetting medical savings benefits (since no additional hospital days would have occurred). It will be important for the program to predominantly refer persons into the transitional housing who would in fact be otherwise kept in the hospital, for this initiative to yield a net savings.

However, savings can still occur for these patients depending on the degree to which the housing and related supports lower the volume of future hospitalizations. The ancillary support provided during the step-down housing stay – the linkages to behavioral health therapy, education regarding adherence to medication regimens, connections with community resources, and the transition supports – all create a meaningful potential for the person to achieve and maintain more stable health status than if he/she were simply stabilized and discharged through an inpatient hospital stay only.

The availability of housing in any given patient situation must also be assessed. If expanded housing capacity is typically fully utilized for other programs, few early discharge opportunities will exist. Conversely, if the additional housing is not fully utilized, the fixed costs of the new housing resources will need to be spread over a smaller patient population of persons who receive housing support. There could also be selection issues in which the housing program receives patients with more complicated social barriers (requiring more

intensive services) because they are better equipped to deal with them than the hospital's non-acute facilities. These issues, while elusive to quantify, should be considered as this initiative is developed, and should be included in the evaluation effort once the initiative is implemented.

5. Care Integration Learning Collaboratives

PPSs can implement two models of Learning Collaboratives to promote care integration—one for smaller community-based agencies (Model A) that need to build capacity to integrate services and one for agencies with two or more New York State (NYS) licenses (Article 28, 31, and/or 32) but not yet fully-integrating services (Model B)—to support and build the infrastructure necessary to integrate primary and behavioral health services for serious mental illness (SMI) and substance use disorder (SUD) populations. The Learning Collaboratives will assist community-based organizations critical to providing distinct cultural and linguistic services in becoming financially viable, providing integrated behavioral health/primary care services to their patients, improving clinical outcomes and reducing avoidable hospital and emergency room use.

> *Supports the following DSRIP Project:*
> *Project 3.a.i Integration of Behavioral Health and Primary Care*

Justification of Need
The network of small mental health, substance use and primary care organizations serving Medicaid and uninsured consumers with SMI, SUD and primary care needs/chronic conditions is crucial to building the capacity of NYS DSRIP Performing Provider Systems (PPS). Many of these smaller, not-for-profit organizations will require additional support to become effective participants in fully integrated delivery systems. These organizations often face two significant challenges: a lack of experience integrating services and a struggle for financial stability. At the same time, these organizations currently serve the health care needs of some of the most frequent and costliest users of service and they add essential capacity to the Medicaid "safety net," often due to their innovative models of care, patient populations served, as well as their linguistic and cultural competence.

The NYS Office of Mental Health (OMH) serves more than 700,000 individuals annually. The majority of services are delivered to individuals with a SMI, or to children and adolescents with Serious Emotional Disorder. The NYS Office on Alcohol and Substance Abuse Services (OASAS) serves some 100,000 individuals on any given day and 245,000 unique individuals annually. At least 50% of individuals with a mental health diagnosis also have a co-occurring substance use diagnosis. Patients with SMI and SUD are often high utilizers of emergency departments for chronic disease and medical reasons. The relationship between mental health and chronic disease is clear, and appears to be bi-directional, with chronic conditions of one type increasing vulnerability and complicating treatment for other conditions. Fifty-two percent (52%) of persons who receive public mental health services in NYC have at least one diagnosed chronic medical condition.[136] Nearly 50% of a large sample of PWH receiving care in the U.S. screened positive for a psychiatric disorder, nearly 40% reported using an illicit drug other than marijuana, and more than 12%

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[136] NYS OMH. *Patient Characteristics Survey DataPortal, NYC Region, 2013*. Accessed December 2014 at https://www.omh.ny.gov/omhweb/statistics/pcs-message.htm

screened positive for SUD during the previous 12 months.[137,138] Depression is found to co-occur in 17% of cardiovascular cases, 23% of cerebrovascular cases, 27% of diabetes patients and more than 40% of individuals with cancer.[139] People with depression are 1.3 times more likely to develop diabetes.[140] AC findings show close to 60% of members have a co-morbid mental health diagnosis. Over 80% of AC members have a history of substance use/abuse, with somewhere between 30-40% actively using. Behavioral health consumers may have relationships with a behavioral health provider or a primary care provider but the care may not be comprehensive and integrated in ways that meet their complex needs. Fragmented care results in costs for treating people with both medical and mental conditions that are two-to-three times higher than costs for those with physical health conditions only. This leads to poorer health outcomes, avoidable hospital admissions, and further complications that drain resources from the wider health system.

Furthermore, agencies that operate Article 31, 32 and 28 clinics are facing a series of events that threaten their viability: inadequate reimbursement, declining philanthropy, as well as government mandates that require programmatic restructuring, radically different rate methodology and more complex administrative functions (required billing systems, Health Information Technology (HIT) and Health Information Exchange connectivity). For years, the business models and reimbursement rates have meant that these clinics have struggled with financial stability. Until recently, not-for-profit agencies have subsidized their clinic services with foundation grants and private donations, underwriting from 10-20% of their operating budget, depending on their payer mix. With private donations plummeting and foundations reducing their grant funding and redirecting priorities, Article 31, 32 and 28 clinics are facing an unprecedented crisis: the gap between revenues and expenses has reached an unsustainable level. Low patient volumes at smaller organizations further complicate matters. Consequently, many agencies have closed clinics, or taken measures to reduce capacity, such as placing limits on individuals with commercial insurance, or not accepting commercial insurance at all. The Coalition of Behavioral Health Agencies (The Coalition) is aware of dozens of Article 31 and 32 clinics in NYC that have recently closed due to these financial and operational pressures. However, integrating primary care and behavioral health services and systems can increase patient volume by creating a single access point for current and potential clients who will benefit from the broader range of services, as well as the ability for providers to bill for multiple services.

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[137] Bing, E.G., et al. (2001). Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. *Archives of General Psychiatry,* 5(8): 721-728.
[138] HRSA HIV/AIDS Bureau. (May 2009). *HRSA Care Action: Mental Health Matters*. Accessed at http://hab.hrsa.gov/newspublications/careactionnewsletter/may2009.pdf
[139] National Center for Chronic Disease Prevention and Health Promotion. *Mental Health and Chronic Disease Brief*. Accessed at http://www.cdc.gov/nationalhealthyworksite/docs/issue-brief-no-2-mental-health-and-chronic-disease.pdf
[140] Rotella, F. & Mannucci, E. (2013). Depression as a risk factor for diabetes: a meta-analysis of longitudinal studies. J Clin Psychiatry, 74(1):31-7.

Project Description
We are at a critical point where the failure to integrate behavioral and physical health care results in suboptimal outcomes. People with serious mental illness die 15-25 years earlier on average than the rest of the population. The leading contributors to this disparity are chronic, co-occurring physical illnesses, which are not prevented or are not being treated adequately.[141] Some of the small primary care, substance use and mental health providers currently serving this patient population are not yet ready to deliver fully integrated, patient-centered care, a necessary element of NCQA Patient Centered Medical Home (PCMH) 2014 recognition and a requirement of DSRIP. Supporting and building the infrastructure to integrate these providers is crucial to ensuring that PPS networks have adequate capacity to deliver better care and improve the health of SMI/SUD populations.

The programs described below (Model A and B) address these important issues by enabling the organizations to become financially viable, provide integrated behavioral health/primary care services to their patients, improve clinical outcomes and reduce avoidable hospital and emergency room use. The recommended projects are powerful in part because they rely on both technical assistance and a Learning Collaborative approach to help targeted organizations move through a set of shared challenges that, once addressed, will enable them to better meet consumers' needs, achieve DSRIP goals and become more robust organizations.

The Learning Collaborative approach, originally developed by the Institute for Healthcare Improvement (IHI), is a short-term learning system that brings together project teams to seek improvement on specific areas of operations. Learning Collaboratives have been effectively used with organizations transforming into PCMHs, addressing issues of access and capacity, implementing the chronic care model for specific clinical conditions (HIV/AIDS, Diabetes, Cardiovascular disease, etc.), and integrating behavioral health and primary care services. The Learning Collaboratives described below involve a combination of in-person learning sessions, customized technical assistance and supporting virtual training designed to "meet the practices where they are" and help them to reach behavioral health and primary care integration goals.

AC, The Coalition and the Primary Care Development Corporation (PCDC) partnered to develop these model projects for customization and implementation across the network of NYS PPSs. The Coalition and PCDC, with their respective expertise in behavioral health and primary care, have years of experience implementing successful learning collaboratives. Both organizations may be available to provide technical assistance to the organizations implementing the PPS's Learning Collaborative.

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[141] Colton, C.W., Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis [serial online]*. Accessed at http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

Model A: Developing New Models of Community-based Integrated Care Delivery
This will emphasize the development of robust collaborative service agreements and mergers among small organizations serving consumers with SMI, SUD and physical health care needs. The project will involve a period of "matchmaking" among primary care providers and behavioral health providers followed by the development of business plans for each participating organization, which may start with shared agreements or even merger possibilities. A learning collaborative (as described below) will support the integration of primary care and behavioral health services. By partnering or merging, both the behavioral health organizations and the primary care practices will access new patients, grow their operations, and strengthen their revenue streams so they can better serve their patients and achieve DSRIP goals.

Target Organizations. This project is designed for small agencies within a PPS or across multiple PPSs within a geographic area serving SMI and/or SUD population(s). These organizations serve key subpopulations and are essential community assets that provide critical culturally and linguistically appropriate services. The Learning Collaborative will assist PPS Leads in identifying agencies operating Article 31, 32 and 28 clinics with the infrastructure, willingness and time to participate and who express strong commitment to the project goals. It will be made clear to the potential participants that executive and senior staff leadership must take part in the business planning process.

Project Phases and Timeline. This project will be implemented over the 5 years of DSRIP and will assist agencies in achieving their organizational goals and moving to an integrated model of care that is consistent with PCMH and DSRIP goals. The four phases of this project are described briefly below:

Phase 1 – (DSRIP Year 1: 4 months) With the support of the Learning Collaborative, the PPS leads will assess capacity and needs, determine criteria for participation, and engage appropriate organizations for participation in this project. The eligibility criteria will account for PPS needs and recognize the need to support agencies based on size, population served, financial model and commitment to participation.

Phase 2 – (DSRIP Year 1: 5 months) This period will involve collaborative learning to explore models of integration and potential partnership relationships. Participants will explore and identify promising practice models for shared and 3rd party provision of administrative services. In addition, the Learning Collaborative will offer targeted business planning consultations to the selected participants providing the agency specific cost benefit and qualitative analysis for outsourcing some or all of their administrative functions. Agency-specific analysis will make it easier for participating agencies to pinpoint the most fruitful initial changes, and to quickly educate their Boards and staff about the necessity for timely action. The end product will be a business plan detailing the options for and benefits of a more efficient business model. Topics to be addressed by agency teams during this phase will include: structure for integration including governance, memoranda of understanding, financial feasibility and meeting regulatory requirements. By the end of this period, participating agency teams (SMI, SUD and primary care) will have articulated

their preferred strategic model (collaboration, shared services, merger, etc.) and will have written formal agreements between partner organizations.

In addition to working with participant teams to develop a business plan, this period will also involve reaching out to agency Boards of Directors to ensure they understand the business plan and accept the proposed new strategic model (collaboration, shared services, merger, etc.).

Phase 3 – (DSRIP Year 2) Teams will use the Learning Collaborative approach to implement their desired model of integration. The Learning Collaborative will leverage expertise in the field as well as participant site's experiences. It will provide a platform for sharing successes and lessons learned across organizations.

Working from the Business Plan, and through the Learning Collaborative, agencies will begin to develop options that will have an immediate and measurable impact on administrative cost savings and more efficient operations of the clinics, most likely focusing on claims and billing, appointment scheduling, documentation of services and outcomes, and IT services. This phase will culminate in the launching of one or several options for sharing and/or outsourcing certain administrative functions/ systems, and will lead to access of more sophisticated software systems, financial/billing expertise, more efficient appointment scheduling systems and more. Topics to be addressed by agency teams during this implementation phase will include:

- Co-location of primary care and behavioral health services
- Integrated evidence-based standards of care including medication management and care engagement processes
- Documenting in electronic health records (EHRs)/health information exchange, the quality and outcome goals and transitions of care between providers. Special attention will be paid to making effective use of HIT to support these efforts.

HIT is still in its early stages with respect to integrating primary care and behavioral health. The project will seek partnerships with vendors to explore the feasibility of included shared medical records, data exchange, and care plans for targeted patients. This phase of the project will also involve two check-in sessions with agency leadership to discuss progress on merger, collaboration and shared services.

Phase 4 – (DSRIP Year 3-5): In DSRIP Year 3, the Learning Collaborative approach will be used to assist all of the (now integrated) organizations to transform their primary care practices to NCQA PCMH 2014 level 3. DSRIP Years 4-5 will focus on continuous quality improvement, sharing best practices and supporting the organizations to achieve outcome goals and reduce avoidable hospitalizations by 25%.

Model B: Optimization of Multi-Licensed Providers
This project is intended for agencies within a PPS holding at least two relevant NYS licenses (Department of Health (DOH), OASAS, OMH) but are not currently operating as a fully integrated provider of behavioral health and primary care services. This could be occurring

because licenses do not allow for the delivery of multiple services in the same facility, or that regulations act as an impediment to achieving full integration. This project will support such agencies to build their internal capacity and work with the state to obtain waivers to provide more integrated services to their current and potential new patient populations.

Although these agencies provide critical services to consumers with complex behavioral and physical disorders: failure to truly integrate care, results in consumers frequenting emergency rooms/departments (ER/Ds) and hospitals unnecessarily. The State's Integrated Licensure Project recognized the potential benefits of fully optimized, multi-licensed providers serving SMI/SUD populations with concomitant physical disorders, like diabetes, heart disease, high blood pressure, etc. Consumers with serious SMI/SUD are also too often re-hospitalized for their physical illnesses. These populations would be best served by a single, integrated, point of access for all of their required services. This project was implemented in nine hospitals, but in order to reach DSRIP goals, integrated licensure and services must also be prioritized in local communities by fully integrating community-based providers into the healthcare delivery system. Assistance in developing integrated treatment plans, improving the exchange of clinical information, enhancing care through Health Home optimization, engagement and linkage across the system can be achieved through the Learning Collaborative. With optimized licensures, additional care coordination resources and training, multi-licensed providers can ensure comprehensive services, an integrated treatment plan and clinical record system, better care coordination and outcomes, consumer education and ultimately a reduction in avoidable hospital use.

Target Organizations. This project is designed for small- or medium-sized agencies within a PPS or across multiple PPS's with at least two licenses seeking either to add an additional license or to more fully integrate the multiple licenses that they already have in place. The optimization of multi-licensed providers will ultimately result in reduced administrative costs, a single point of access for consumers with multiple service needs and long-term reduction in avoidable hospital use.

Project Phases and Timeline. This project will be implemented over the 5 years of DSRIP and will assist agencies in achieving their organizational goals and moving to an integrated model of care that is consistent with PCMH and DSRIP goals. The four phases of this project are described briefly below:

Phase 1 – (DSRIP Year 1 – 3 months) PPS leads, with technical assistance from PCDC and The Coalition will define criteria and select sites to be included in the Learning Collaborative. Agencies selected must be committed to working on optimizing licenses to provide consumers with a single point of access, streamlined operations and a new model of integrated care to better serve their patients comprehensive health needs.

Phase 2 – (DSRIP Year 1 – 6 months) This is the re-engineering and redesign phase. Participating sites will use the Learning Collaborative modality, to design their new model of integrated care, develop a detailed project plan, apply for new licenses required and

define the resources required to implement their redesign plans. There will be a specific focus during this phase on redesigning organizations so that they are able to serve as a single point of access to the health care system for their consumers. Participating sites will complete detailed project implementation plans during this phase of the Learning Collaborative.

Phase 3 – (DSRIP Year 2) During this phase the sites will begin to launch the plans they developed during Phase 2 of this Learning Collaborative. Teams will use the Learning Collaborative approach to work through the challenges of implementing their desired model of integration. The Learning Collaborative will draw out individual participant site's experiences and provide a platform for sharing best practices across teams. Topics to be addressed by agency teams during this implementation phase will include: co-location of primary care and behavioral health services, collaborative evidence-based standards of care including medication management and care engagement processes, documenting in EHRs, quality and outcome goals. PPS participants will be supported by the Learning Collaborative to navigate the regulatory environment applicable to providing such services.

The technical assistance offered through the Learning Collaborative will identify opportunities for participants to contract for administrative services, and/or provide support for development of collaborative member partnerships. The Learning Collaborative will offer participants at least six months of staff/consultant business planning/technical assistance for their specific projects. This phase will culminate in the launching of one or several options for:
- Merging, sharing and/or outsourcing certain administrative functions/systems
- Access to more sophisticated software systems
- Access to financial/billing expertise, more efficient appointment scheduling systems and more

The result of this phase of Learning Collaborative work will be more integrated organizations, optimizing all of their licensure to provide their consumers with more comprehensive services to meet their needs.

Phase 4 – (DSRIP Year 3-5) In DSRIP Year 3, the Learning Collaborative approach will be used to assist all of the more fully integrated organizations to transform to NCQA PCMH 2014 level 3. Years 4-5 will focus on continuous quality improvement of systems, care planning, electronic medical records, sharing best practices and supporting the organizations to achieve outcome goals and reducing avoidable hospitalizations by 25%.

The following chart summarizes the program components and general timeline of both Learning Collaboratives:

DSRIP Timeline	Model A: Develop New Models of Integrated Care	Model B: Optimization of Multi-Licensed Providers
Phase 1 (Year 1, 3 months)	Recruit eligible providers and access their capacity and needs	
Phase 2 (Year 1, 6 months)	Create plans to integrate services and increase operating efficiency between providers	Create plans to optimize integration and increase operating efficiency within the organization
Phase 3 (Year 2)	Begin integrating services and/or facilitating mergers between providers	Begin implementing integration plans towards achieving single point of access for clients
Phase 4 (Year 3-5)	Achieve NCQA PCMHM 2014 Level 3 and conduct continuous quality improvement of systems to reduce avoidable hospitalizations	

Meaningful Impact/Evidence Base

State Medicaid agencies across the country are seeking to make administrative, purchasing, and regulatory reforms in order to promote integrated care for Medicaid beneficiaries with comorbid physical and behavioral health needs.[142] Health care providers and payers are exploring a range of promising approaches to better integrate physical and behavioral health care for Medicaid beneficiaries, from relatively modest steps to coordinate care between the two systems, to more ambitious efforts to implement a single integrated system of care.[143] Colocation of general medical and mental health services is one modal that has been associated with significantly fewer preventable hospitalizations.[144]

A recent analysis commissioned by the American Psychiatric Association (APA) found that health care spending for patients with comorbid behavioral health conditions is 2.5 to 3.5 times higher than for those without such problems, with most of the increased spending attributable to treatment of medical conditions, creating a large opportunity for savings through integration of behavioral and medical services.[145] The authors of the review estimate that 9-16% of this total additional spending could be saved through effective integration of care.[146] Collaborative care programs have been found to be at least cost neutral, with most studies indicating savings, including one comparison of clinics practicing

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[142] D. Bachrach, et al. (2014). *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment.* The Commonwealth Fund, New York, NY.

[143] Kaiser Family Foundation. (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models.* February 2014 Issue Brief. Retrieved from: http://kff.org/medicaid/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicaid-models/

[144] Pirraglia, P.A., et al. (2011). Co-located general medical care and preventable hospital admissions for veterans with serious mental illness. *Psychiatric Services*, 62: 554–557.

[145] Melek, S.P., et al. (2014). Economic impact of integrated medical-behavioral healthcare: Implications for psychiatry. Report prepared by Milliman, Inc. for the American Psychiatric Association. Retrieved from: http://www.psychiatry.org/practice/professional-interests/integrated-care/integrated-care-reconnecting-the-brain-and-the-body

[146] Ibid.

collaborative and usual care that found collaborative care patients were 54% less likely to use the emergency department, and 49% less likely to use inpatient psychiatric care.[147]

AC's own approach to integrated care – working with physicians and community-based providers to address medical, behavioral, psychosocial, care management and housing needs – has significantly decreased health care expenses, including a 74% reduction in inpatient admissions/re-admissions and a 63% reduction in ED visits during the period 2008-2011.[148] This integrated care approach appears to support VL suppression for PWH: among adult PWH enrolled in all SNPs in 2012, 71% of all patients and 83% of patients prescribed ARVs were virally suppressed at last viral load test.[149]

Additionally there is growing concern that small, community-based providers are unable to remain financially solvent in the rapidly changing healthcare environment. The Coalition of Behavioral Health Agencies, which served on AC's PAC and as a consultant to the Integrated Care subcommittee, reported dozens of its members closing their doors in the last five years. Since 2010 over 15 member organizations either closed down completely or rapidly scaled back their services. For example, South Bronx Mental Health Services shut down its operations after 45 years in the community.[150]

Even if new organizations and clinics open and replace the ones that closed, the loss of organizations that provided culturally competent and linguistically correct services throughout the city is a major concern. With the ACA and as more individuals enroll into Medicaid, there is growing need to maintain and strengthen the niche, community-based providers vital to the provision of integrated, culturally-relevant care and also the successful implementation of DSRIP.

Cost/Benefit Analysis
Creation and operation of the Learning Collaborative is a valuable – if not critical – stepping stone in fulfilling the DSRIP goal of achieving more widespread and more effective integration of behavioral health and physical health services and fostering a successful future for small safety net providers. The costs of operating the Learning Collaborative are estimated to total $1 million per PPS over a five-year period. The distribution of these costs by task area and by year is summarized in the chart below.

Note that as these integrated partnerships take form, additional capital cost requirements may emerge (such as investments in enhanced information systems technologies). The nature and amount of these investments cannot be specified at this time but may well

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[147] Ibid.
[148] Personal communication with Dr. Jerome Ernst, Chief Medical Officer, Amida Care.
[149] NYSDOH AIDS Institute. (CY 2012). *Quality of Care Program, Performance Summary: HIV Care of Adult Patients Enrolled in SNP.*
[150] Information provided by Patricia Goldstein, Chief Operating Officer, The Coalition of Behavioral Health Agencies, Inc.

warrant inclusion in the request for DSRIP funding to secure/ensure providers' successful collaboration.

The offsetting medical cost benefits specifically *attributable* to the Learning Collaborative cannot be quantified accurately. Clearly, longer range cost efficiencies are available through improved integration of behavioral and physical health and a more efficient "whole person focus" in the health care delivery system. While a specific "benefit" figure has not been calculated, it is anticipated that this Learning Collaborative initiative represents a highly valuable, cost-effective investment in fostering the needed transformation.

Fixed Cost Estimates

Year	Task Area	Expense Area	Per PPS Cost
Year 1	Assess capacity and needs, determine criteria for participation, and engage appropriate organizations for participation	Consultant to identify/recruit organizations	$25,000
Year 1	Participants will explore and identify promising practice models for shared and 3rd party provision of administrative services.	Consultant to organize/facilitate monthly meetings, take notes, etc.	$100,000
Year 1	Targeted business planning, and cost benefit and qualitative analysis for outsourcing some or all of the administrative functions.	Consultant to conduct analyses	$100,000
Year 1	Business plan document detailing the options and benefits	Consultant to prepare business plan document	$75,000
Year 2	Launch one or several options for sharing and/or outsourcing certain administrative functions/systems	Consultant to assist in developmental activities as needed	$150,000
Year 2	Operate the partnership, group purchasing, etc. initiatives	Consultant to assist in operational activities as needed	$150,000
Year 3	Assist all of the (now integrated) organizations to transform their primary care practices to NCQA PCMH 2014 level 3.	Consultant to assist in PCMH Certification activities as needed	$250,000
Years 4-5	Support continuous quality improvement, sharing best practices, business success	Consultant to assist in ongoing evaluation, support as needed	$150,000
TOTAL			**$1,000,000**

V. Advocacy Efforts

Advocacy has been a central component of AC's DSRIP process. AC has worked to advance efforts that will have a meaningful impact on the chronic illness sector.

Membership in Multiple PPSs: AC participated in the PAC of multiple DSRIP PPSs to support their efforts and forward recommendations, priorities and domain activities that are detailed in this report.

Facilitation of Cross-PPS HIV/AIDS Workgroup: AC facilitated the development of a NYC PPS-wide HIV/AIDS working group committed to the continued planning, implementation and operations of Domain 4.c.ii projects. Seven PPSs (Health and Hospital Corporation, Community Care of Brooklyn, Bronx Partners for Healthy Communities, Lutheran Medical Center, Bronx-Lebanon Hospital Center, New York Hospital of Queens and Mt. Sinai Hospitals) participated in the workgroup and agreed "to actively participate in the Domain 4 HIV workgroup, collaborate on select projects, identify interventions or activities that would benefit from joint funding, identify promising practices and determine how they can be adapted by the PPSs, and serve as a forum to provide guidance and feedback on the progress of implementation." Doug Wirth, President/CEO of Amida Care, chairs the workgroup and AC plans to remain actively involved during the implementation phase of DSRIP, offering its expertise and acting as a coordinating body among the PPSs. In addition, consultant support was provided through Manatt and KPMG.

Leadership on NYS EtE Task Force: Numerous PAC members serve on the State's EtE Task Force, including Doug Wirth, President/CEO of AC and Charles King, President/CEO of Housing Works who serves as co-chair of the State Taskforce. The End of AIDS Subcommittee developed eight project recommendations that were submitted to the Taskforce.

Participation in HIV/AIDS Kitchen Cabinet Workgroup: AC has been supporting the efforts of community efforts, including an ad hoc community group called the "Kitchen Cabinet". The group has developed 70 recommendations that were submitted to the EtE Task Force.

Meetings with Policymakers: AC met with policymakers as part of its commitment to government engagement and collaboration. Frequently Doug Wirth, Jason Lippman, AC's Director of Public Policy and Government Relations, and PAC members briefed city and state lawmakers on DSRIP progress. AC viewed these face-to-face meetings as a vital means to build strong political support for achieving DSRIP goals.

Testifying at Public Meetings: AC provided testimony at planning forums convened by the NYS OMH, OASAS and NYC DOHMH; as well as NYC Council's policy oversight hearings.

VI. Appendix

Table of Contents

Document Name	Author	Page	Summary
AC's PPS PAC Calendar	Amida Care	84	Calendar of all PAC meetings
AIDS-FREE NY 2020 Materials	Housing Works	86	Summary of HIV/AIDS "Cascades" for NYS and NYC
Preliminary NYS Health Home Rollout Plan	SDOH	87	Preliminary plan for Health Home implementation including target population information
State of Medicaid Spending: High Cost Enrollees	SDOH	90	Provides a breakdown of Medicaid spending on multiple populations experiencing chronic illness
DSRIP and Requests for Regulatory Relief	CHCANYS	92	Regulatory and policy relief suggestions that may be requested, depending on the PPS and its proposed projects
Retention to Care Unit	Amida Care	101	Summarizes AC's Retention to Care unit, which includes peer workers as community health outreach workers and navigators
Peer Support Services for Individuals With Serious Mental Illness: Assessing the Evidence	Chinman et al	103	Assesses the published research on the effectiveness of peer programs
State Medicaid Director Letter on Peer Support Services	Dennis G. Smith	116	Letter from the State Medicaid Director explaining that peer services are an evidence-based model of care for SMI and SUD populations, and that peer services could be built into state plans
Academy of Peer Services Course Catalog	OMH	119	Academy of Peer Services is OMH's training and credentialing program for peer specialists. The course catalog is included here as a reference to the possible topics that may be incorporated.
Written comments prepared for NYC Health Resource Administration (addressing 2014 Biennial HRA Employment Plan)	New York HIV Employment Network	134	Written comments addressing proposed policy changes impacting PLWHA in NYC

The Impact of Implementing a Financial Incentive Program for Viral Suppression on the Clinic Environment: Findings from a Qualitative Sub-study of HPTN 065	Greene et al	137	Describes a qualitative evaluation of the HIV Prevention Trials Network (HTPN) 065 study of financial incentives for viral load suppression initiatives
Medical Respite Research	National Health Care for the Homeless Council	138	Overview of published medical respite research
Renters and their Home & Homeowners and their Homes	NYU Fuman Center	140	Two inforgraphics illustrating the housing crisis in New York City
Technical Assistance to Improve Patient Outcomes in the Crescent City Beacon Community	Primary Care Development Corporation (PCDC)	142	Published case study of a PCDC-led learning collaborative
Integrating Physical and Behavioral Health Care: Promising Medicaid Models	The Henry J. Kaiser Family Foundation	153	Issue brief examining five promising Medicaid approaches to integrating physical and behavioral health care. The five approaches are universal screening, navigators, co-location, Health Home and system-level integration of care
Caring for Brain and Body: Integrating Care for Adults with Serious Mental Illness in New York State	Rand Corporation	165	Research brief exploring policy recommendations to improve integrated care for adults with serious mental illness
HRSA Care Action: Mental Health Matters	HRSA	167	Issue brief detailing HIV Costs and Services Utilization Study about people living with HIV and co-morbid behavioral health conditions

Amida Care DSRIP PPS PAC Committee Meetings
August-December 2014

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AUGUST	8	9	10 Steering Committee	11	12
SEPTEMBER	2	3	4	5	6
	8	9	10	11	12
	15	16 End of AIDS Subcommittee	17	18 Consumer Workforce Development	19
	22	23 Crisis Bed Diversion & Temporary	24	25 Rosh Hashanah	26
	29 Integrated Care Subcommittee	30	1	2	3
OCTOBER	6	7 Crisis Bed Diversion & Temporary	8 End of AIDS Subcommittee	9	10 Consumer Workforce Development
	13 Columbus Day	14	15 Steering Committee	16	17 End of AIDS Subcommittee
	20	21 Integrated Care Subcommittee	22	23	24
	27	28	29	30 Integrated Care Subcommittee	31 Consumer Workforce Development

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
NOVEMBER	3	4	5	6	7
		End of AIDS Subcommittee			Shared draft recommendations with KPMG
	10	11	12	13	14
	Crisis Bed Diversion & Temporary			Integrated Care Subcommittee	Consumer Workforce Development
	17	18	19	20	21
			Steering Committee		
	24	25	26	27	28
	Recommendations disseminated to PPSs			Thanksgiving	
DECEMBER	1	2	3	4	5
			AC Member Adivsory Council Meeting		
	8	9	10	11	12
		CBD-TH & End of AIDS Subcommittees		Integrated Care Subcommittee	Consumer Workforce Development
	15	16	17	18	19
		Steering Committee			
	22	23	24	25	26
	Project Plan Due				
	29	30	31		

AIDS-FREE NY 2020

NEW YORK STATE HIV CONTINUUM OF CARE

Out of **154,000** New Yorkers living with HIV:

86%

56%

48%

44%

132,000 are aware of their HIV+ status

86,000 are linked to HIV care

75,000 have stayed in HIV care

68,000 are virally suppressed, or undetectable
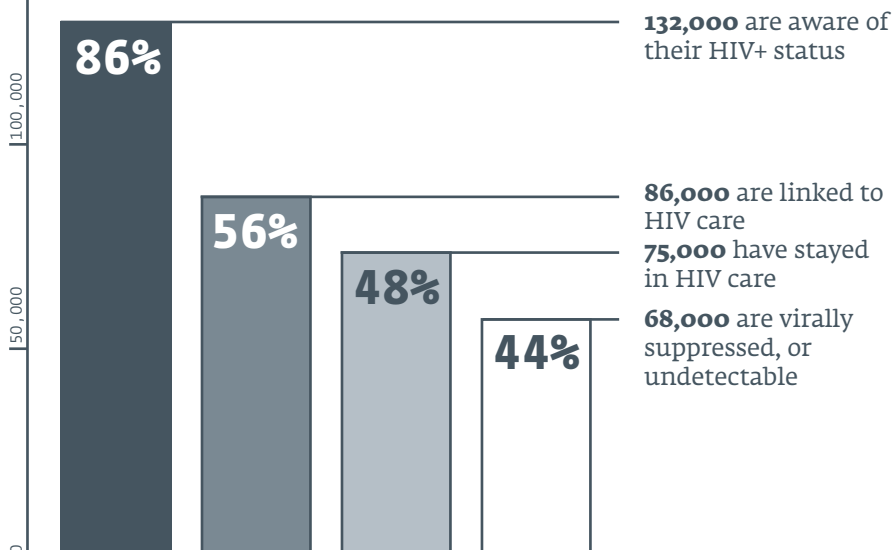
NEW YORK CITY HIV CONTINUUM OF CARE

Out of **133,635** New York City residents living with HIV:

86%

73%

55%

51%

41%

114,926 are aware of their HIV+ status

97,940 are linked to HIV care

72,918 have stayed in HIV care

67,624 are receiving treatment**

55,453 are virally suppressed or undetectable*

* or <200 copies/ml
** presumed ever started on ART
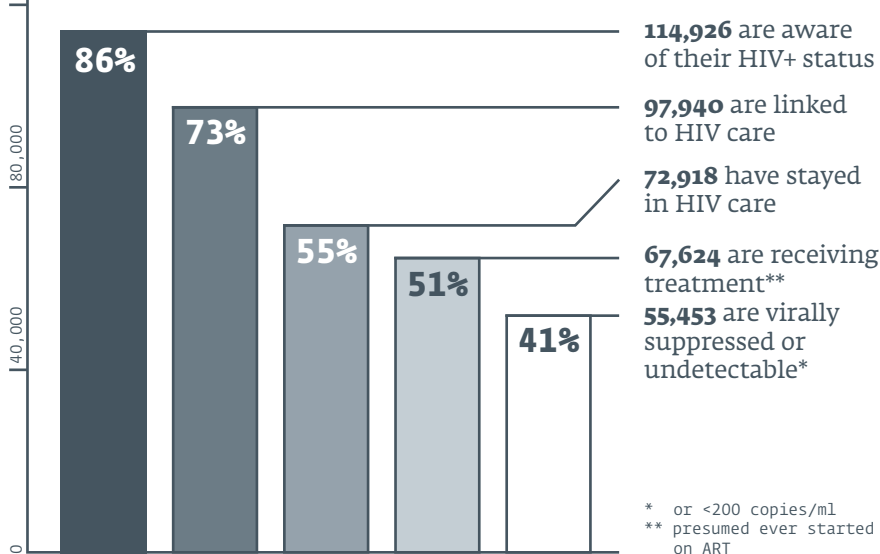
What is AIDS-FREE?

Housing Works' AIDS-FREE NY 2020 campaign is a collaborative, multi-year initiative committed to ending the AIDS epidemic in New York State by the year 2020. With recent advancements in science and data, we can end AIDS, even without a cure, by reducing annual new HIV infections in NY State—from 3,000 to 750 by 2020—and by bringing those living with HIV/AIDS to optimal health. An HIV+ person on treatment who renders the virus "undetectable" is not only healthy but also virtually unable to transmit HIV to others. By combining effective biomedical strategies with interventions addressing social drivers of the disease, we can bring HIV below epidemic levels statewide by 2020 by fighting for...

→ **21ST-century testing & enhanced data sharing** that increases our ability to diagnos HIV early, get HIV+ persons into care while they're healthy, and help all persons at risk of and living with HIV benefit from new therapies.

→ **Prevention & treatment** that reduce new HIV infections— education, condoms, PrEP, PEP, antiretrovirals & primary care.

→ **Utilization of the HIV continuum of care** to bridge existing gaps and maximize the speed, proportion & the number of people able to achieve and maintain HIV viral suppression (undetectable status).

→ **Social justice work** that ensures housing and other support services, ends HIV stigma, and ends disparities in incidence and prevalence for every key population.

→ **Shared commitment & strategic partnerships**, including the support of government leadership and policies and aligned health and development efforts.

For more on the Housing Works' AIDS-FREE Campaign:
http://info.housingworks.org/aidsfreecampaign

For more about Housing Works' advocacy efforts:
http://www.housingworks.org/advocate/

HOUSING WORKS

Preliminary NYS Health Home Rollout Plan

The State has organized the Health home population into four mutually exclusive categories of illness/disability. This model allows the State to tailor a health home care management approach taking into account the unique service delivery structures that each of these patient groups is currently receiving their care from. The overarching goal is to build care management that is a close to patient service delivery as possible.

Below is a graphic on these four populations will some Medicaid data on each:

HH Populations - 2010

- **Developmental Disabilities**
- **52,118 Recipients**
  - **$10,429 PMPM**

- **Long Term Care**
- **209,622 Recipients**
  - **$4,509 PMPM**

Total Complex
N=976,356
$2,338 PMPM
52% Dual
51% MMC

10% MMC

18% MMC

$25.9 Billion

$6.3 Billion

$2.4 Billion

- **Mental Health and/or Substance Abuse**
- **408,529 Recipients**
  - **$1,370 PMPM**

- **All Other Chronic Conditions**
- **306,087 Recipients**
  - **$698 PMPM**
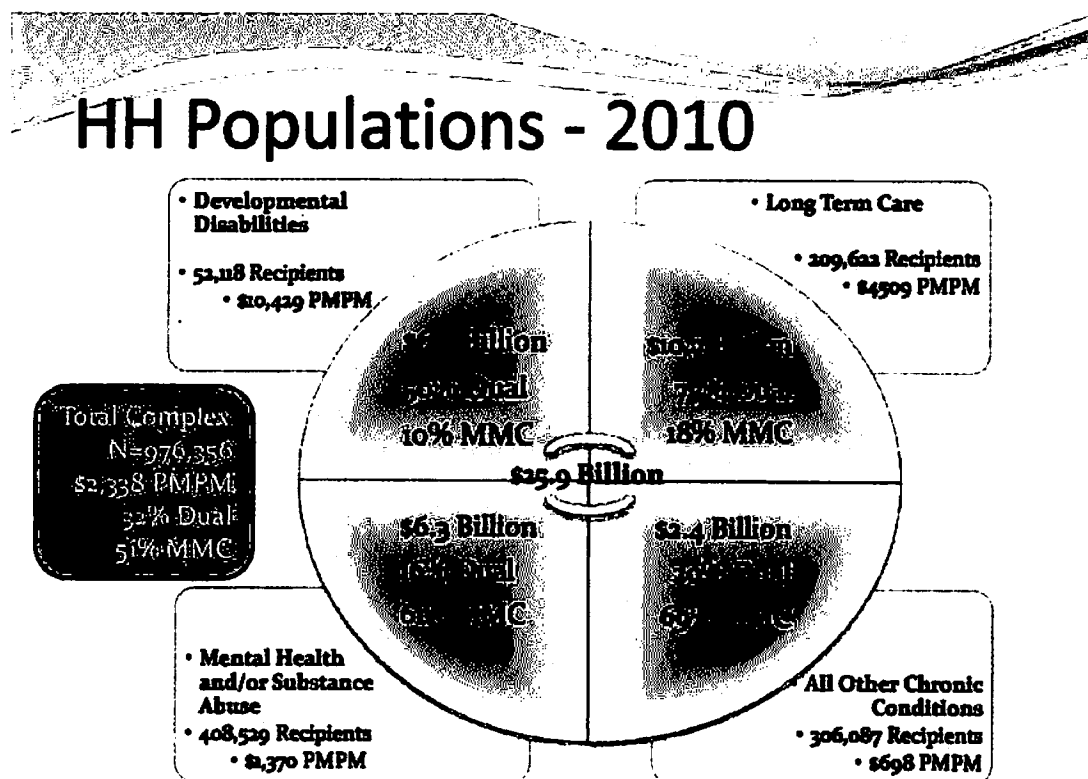
Overall Rollout plan

The first wave of health home implementation will include the bottom two quadrants Mental Health/Substance abuse and the Other Chronic medical. The detailed roll out information for those two groups is included below.

In the second wave of health home implementation the Long Term Care population is targeted. The long term care health home approach includes two potential components both of which are still under development. The first component is to build a health home from within the existing managed long term care plan (MLTCP) structure and leverage and improve the existing care management that exists inside of that program. The other long term care component would include building care management networks of nursing homes and non-institutional providers to manage services (potentially both Medicaid and Medicare services). Both of these long term care components are the subject of ongoing discussions between State staff and CMS and the Innovations Center on how best to implement a health home for these populations. The MLTCP model could be implemented rather quickly.

In the third wave of health home implementation the developmentally disabled population is targeted. The development disabilities population is currently served in an existing targeted care management (TCM) program which will likely convert to health home after work is more completed on a very large Medicaid waiver that is being developed for this population.

Table 1: Preliminary snapshot of the State's overall HH role out plan:

Population	Preliminary Start Date for HH	Potential Members to Enroll (High and Mid Cost) *
Mental Health/Substance Abuse	Adults January 2012 (children later)	191,000
Other Chronic Medical	Adults January 2012 (children later)	143,000
Long Term Care	Spring 2012	98,000
Developmental Disabilities	Fall 2012	24,500
Total		456,500

* (Actual numbers will be based on capacity and further assessment of need for HH services – assumes 47 percent of each pop is high to mid cost – based on Analysis of MH/SA and Other Chronic Group expenditure – analysis is being refined for each population)

Health Home First Wave – Mental Health/Substance Abuse/Other Chronic Medical

The first wave of Health Home enrollment targeted to the Mental Health/Substance Abuse and Other Chronic medical groups in NYS will be done in three phases by county of recipient residence.

Table 2: Wave One Health Home Rollout by SFY and FFY - Mental Health/Substance Abuse/Chronic Medical Cohort

Health Home Enrollment Phasing			Phase Tier									Total
			Phase 1			Phase 2			Phase 3			
State Fiscal Year	State Quarter	FFY & Qrt	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	
SFY '11-'12	Qrt 1	FFY '10-'11 Qrt 3	-	-	-	-	-	-	-	-	-	-
	Qrt 2	FFY '10-'11 Qrt 4	-	-	-	-	-	-	-	-	-	-
	Qrt 3	FFY '11-'12 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '11-'12 Qrt 2	3,715	10,661	16,401	-	-	-	-	-	-	30,778
SFY '11-'12 Total			3,715	10,661	16,401	-	-	-	-	-	-	30,778
SFY '12-'13	Qrt 1	FFY '11-'12 Qrt 3	9,289	26,652	41,003	3,663	10,510	16,168	-	-	-	107,285
	Qrt 2	FFY '11-'12 Qrt 4	-	-	-	9,157	26,274	40,421	607	2,314	3,560	82,533
	Qrt 3	FFY '12-'13 Qrt 1	5,573	15,991	24,602	-	-	-	2,016	5,765	8,901	62,869
	Qrt 4	FFY '12-'13 Qrt 2	3,715	10,661	16,401	5,494	15,764	24,263	-	-	-	76,289
SFY '12-'13 Total			18,577	53,305	82,007	18,313	52,548	80,842	2,623	8,100	12,461	328,976
SFY '13-'14	Qrt 1	FFY '12-'13 Qrt 3	1,858	5,330	8,201	3,663	10,510	16,168	1,210	3,471	5,340	55,751
	Qrt 2	FFY '12-'13 Qrt 4	-	-	-	1,831	5,255	8,084	607	2,314	3,560	21,651
	Qrt 3	FFY '13-'14 Qrt 1	1,858	5,330	8,201	-	-	-	403	1,167	1,780	18,729
	Qrt 4	FFY '13-'14 Qrt 2	1,858	5,330	8,201	1,831	5,255	8,084	-	-	-	30,559
SFY '13-'14 Total			5,573	15,991	24,602	7,325	21,019	32,337	2,420	6,943	10,681	126,891
SFY '14-'15	Qrt 1	FFY '13-'14 Qrt 3	-	-	-	1,831	5,255	8,084	403	1,167	1,780	18,511
	Qrt 2	FFY '13-'14 Qrt 4	-	-	-	-	-	-	403	1,167	1,780	3,340
	Qrt 3	FFY '14-'15 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '14-'15 Qrt 2	-	-	-	-	-	-	-	-	-	-
SFY '14-'15 Total			-	-	-	1,831	5,255	8,084	807	2,314	3,560	21,851
Total			27,866	79,957	123,010	27,470	78,822	121,263	6,049	17,356	26,702	508,498

* Low Cost Members are not slated for health home enrollment under the current plan but this could change as the project progresses and as high and mid cost members are assigned in a given region.

Wave One HH Member Assignment Algorithm

Eligible health home members will be assigned directly to approved HH networks by the State and will be assigned through health plans for members enrolled in Medicaid Managed Care. Initial assignment to State approved Health Home providers will be based on:

1. Higher Predictive Risk for Negative Event (Inpatient, Nursing Home, Death)
2. Lower or no Ambulatory Care Connectivity
3. Provider Loyalty (Ambulatory, Case Management, ED and Inpatient)
4. Geographic Factors

The State has provided each managed care plan with a HH eligible list of patients sorted from highest to lowest predictive risk. The State is working on the development of Patient Rosters for each county in the wave one rollout that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the State and health plans will move down the list using provider loyalty and geography as markers for initial health home assignment. The details of this algorithm will be approved by all the State partners (DOH, OMH, AIDS Institute and OASAS) and will be recommended to health plans as one means of distributing members through intelligent assignment to each of the State approved health homes.

State of Medicaid Spending: High Cost Enrollees

975,000 Patients with Multiple Chronic Illnesses

Long Term Care

- 209K Recipients
- $10.5B/$4,500 PMPM

Issues: High Cost; Lack of Management; High Intensity LTC and IP Services without coordination

Chronic Medical

- 306K Recipients
- $2.4B/$695 PMPM

Issues: High Cost; Lack of Services Management; Lack of Physical Care Coordination

I/Developmental Disability

- 52K Recipients
- $6.4B/$10,500 PMPM

Issues: Very High Cost - Waiver and FFS Expense Is Growing Rapidly

Behavioral Health

- 408K Recipients
- $6.3B/$1,400 PMPM

Issues: High Cost; Socially Unstable, Lack of Services Management; Lack of BH and Physical Health Care Coordination

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Patient Flow

975,000 high cost/high need Medicaid enrollees

(1) Serious & Persistent Mental Health Condition

(2) Chronic conditions

(1) Chronic conditions at risk for 2° chronic
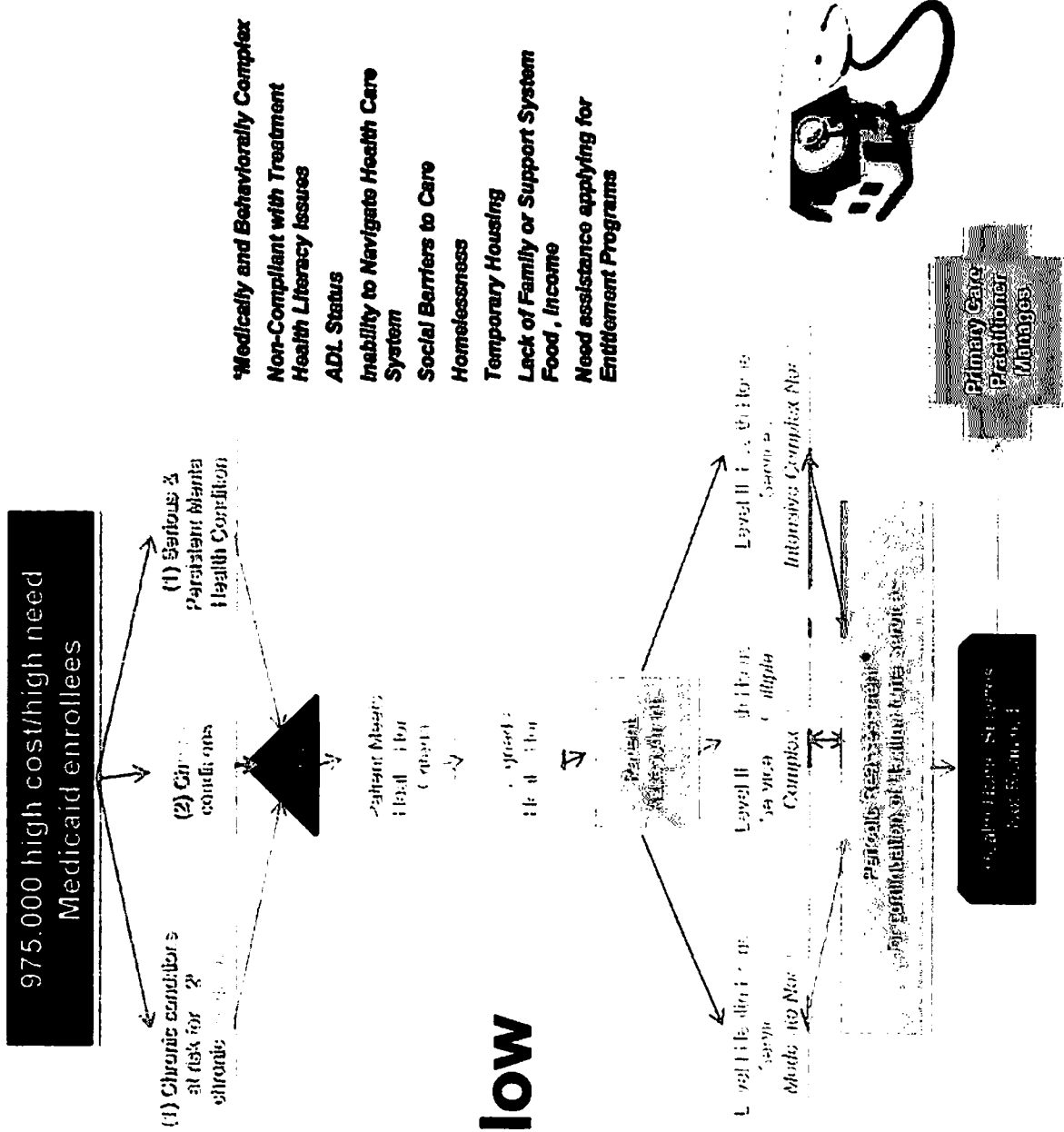
Medically and Behaviorally Complex

Non-Compliant with Treatment

Health Literacy Issues

ADL Status

Inability to Navigate Health Care System

Social Barriers to Care

Homelessness

Temporary Housing

Lack of Family or Support System

Food, Income

Need assistance applying for Entitlement Programs

Patient Needs Health Care Coaching

Level III ... Service Intensive Complex Nee...

Level II ... Service Complex

Level I Service Moderate Needs

Patient Self-Management

Primary Care Practitioner (Manager)
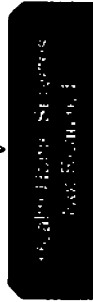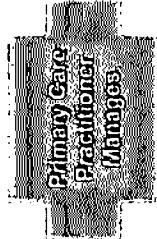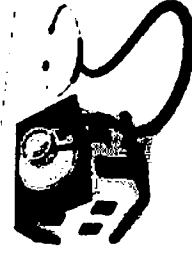
DSRIP and Requests for Regulatory Relief

The Delivery System Redesign Incentive Payment (DSRIP) program allows performing provider systems (PPSs) to request from the State waivers of regulations that would impede the PPS's ability to execute on their reform projects. The following document suggests the type of regulatory and policy relief that may be requested, depending on the PPS and its proposed DSRIP projects.

Please note that the regulations identified herein are intended to be illustrative; this is not intended to be an exhaustive list.

Certificate of Need (CON) Regulations and Processes
Many requirements defining actions that trigger a CON review are regulatory. The overarching principle for requesting waiver of CON regulations/requirements is that most, if not all, of the PPSs will engage in activities or transactions that require various levels of CON approval, which can be time consuming and constrictive – particularly if the PPS is engaged in transformative work that does not conform to traditional CON projects.

PPS Public Need and Financial Feasibility Reviews
As a general proposition, the PPS should argue that its component entities should be exempt from separate Public Need and Financial Feasibility reviews (both of which will be covered under State's review of the PPS). 10 NYCRR § 600.1 and Parts 670 and 700.

Assessment of PPS Capital Debt Component
With regard to the assessment of any capital debt component, the State should accept applicant descriptions of terms (rather than letters of interest), and conduct a streamlined review at the loan commitment stage. All loan assessments should be completed by DOH within 15 days of commitment; approvals should be granted no later than 15 subsequent days. 10 NYCRR Parts 600 and 700.

Alignment of CON Approvals and PPS Objectives/Financing
A PPS could request that the State exercise discretion in the use of limited life approvals that may be contrary to meeting the PPS's objectives and financing.

Expediting the CON Process
- *Generally:* The PPS should recommend that the Public Health and Health Planning Council (PHHPC) schedule bi-weekly videoconference meetings to accommodate any required approvals emanating from approved PPSs.

6/23/2014

- *Relocations:* Bed and service relocations between established providers in approved PPS should only require letter notification to DOH, and a maximum time frame of DOH approval of 15 days. This recommendation is modeled after 10 NYCRR 708.3. And 708.4 (appropriateness review procedures).
- *Facility and service closures:* A PPS might recommend replacing the 90-day DOH timeline with a maximum 30-day timeline. 10 NYCRR 401.3(g).

Construction projects (including new sites and blending of services licensed by different state agencies)

- *Level of CON review:* The PPS could request that this be limited to architectural review, with a 30-day maximum DOH turnaround. 10 NYCRR Part 600.
- *Self-certification:* Allowing use of self-certification for Architectural and other code compliance could help in expediting PPS projects. 10 NYCRR Part 610.
- *Expediting review:* Imposing a maximum 15-day DOH review for construction start approval. 10 NYCRR Part 600.
- *Pre-opening surveys:* A PPS should request a liberal use of self-certifications and waivers regarding these surveys, and should also request that DOH complete all such surveys within 15-days written notice to DOH. Additionally, a PPS should request that facilities be allowed to open while waivers to non-patient care areas are in process. The pre-opening survey regulation does not impose any timeframe within which DOH to complete the survey. See 10 NYCRR 710.9. The waiver provisions are in 10 NYCRR 711.9.

Multiple Agency Reviews and Approvals. A PPS should request that approvals required from multiple state agencies for the same project should be consolidated into one review process by the state.

Behavioral Health CON Regulations. Specific regulations governing authorization of construction, acquisition or operation of behavioral health facilities or services include the following, which a PPS should consider requesting waiver:

- 14 NYCRR Part 77 (governing physical plant standards for behavioral health facilities)
- 14 NYCRR Part 321 (regarding financing and constructing substance use disorder facilities)
- 14 NYCRR Part 521 (regarding financing assistance for capital construction or acquisition of behavioral health facilities)
- 14 NYCRR Part 551 (regarding expediting project reviews for OMH regulated facilities)
- 14 NYCRR Part 573 (regarding issuing operating certificates to OMH regulated providers)

6/23/2014

- 14 NYCRR Part 810 (regarding establishing, certifying substance use disorder services)
- 14 NYCRR Part 814 (regarding OASAS facility requirements)
- 14 NYCRR Parts 620 and 621 (CON Process and financial assistance for construction or other capital projects under OPWDD jurisdiction)
- 14 NYCRR Part 635-6 (Permitted capital costs and transactions with related parties for OPWDD regulated entities)

Regulations that Would Impede Integrated Models

Prohibitions Against Fee-Splitting (10 NYCRR § 600.9). This regulation prohibiting fee splitting or sharing in gross revenues of non-established entities should be waived with respect to the financial components of any agreements dictating the flow of dollars, such as distribution of DSRIP proceeds among PPS providers sharing a patient population.

Co-location. Given the focus of DSRIP on developing integrated delivery systems, particularly addressing integration of behavioral health and medical care, any PPS should request waiver of state regulatory impediments to the co-location of services (i.e., co-locating services licensed by DOH, OMH, OASAS, OPWDD and/ or private practices) to support PPS partnerships and implementation of DSRIP projects. For example, such waivers will ensure redirection away from the ED and reduce hospital admissions through availability of primary and secondary care. Additionally, because not all restrictions against co-location are imposed by the State, a PPS should request that the State petition CMS for the authority to waive its regulations pertaining to the co-location of services when it is deemed to be in the best interests of promoting the objectives of DSRIP. In addition to the CON regulations above, specific regulations that may pose barriers to co-location include:

- 10 NYCRR Part 83 (Shared Health Facilities)
- 14 NYCRR § 814.7 (governing spaces shared with substance use disorder services)
- 14 NYCRR Part 511 (standards and rules around personalized recovery oriented services (PROS))
- 14 NYCRR § 527.6 (rights of behavioral health IP patients to object to treatment)
- 14 NYCRR Part 587 (regarding standards and requirements for operating out patient behavioral health programs, including day treatment, partial hospitalization and other types of programs, and record retention/sharing of such programs)
- 14 NYCRR Part 599 (regarding standards and requirements for clinic treatment programs)
- 14 NYCRR Part 592 (Governing Comprehensive Outpatient Programs)

- 14 NYCRR Part 594 (Governing Operation of Licensed Housing Programs for Children and Adolescents with severe emotional disturbances)
- 14 NYCRR Part 595 (governing operation of residential programs for adults)
- 14 NYCRR Part 816 (governing IP and OP chemical dependence withdrawal and stabilization)
- 14 NYCRR Part 819 (governing standards, operation, staffing for chemical dependence residential services)
- 14 NYCRR Part 822-2 (governing outpatient chemical dependency and opioid treatment)
- 14 NYCRR Part 822-4 (regarding staffing, treatment plans, etc., for outpatient chemical treatment programs)
- 14 NYCRR Part 822-5 (regarding opioid treatment programs)
- 14 NYCRR Part 823 (governing standards, admissions, record keeping treatment plans of chemical dependency OP services for youth)

Data Sharing. There are various regulations that govern and restrict how health and behavioral information can be shared. A PPS should consider the following regulations and how they relate to, support or impede a DSRIP project that involves integrated systems.
- 14 NYCRR Parts 510 & 520 (accessing or correcting OMH records)
- 14 NYCRR Parts 803 & 804 (accessing OASAS records)
- 10 NYCRR §405.10 (Hospital records)
- 10 NYCRR § 751.7 (D&TCs)

Governance Models. Currently, entities and their governance models may be governed under Article 28 of the Public Health Law or Articles 31 or 32 of the Mental Hygiene law. A PPS, or entities' participation in a PPS may require a governance model, or changes to a governance model, that are beyond the scope of the traditional regulatory environment. Accordingly, a PPS or its component entities may choose to request the following types of relief.

- *For un-regulated PPS partners OR a new entity formed for the purpose of serving as the PPS (e.g., "New Company, LLC").* A PPS may ask that DOH only require self-certification of the NewCo PPS. For un-regulated PPS partners in any kind of PPS, a PPS could request that DOH allow self-certification of those partners for appropriate compliance.
- *For a PPS consisting of Article 28s with another regulated entity (Art. 28, 31, and/or 16).* If controlling entity is already established, a PPS might request that DOH limit character and competence review to current board and allow new members or structures to self-certify (attest to character and competence). DOH could reserve the right to audit and subsequently disqualify or modify the entity; and the PPS entity would be held harmless.
- A PPS may desire that powers be controlled and distributed only at parent level;

6/23/2014

and may want notification only to DOH. 10 NYCRR § 405.1.

- PPSs should request that the State expedite approvals of required changes to corporate certificates.

Regulations to consider include:

- 10 NYCRR § 405.2 (hospital governing bodies, minimum standards)
- 10 NYCRR Parts 600-670 (Establishment of hospitals)
- 10 NYCRR Part 1001 (Assisted Living)
- 10 NYCRR Part 751 (D&TCs)

Corporate Practice of Medicine. For PPSs with a community-wide practitioner base, corporate practice of medicine rules need to be addressed. To support the development of an effective PPS partnership, state must address how corporate practice of medicine rules will apply to a central governing entity that intends to carry out the role expected by the state. Various provisions of the Education Law and case law apply. *For a comprehensive article on the issue, see "Corporate Practice of Medicine: An Old Doctrine Breathing New Life," New York Law Journal (6/25/2014).*

Paying FQHCs for Multiple Visits in a Single Day

State law does not address the issue of FQHCs being reimbursed for more than a single service a day. Public Health Law Sec. 2807(8). State regulation governing a "threshold visit" imposes the restriction on all clinics (FQHCs or not). The policy is explained in the e-MedNY guidance (https://www.emedny.org/ProviderManuals/Clinic/PDFS/Clinic_Policy_Guidelines.pdf) , excerpted in part, below:

> For Medicaid patients, the basis of payment for most clinic services provided in hospital outpatient departments and diagnostic and treatment centers under Article 28 of the Public Health Law is the threshold visit. New York State Department of Health (DOH) regulation at 10 NYCRR 86-4.9 states:

> "A threshold visit occurs each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit."

> Only one threshold visit per patient per day is allowed for reimbursement purposes, except for transfusion services to hemophiliacs, in which case each transfusion visit constitutes an allowable threshold visit. The visit is all-inclusive as it includes all of the services medically necessary and rendered on that date.

> This policy does not apply to those services for which rates of payment have been established for each procedure, such as dialysis and freestanding

6/23/2014

ambulatory surgery.

When a Medicaid patient receives treatment(s) during a threshold clinic visit that cannot be completed due to administrative or scheduling problems, the Article 28 facility may not bill additional clinic visits for the completion of the service.

Patient Transitions, Discharges, Transfers
Currently, various agencies have rules and regulations governing patient transitions. These processes must be waived or streamlined in an integrated environment. Regulations to consider include:
- 10 NYCRR §§ 405.9, 400.9, 400.11, 700.3, 415.38
- 18 NYCRR §§ 505.20 and 540.5
- 14 NYCRR § 36.4 and 14 NYCRR § 504.5 (governing community placement after IP behavioral health discharge)
- 14 NYCRR Part 815.7 (regarding discharge from OASAS services)

Long Term Care Regulations
A PPS with long term care service projects should review the following regulations.

- Hospice need requirements and geographic limitations (10 NYCRR Part 790).
- Nursing home regulations, interpreted to protect the safety of other residents that compel nursing homes to transfer patients (especially behavioral patients) to hospitals (*See* 10 NYCRR Part 415).
- Limitations on home care ordering authority (10 NYCRR Part 763).
- Home health aide supervision restrictions (10 NYCRR Part 763).

Anti-Trust
Developing PPSs, forming integrated delivery systems, or even collectively working on a specific DSRIP project may raise anti-trust issues. Currently, the State has not issued any final regulations allowing for PPSs and others to apply for certificates of public advantage (COPAs) or to apply as Medicaid Accountable Care Organizations (ACOs) – both of which would allow for anti-trust protections. Given that these processes are not finalized and entities are not able to apply for such protections, PPSs should request waiver of anti-trust regulations. In addition to state enacted safe harbors, the state must confer state action immunity to shield PPSs from federal antitrust liability.

Management Contracts
Regulatory requirements regarding management contracts may need to be considered for waiver if the management contract vehicle is chosen in PPS formation. A PPS should request waiver of appropriate provisions of the regulations governing approval of Management Contracts when such underlying arrangements are in the best interests of meeting approved PPS objectives. *See, e.g.,* 10 NYCRR §§ 405.3 and 600.9

6/23/2014

Workforce

Given DSRIP's requirement that PPSs address workforce issues, as well as provide for innovative care models. A PPS should consider requesting the following relief/State action.

Credentialing. Practitioner credentialing and the ability for practitioners to treat patients throughout a PPS is essential. Effective PPS credentialing will require application of a single system wide credentialing process, and waiver of various state agency requirements. Administrative delays relating to multiple credentialing processes of the State and managed care organizations can impede a PPS's ability to provide access to care, and this is particularly true given that credentialing processes are not tailored to recognize a PPS structure. A PPS should ask the State to develop an expedited single credentialing process that will meet the needs of the PPS and address quality and liability concerns of the State and payers. Regulations to consider include the following:

- 14 NYCRR Part 853 (OASAS Providers)
- 10 NYCRR Parts 94 and 707 (Governing physicians' assistants)
- 10 NYCRR §§ 405.2 and 405.4 (hospitals)

Scope of Practice. Because access to care and cost likely will be issues for any PPS, a PPS should consider requesting DOH work with the State Education Department to address relaxing scope of practice requirements, provided that this does not result compromise patient safety. The State Education Department regulates the professions, including those in the health and social services fields. Regulatory provisions include 8 NYCRR Parts

- 60 (Medical and physicians assistants) (see, e.g., experience requirements in 60.3)
- 61 (Dental and Dental Assistants)
- 64 (Nursing) (see particularly 64.5 and 64.6)
- 72 (Psychology)
- 74 (Social Work)
- 76 (OT) (see, e.g., 76.5 and 76.8)
- 77 (PT)

Provider Licensure. PPS providers are licensed by different state agencies. Therefore, a common set of standards applicable across providers will be needed for effective PPS partnership, which may require waiver of various regulations.

Auditing and Reporting Requirements

PPSs will likely be subject to auditing and reporting requirements from multiple agencies on top of the auditing and reporting requirements specific to DSRIP. A PPS may wish to request waiver of audit and reporting requirements for DSRIP project services other than what is required under the federal waiver. Regulations that may be relevant include:

6/23/2014

- 14 NYCRR Part 635-4 (OPWDD)
- 14 NYCRR Part 552 (OMH)
- 14 NYCRR Part 836 (OASAS incident reporting)
- 10 NYCRR Part 86 (DOH audits)
- 10 NYCRR § 400.18 (SPARCS data reporting)
- 10 NYCRR § 751.10 (D&TC adverse event reporting)

Administrative Appeals Processes

With DSRIP projects likely involving providers and services regulated by multiple State agencies, a PPS should consider requesting waiver of duplicative administrative appeals processes in favor of a single, streamlined process. Regulations to consider are listed below.

- 14 NYCRR Part 831 (OASAS administrative appeals)

Behavioral Health Regulations

Consideration should be given to the various regulations in ensuring the coordination of DSRIP integrated care models and regulatory requirements requiring behavioral health care professionals to take certain specific actions relating to provision of medical care.

Consider:
- 14 NYCRR Part 77 (governing physical plant standards for behavioral health facilities)
- 14 NYCRR Part 321 (regarding financing and constructing substance use disorder facilities)
- 14 NYCRR Part 521 (regarding financing assistance for capital construction or acquisition of behavioral health facilities)
- 14 NYCRR Part 551 (regarding expediting project reviews for OMH regulated facilities)
- 14 NYCRR Part 573 (regarding issuing operating certificates to OMH regulated providers)
- 14 NYCRR Part 810 (regarding establishing, certifying substance use disorder services)
- 14 NYCRR Part 814 (regarding OASAS facility requirements)
- 14 NYCRR § 814.7 (governing spaces shared with substance use disorder services)
- 14 NYCRR § 36.4 and 14 NYCRR § 504.5 (governing community placement after IP behavioral health discharge)
- 14 NYCRR Part 815.7 (regarding discharge from OASAS services)
- 14 NYCRR Part 506 (rates and standards relating to intensive case management)
- 14 NYCRR § 507.7 (standards for participation in community based behavioral health services for children)
- 14 NYCRR Parts 510 & 520 (accessing or correcting OMH records)
- 14 NYCRR Parts 803 & 804 (accessing OASAS records)

6/23/2014

- 14 NYCRR Part 511 (standards and rules around personalized recovery oriented services (PROS))
- 14 NYCRR § 527.6 (rights of behavioral health IP patients to object to treatment)
- 14 NYCRR Part 587 (regarding standards and requirements for operating out patient behavioral health programs, including day treatment, partial hospitalization and other types of programs, and record retention/sharing of such programs)
- 14 NYCRR Part 599 (regarding standards and requirements for clinic treatment programs)
- 14 NYCRR Part 592 (Governing Comprehensive Outpatient Programs)
- 14 NYCRR Part 594 (Governing Operation of Licensed Housing Programs for Children and Adolescents with severe emotional disturbances)
- 14 NYCRR Part 595 (governing operation of residential programs for adults)
- 14 NYCRR Part 816 (governing IP and OP chemical dependence withdrawal and stabilization)
- 14 NYCRR Part 819 (governing standards, operation, staffing for chemical dependence residential services)
- 14 NYCRR Part 822-2 (governing outpatient chemical dependency and opioid treatment)
- 14 NYCRR Part 822-4 (regarding staffing, treatment plans, etc., for outpatient chemical treatment programs)
- 14 NYCRR Part 822-5 (regarding opioid treatment programs)
- 14 NYCRR Part 823 (governing standards, admissions, record keeping treatment plans of chemical dependency OP services for youth)
- 14 NYCRR Part 831 (OASAS administrative appeals)

6/23/2014

17. RETENTION IN CARE UNIT

The Retention in Care Unit was developed to prevent members from falling out of care and to re-engage members who have done so. It has been well documented that psychosocial factors such as homelessness, mental illness, substance abuse, and lack of financial resources, among others, can be a significant barrier in establishing and maintaining regular medical care. In addition, ancillary services such as case management, mental health treatment, substance abuse treatment, housing services, transportation, translation, and legal services play a substantial role in keeping HIV-positive patients connected to medical care. The Retention in Care Unit seeks to address barriers to accessing regular medical care with an HIV specialist and link Amida Care members with community service providers who will afford them ongoing management of their bio-psychosocial needs.

Community Health Outreach Workers (CHOW)

Amida Care's Retention in Care Unit uses specially trained, professional peer Community Health Outreach Workers (CHOWs) to assist a select group of members and serve as a bridge between the members, the healthcare and social systems and the health plan. CHOWs provide their assigned members with information and specialized services so that they will engage in their healthcare. CHOW's work with members on a short term basis and generally have one to two contacts with them.

CHOWs provide the following functions:
- Escort - assist to and from appointments;
- Community Canvasser - outreach to members who have failed to attend their initial appointments;
- Translator- clarify benefits and access; and
- Buddy - check on assigned caseload regularly to assess progress in adherence to care plan and assist with any emerging needs.

Training of CHOWs is completed by the Director of Retention in Care Unit. However, peers already certified as outreach workers by another HIV/AIDS Community Based Organization may have training requirements waived at the discretion of the Director of Retention in Care Unit.

The Director of Retention in Care Unit closely supervises CHOWs. To refer a member for CHOW services, contact the Director of Retention in Care Unit at (646) 745-1025.

Health Navigators

Health Navigators work with members who have fallen out of care, as defined by not having a primary care appointment with an HIV specialist in six months or more, or members who have been identified as being at risk for falling out of care by their PCP, Care Coordinator or other community based provider. Health Navigators work with members anywhere from 60 days to 6 months, depending on need.

Health Navigators provide the following functions:
- Conduct needs assessments to determine what services members need to be connected to
- Develop individualized member goals and objectives
- Refer and connect members to appropriate services/service providers
- Schedule intake/initial appointments at indicated facilities
- Escort members to initial appointments
- Escort members to PCP appointments
- Provide transportation to members when appropriate
- Follow up with service providers
- Follow up with members

Health Navigators are professional staff, all of whom have a background in HIV case management and/or have knowledge of the benefits and services entitled to PLWHA in New York City. To refer a member for Health Navigation services, contact the Health Navigator Supervisor at (646) 784-5469.

Mobile Engagement Teams (MET)

Through the Social Innovation Fund, Amida Care sponsors Mobile Engagement Teams at three community based sites who work with members experiencing co-occurring mental health and/or substance abuse issues. The goal of the program is to stabilize clients in order to engage them in regular primary medical care and mental health/substance abuse treatment. METs provide field based services to clients using motivational interviewing to incite change behavioral. MET sites include:

- Harlem United-responsible engaging clients in Manhattan
- Housing Works-responsible for engaging clients in Brooklyn
- Help/PSI-responsible for engaging clients in the Bronx

Each Mobile Engagement Team consists of an Outreach Worker/Health Educator, Intensive Care Manager, and either a Licensed Clinical Social Worker or a Psychiatric Nurse Practitioner. Team staff provides field based services to Amida Care members who have difficulty maintaining regular primary care due to an underlying mental health or substance abuse problem. Services are individualized and intensive and include the following services:

- Assessments and Service Plans
- Psychiatric Evaluation
- Monitoring of Goals
- Case Management
- Housing Assistance
- Arrangement of PCP visits
- Arrangement of Mental Health/Substance Abuse Services
- Appointment Escorts
- Health Education

To refer an Amida Care member for MET services, contact the Outreach Liaison at (646) 545-2758.

Peer Support Services for Individuals With Serious Mental Illnesses: Assessing the Evidence

Matthew Chinman, Ph.D.
Preethy George, Ph.D.
Richard H. Dougherty, Ph.D.
Allen S. Daniels, Ed.D.
Sushmita Shoma Ghose, Ph.D.
Anita Swift, M.S.W.
Miriam E. Delphin-Rittmon, Ph.D.

Objective: This review assessed the level of evidence and effectiveness of peer support services delivered by individuals in recovery to those with serious mental illnesses or co-occurring mental and substance use disorders. Methods: Authors searched PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature for outcome studies of peer support services from 1995 through 2012. They found 20 studies across three service types: peers added to traditional services, peers in existing clinical roles, and peers delivering structured curricula. Authors judged the methodological quality of the studies using three levels of evidence (high, moderate, and low). They also described the evidence of service effectiveness. Results: The level of evidence for each type of peer support service was moderate. Many studies had methodological shortcomings, and outcome measures varied. The effectiveness varied by service type. Across the range of methodological rigor, a majority of studies of two service types—peers added and peers delivering curricula—showed some improvement favoring peers. Compared with professional staff, peers were better able to reduce inpatient use and improve a range of recovery outcomes, although one study found a negative impact. Effectiveness of peers in existing clinical roles was mixed. Conclusions: Peer support services have demonstrated many notable outcomes. However, studies that better differentiate the contributions of the peer role and are conducted with greater specificity, consistency, and rigor would strengthen the evidence. (Psychiatric Services 65:429–441, 2014; doi: 10.1176/appi.ps.201300244)

Dr. Chinman is with the Mental Illness Research, Education and Clinical Center, U.S. Department of Veterans Affairs Pittsburgh Medical Center, Pittsburgh, Pennsylvania. Dr. George, Dr. Daniels, and Dr. Ghose are with Westat, Rockville, Maryland. Dr. Dougherty is with DMA Health Strategies, Lexington, Massachusetts. Ms. Swift is with Swift Consulting, Newport, Kentucky. Dr. Delphin-Rittmon is with the Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland. Send correspondence to Dr. Chinman (e-mail: chinman@rand.org) or Dr. George (e-mail: preethygeorge@westat.com). This article is part of a series of literature reviews that will be published in Psychiatric Services over the next several months. The reviews were commissioned by SAMHSA through a contract with Truven Health Analytics and were conducted by experts in each topic area, who wrote the reviews along with authors from Truven Health Analytics, Westat, DMA Health Strategies, and SAMHSA. Each article in the series was peer reviewed by a special panel of Psychiatric Services reviewers.

As stated in the 2003 report of the President's New Freedom Commission on Mental Health (1), mental health care should be "recovery-oriented"—meaning that services should be collaborative and respectful and should aim to help those with serious mental illnesses achieve a satisfying life even in the presence of symptoms. Peers are individuals with histories of successfully living with serious mental illness who, in turn, support others with serious mental illness. Many terms have been used to describe this group, including peer specialists and consumer-providers. However, they are frequently referred to as "peers," and we have chosen to use that term here. Peers are believed to be particularly helpful in promoting recovery; therefore, the presence of peers within the continuum of care has expanded considerably for individuals with serious mental illnesses, and, in many cases, peer support services are provided to those with co-occurring substance use disorders (1–3).

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base (AEB) Series (see box on next page). For purposes of this series, the Substance Abuse and Mental Health Services Administration (SAMHSA) has described peer support services as a direct service that is delivered by a person with a serious mental illness to a person

About the AEB Series

The Assessing the Evidence Base (AEB) Series presents literature reviews for 13 commonly used, recovery-focused mental health and substance use services. Authors evaluated research articles and reviews specific to each service that were published from 1995 through 2012 or 2013. Each AEB Series article presents ratings of the strength of the evidence for the service, descriptions of service effectiveness, and recommendations for future implementation and research. The target audience includes state mental health and substance use program directors and their senior staff, Medicaid staff, other purchasers of health care services (for example, managed care organizations and commercial insurance), leaders in community health organizations, providers, consumers and family members, and others interested in the empirical evidence base for these services. The research was sponsored by the Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be covered in public and commercially funded plans. Details about the research methodology and bases for the conclusions are included in the introduction to the AEB Series (25).

with a serious mental disorder (primarily schizophrenia, schizoaffective, or bipolar disorder) or a co-occurring mental and substance use disorder. The peer providers have progressed in recovery (often using treatment services) to the stage where they can manage their illness and pursue fulfilling lives. This specialized assistance offers social support before, during, and after treatment to facilitate long-term recovery in the community in which the recovering person resides.

Table 1 presents the definition, goals, targeted populations, and service delivery settings for peer support services. These services are a form of peer support provided within the formal behavioral health services continuum (4). SAMHSA has included peer-based services in its National Registry of Evidence-Based Programs and Practices (5). Although peer2 support services described in this review are often delivered to those with co-occurring mental and substance use disorders, the primary aim of these services has been to address mental illness, and the commonality for individuals receiving these services has been the presence of a mental illness. An emerging type of peer support services is peer recovery

support, which involves an individual in recovery from a substance use disorder providing services to others with substance use disorders. These services are addressed in a separate review in this series (6).

Policy makers and other leaders in behavioral health care need information about the effectiveness of peer support services and their value as a benefit covered by insurers. The objectives of this review were to describe peer support services and peer roles, rate the level of evidence of the research (defined here as methodological quality), and describe the effectiveness of the service (defined here as positive, negative, mixed, or null findings). To be useful for a broad audience, the scope of the review is brief and focuses on key findings and an overall assessment of research quality.

Other reviews of peer support services have been conducted. In 2002, Simpson and House (7) reviewed studies on this topic. In 2005, Doughty and Tse's report (8) for the New Zealand Mental Health Commission used a broader typology that included "service user-run" and "service user-led" mental health services. In 2009, Rogers and colleagues' report (9) from the Center for Psychiatric Rehabilitation categorized a variety of peer-delivered services that included those added to traditional services, those offered as a one-to-one service, and peer-delivered residential services. In 2011, Repper and Carter (10) reviewed the literature on peer support workers employed in mental health services, and Wright-Berryman and colleagues (11) examined the effects of peers on case management teams. In 2013, Pitt and colleagues (12) published a Cochrane review of peer support services that excluded quasi-experimental trials and studies involving peer-delivered curricula, and they conducted analyses pooling data across peer support services that may have varied. This AEB Series review is more inclusive than the Cochrane review, updates the other reviews, and provides an assessment of three specific types of peer support services delivered in traditional mental health systems.

Table 1

Description of peer support services for individuals with serious mental illnesses

Feature	Description
Service definition	Peer support services are delivered to a person with a serious mental illness or co-occurring mental and substance use disorders by a person in recovery. This specialized assistance offers social support before, during, and after treatment to facilitate long-term recovery in the community.
Service goals	Assist in the development of coping and problem-solving strategies to facilitate self-management of a person's mental illness; draw upon lived experiences and empathy to promote hope, insights, and skills; help individuals engage in treatment, access supports in the community, and establish a satisfying life
Populations	Individuals with serious mental illnesses or those with co-occurring mental and substance use disorders
Settings of service delivery	Settings may vary and include inpatient facilities; outpatient facilities, including a range of clinical team types (for example, case management and homeless services); day treatment programs; and psychosocial clubhouses

Description of peer support services

Various forms of peer support have been addressed in the literature and are evident in practice. Historically, peer support began in the form of peer groups, in which participants with similar difficulties met to provide mutual support, discuss their problems, and receive empathy and suggestions from other members on the basis of shared experiences (13). From those origins, other variants of peer support were developed, including the establishment of organizations and programs run by individuals with mental illness.

This review, however, focuses on a particular aspect of peer support: the hiring of a person in recovery from a serious mental illness as an employee to offer services or supports to others with serious mental illnesses (4). Solomon (14) defined peer employees as "individuals who fill designated unique peer positions as well as peers who are hired into traditional mental health positions." When peers are hired into existing mainstream positions, they typically must self-identify as having a serious mental illness and having received mental health services in the past (14). However, a defining characteristic of the peer as employee or provider is that the relationship between the peer provider and a service recipient is not reciprocal (4). The peer provider and the recipient are not at the same level of skills or degree of recovery, and both parties are not expected to receive mutual benefit. This asymmetrical relationship differs from other forms of peer support in which peers of varying levels of skill and recovery work together and benefit from each other's experiences.

The literature describes a number of different peer services and supports. They can include services to promote hope, socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills (15). They also can be a component in the implementation of peer-run education and advocacy programs, such as Wellness Recovery Action Plans (WRAP) (16). Salzer and colleagues (17) documented a wide range of peer support

services and roles through a national survey. They found that the most frequently reported role for peers was to share personal experiences and provide mutual aid. Other roles or services provided by peers included the "encouragement of self-determination and personal responsibility; a focus on health and wellness; addressing hopelessness; assistance in communications with providers; education about illness management; and combating stigma in the community" (17).

Peer support services generally include three types of activities, although they may overlap in practice (18): a distinct set of activities or a curriculum that includes education and the development of coping and problem-solving strategies to facilitate self-management of a person's mental illness, activities that are delivered as part of a team that may include nonpeers (for example, an assertive community treatment [ACT] team), and traditional activities (for example, forms of case management involving linkage to services) that are delivered in a way that is informed by a peer's personal recovery experience.

Regardless of the service type, there seems to be agreement that peers as providers "draw upon their lived experiences to share 'been there' empathy, insights, and skills . . . serve as role models, inculcate hope, engage patients in treatment, and help patients access supports [in the] community" (19). The use of peers is supported by social modeling theory, which states that other people in similar circumstances might have the most influence on behavior change (20).

Peer support services are becoming professionalized. Organizations such as the International Association of Peer Supporters are developing standards of practice. Peer providers receive training and certification to deliver their services in the field. This training varies but typically involves passing a written examination after completing a 30- to 40-hour week of class instruction that addresses topics in recovery, mental illness, medications, and rehabilitation. This credentialing and certification process allows for reimbursement of services beyond block grant funding. Based on the "Georgia model" of Medicaid-

reimbursed peer services (21), several organizations in the United States, including the Veterans Health Administration, provide this type of training. States in which peer support services are Medicaid reimbursable and the Veterans Health Administration require peers to pass the certification exam as a condition of being hired. Many states are including supports offered by certified peer support specialists as Medicaid-reimbursable services (15). The Centers for Medicare & Medicaid Services recognizes peer support services as an evidence-based model of care for mental health and an important component of a state's effective delivery system (22,23).

Given the growing interest among many in the mental health services field in using peers as providers, policy makers and others have questions about their effectiveness as an intervention. This assessment of the available research will help inform mental health system leaders who are making decisions about whether to provide peer support services or to include them in health insurance plans for Medicaid or benchmark plans.

Methods
Search strategy
We conducted a literature search of outcome studies about peer support services published from 1995 through 2012. We searched the major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. We also examined bibliographies of major reviews and searched for nonjournal publications, such as government reports. Search terms included combinations of mental health, mental health services, psychotic disorders, mental disorders, psychiatry, peer support, consumer service, consumer run, consumer operated, consumer advocacy, patient

advocacy, consumer-provider, psychiatric survivor, and case manager aide.

Inclusion and exclusion criteria

This review was limited to U.S. and international studies in English and included the following types of articles: randomized controlled trials (RCTs), quasi-experimental studies, single-group time-series design studies, and cross-sectional correlational studies; studies that were focused on peer support services for adults with serious mental illnesses only (a *DSM* diagnosis of a psychotic spectrum disorder or bipolar disorder and persistent impairment in psychosocial functioning); and studies of peer support services for adults with co-occurring substance use disorders (although this population was not the focus of this review). We defined peer support providers as individuals in recovery from serious mental illness who were operating within the formal behavioral health service continuum that included various types of treatment or case management (for example, ACT) within government or private nonprofit treatment facilities. Older reviews were consulted only to ensure that all relevant studies were identified. Given the existence of different types of peer support services, we divided the review of studies into three categories: peers added to traditional services (peers added), peers assuming a regular provider position (peers in existing roles), or peers delivering structured curricula (peers delivering curricula). Within these types, the definition and model of peer support services sometimes differed across studies. Various measures were used to define the effectiveness of these services.

This review did not include peer recovery support services provided to individuals with substance use disorders apart from mental illness. These services are delivered to an individual with a substance use disorder by a provider in recovery from addiction (6,24). Although similarities exist between peer support services and peer-based recovery support services, each has its own extensive and separate body of literature. Because peer support groups and "consumer-operated services" (stand-alone programs run by peers) typically serve as adjuncts to traditional behavioral health services, they were not included in this review. Studies about the effectiveness of online peer support, studies of services for smoking cessation, studies of peer support for individuals with developmental disabilities, and studies that focused on children and adolescents were also excluded.

Strength of the evidence

The methodology used to rate the strength of the evidence is described in detail in the introduction to this series (25). The research designs of the studies that met the inclusion criteria were examined. The series established three levels of evidence (high, moderate, and low) to indicate the overall research quality of the studies. Ratings were based on predefined benchmarks that considered the number of studies and their methodological quality. Each of the three types of peer support services mentioned above (peers added, peers in existing roles, and peers delivering curricula) was rated separately. We discussed the ratings to confirm a consensus opinion.

In general, high ratings indicate confidence in the reported outcomes and are made when there are either three or more RCTs with adequate designs or two RCTs plus two quasi-experimental studies with adequate designs. Moderate ratings indicate that there is some adequate research to judge the service, although it is possible that future research could influence initial conclusions. Moderate ratings are based on the following three options: two or more quasi-experimental studies with adequate design; one quasi-experimental study plus one RCT with adequate design; or at least two RCTs with some methodological weaknesses or at least three quasi-experimental studies with some methodological weaknesses. Low ratings indicate that research for this service is not adequate to draw evidence-based conclusions. Low ratings indicate that studies have nonexperimental designs, there are no RCTs, or there is no more than one adequately designed quasi-experimental study.

We considered other design factors that could increase or decrease the evidence rating, such as sample size; how the service, populations, and interventions were specified; use of statistical methods to account for baseline differences between experimental and comparison groups; identification of moderating or confounding variables with appropriate statistical controls; examination of attrition and follow-up; use of psychometrically sound measures; and indications of potential research bias.

Effectiveness of the service

We described the effectiveness of each of the peer support service types—that is, how well the outcomes of the studies met the service goals. We compiled the findings for separate outcome measures and study populations, summarized the results, and noted differences across investigations. We considered the quality of the research design in our conclusions about the effectiveness of the three service types.

Results

Level of evidence

We were unable to find any meta-analyses on this topic through 2012. The literature search yielded 20 individual studies examining the impact of peer support services (as conceptualized in this review) compared with services without peer support (for example, treatment as usual, treatment teams with nonpeers, and wait-list control groups). There were 11 RCTs published in 15 articles (26–40), six quasi-experimental studies (41–46), and three correlational or descriptive studies (15,47,48). Across the three types of peer support services, there were 13 studies of peers added to traditional services: six RCTs (26,27,36–39), six quasi-experimental designs (41–46), and one correlational study (15). There were three studies of peers assuming a regular provider position: two RCTs published in three articles (28–30) and one correlational study (47). Finally, there were four studies of peers delivering structured curricula: three RCTs published in six articles (31–35,40) and one correlational study (48). These are the only published studies we identified; they

may not reflect the total pool of studies, which includes those that were not published because of a bias toward positive results. Summaries of the RCTs are provided in Table 2. Summaries of the quasi-experimental and correlational studies are provided in Table 3.

The level of evidence (that is, methodological quality) was rated as moderate for all three types of peer support services. This rating was based on two RCTs with adequate designs for peers added to traditional services (26,27), two RCTs with limitations (published in three articles) for peers in existing roles (28–30), and two RCTs with adequate designs (published in five articles) for peers delivering curricula (31–35). There were no discrepancies among the author ratings.

Despite the large number of RCTs we identified, the studies addressed various models of peer support services, and methodological problems and design flaws decreased the research quality rating. For example, sample sizes in various studies often were small, outcome measures with unknown reliability or validity were used, data collectors usually were not blind to the treatment group (raising the issue of possible bias), self-reported data on symptomatology did not have corroborating reports from other sources, and research designs involved wait-list control groups rather than active control groups.

Effectiveness of the service
Effectiveness of peer support services varied across the three service types. There were limitations inherent in the research designs and differences in how effectiveness was defined and measured, making it difficult to draw definitive conclusions. Some study outcomes included clinical measures, such as hospitalization rates, symptomatology, or functioning. Other studies examined process outcomes, such as treatment engagement, retention in treatment, quality of life, or empowerment. One consistent finding across studies was that peers were at least as effective in providing services as nonpeers. The research was less consistent about the extent to

which peer support services were more effective than traditional services alone in improving clinical outcomes such as symptomatology and functioning. For example, although reduced inpatient service use was found in two RCTs (28,36) and two quasi-experimental studies (42,44), this result was not found in other RCTs and quasi-experimental trials.

Among the 13 studies in the peers added service type, eight found some positive benefit (15,36,38,39,41,42,44,46). Three of the six RCTs examining the peers added service type documented a benefit to peers, although these three RCTs were judged to have design limitations. One suggested that service users who had involvement from a peer mentor had fewer rehospitalizations and hospital days than those who did not have a peer mentor (36). A second RCT compared patients randomly assigned to an ACT team either with or without peers and found that patients in the team with peers had better treatment engagement six months after entering treatment (39). Although these effects disappeared at 12 months, this enhanced engagement at six months predicted higher levels of self-reported motivation for treatment and more frequent use of Alcoholics Anonymous and Narcotics Anonymous at 12 months. In the third RCT, patients randomly assigned to an ACT team with peers had lower rates of nonattendance at appointments and higher levels of participation in structured social care activities than patients assigned to an ACT team without a peer (38). The remaining three RCTs examining the peers added service type showed no peer-related effects comparing "client-focused" teams with peers versus client-focused teams without peers versus standard care (37), intensive case management with peers versus intensive case management without peers versus standard care (26), and use of a peer volunteer versus a non-peer volunteer versus no volunteer (27). Of these three RCTs, the first was judged to have design limitations (37), and the other two were judged to have adequate research designs (26,27).

The quasi-experimental and correlational or descriptive studies of the

peers added service type generally had more positive outcomes than the RCTs: five showed some positive benefit (15,41,42,44,46), and the remaining two showed no group differences (43,45) For example, Felton and colleagues (41) found that patients served by peers on a case management team had greater treatment engagement, more satisfaction with life situation and finances, and fewer life problems than a comparison group of those served by a team with either a paraprofessional or no additional staff. Klein and colleagues (42) and Min and colleagues (44) found that over time the proportion of clients with inpatient use was lower among those with peer support services than among those without peer support services. Klein and colleagues (42) also reported improved social functioning and quality of life among patients receiving peer support services. Van Vugt and colleagues (46) compared patients from four ACT teams with peers and from 16 ACT teams without peers and found that the presence of a peer was associated with an improvement over time in mental and social functioning, homeless days, and recovery needs. However, the study also found that the presence of a peer was associated with an increase in psychiatric hospitalization days. This was the only study reviewed that documented a negative finding. In the one correlational study of the peers added service type, Landers and Zhou (15) conducted a retrospective review of Medicaid claims data. They found that users of peer support services were less likely to be admitted to a psychiatric hospital compared with nonusers of peer support services with similar diagnoses, but the relationship was statistically significant only if patients did not use crisis stabilization services. There were no peer-related effects in two quasi-experimental studies comparing patients receiving peer support services in addition to standard outpatient care versus standard care alone (43) and comparing patients of case management teams with and without peers (45).

Among the three studies in the service type of peers in existing roles, only one had positive effects. Clarke

Table 2

Randomized controlled trials of peer support services for individuals with serious mental illnesses included in the review[a]

Study	Sample description and intervention	Outcomes measured	Major findings	Study rating and explanation[b]
Peers added				
O'Donnell et al., 1999 (37)	119 individuals referred for case management and assigned to standard case management versus client-focused case management versus client-focused case management plus peer advocate	Functioning, disability, quality of life, service satisfaction, family burden	No significant between-group differences were found on outcomes at the 12-month follow-up.	Limited. There was a small sample and a high attrition rate and different client loads between conditions. Because of high attrition, the sample may have been less representative of community-based clients with schizophrenia and bipolar disorder.
Craig et al., 2004 (38)	45 individuals assigned to an ACT team with standard case management versus an ACT team with case management plus a peer assistant on the team	Service uptake and engagement, need for care, life skills, social network, service satisfaction	At 12 months postrandomization, participants with peers on their team had lower rates of non-attendance, higher levels of participation in structured social care activities, and fewer unmet needs than those without peers. No significant between-group differences were found on social networks or satisfaction with services.	Limited. The small sample limited generalizability. Most outcome measures were collected from staff who were not blind to study conditions.
Davidson et al., 2004 (27)	260 individuals receiving outpatient services assigned to a peer volunteer versus a non-peer volunteer versus no volunteer	Depression, other psychiatric symptoms, well-being, self-esteem, functioning, functional impairment, diagnosis, client satisfaction	No significant between-group differences were found on outcomes at the 4- or 9-month follow-up.	Adequate. There was a restricted sample and possible selection bias.
Sells et al., 2006 (39)	137 adults, 70% of whom had a co-occurring substance use disorder, assigned to ACT alone versus ACT plus peer-delivered case management	Therapeutic relationship, frequency and severity of substance use, utilization of various outpatient and day-treatment services, treatment engagement	Participants with peers reported a better therapeutic relationship than those in the control group at the 6-month follow-up. Those who were least engaged with peers had more provider contact than the control group. The therapeutic relationship at 6 months predicted treatment engagement and service use at 12 months, but no between-group differences were found.	Limited. The analysis relied on self-report. The small sample limited the ability to generalize to all individuals with serious mental illness.
Rivera et al., 2007 (26)	203 adult inpatients with ≥2 hospitalizations in the past 2 years assigned to standard care versus case management with nonpeers versus case management with peers	Quality of life, service satisfaction, symptoms	No significant between-group differences were found on outcomes at the 12-month follow-up.	Adequate. It was unclear whether participants were blind to the purpose of the study.

Table 2

Continued from previous page

Study	Sample description and intervention	Outcomes measured	Major findings	Study rating and explanation[b]
Sledge et al., 2011 (36)	74 patients hospitalized ≥3 times in the past 18 months assigned to usual care versus usual care plus a peer mentor	Number of hospitalizations and hospital days	At the 9-month follow-up, participants with peers had significantly fewer admissions and fewer hospital days than those in usual care.	Limited. The small sample limited the ability to generalize to all psychiatric inpatient admissions.
Peers in existing roles				
Solomon and Draine, 1995 (29); Solomon et al., 1995 (30)[c]	96 individuals in a community mental health center at risk for hospitalization assigned to a case management team of peers versus a case management team of nonpeers	Therapeutic alliance, income, social network size, days hospitalized, psychiatric symptoms, attitudes toward medication compliance, quality of life, interpersonal contact, social functioning, treatment satisfaction	No significant between-group differences were found on outcomes 2 years after initiation of services.	Limited. The analysis relied on self-report, and the sample was small.
Clarke et al., 2000 (28)	163 adults assigned to usual care versus ACT without peers versus ACT with peers	Percentage of participants hospitalized and number of days to hospitalization; time to first emergency department visit, arrest, homelessness	Time to first hospitalization was earlier for the ACT nonpeer group than the ACT with peer group, but no significant differences were found between these groups for the first instance of homelessness, first arrest, or first emergency department visit. Compared with the ACT group with peers, more participants in the ACT group without peers had hospitalizations and emergency department visits.	Limited. The sample was small. Participants had less severe symptoms than those in other studies of ACT, limiting generalizability. There was low fidelity to the ACT model.
Peers delivering curricula				
Druss et al., 2010 (40)	80 individuals with chronic general medical illness assigned to a HARP program versus usual care	Patient activation, primary care visits, physical activity, medication adherence, health-related quality of life	Six months after the intervention, HARP program participants had higher patient activation and higher rates of primary care visits than those with usual care. No between-group differences were found in medication adherence, physical health, quality of life, or physical activity.	Limited. The small sample limited power to detect effects. The analysis used self-reported outcome measures.
Cook et al., 2012 (32); Cook et al., 2012 (31); Jonikas et al., 2013 (34)[c]	519 outpatients assigned to a WRAP program versus a wait-list control group	Patient self-advocacy, psychiatric symptoms, perceived recovery from mental illness, hopefulness, quality of life	Compared with the control group, WRAP participants reported greater reductions in psychiatric symptoms at 6- and 8-month follow-ups. They also had greater improvements in total and subscale scores for hopefulness and self-advocacy and in subscale scores for quality of life at the 6-month follow-up and for self-perceived recovery at the 8-month follow-up. No significant between-group differences were found for the other measures.	Adequate. The analysis relied primarily on self-report. The sample was restricted to outpatients, and there was a nonactive control group.

109

Table 2

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Study	Sample description and intervention	Outcomes measured	Major findings	Study rating and explanation[b]
Cook et al., 2012 (33); Pickett et al., 2012 (35)[c]	428 outpatients assigned to a BRIDGES program versus a wait-list control group	Self-perceived recovery from mental illness, hopefulness, empowerment, patient self-advocacy	Compared with the control group at 6-month follow-up, BRIDGES participants reported greater improvements in total and subscale scores for empowerment and recovery and in subscale scores for hopefulness and self-advocacy. After the analysis controlled for depressive symptoms, effects remained for total and subscale scores for recovery and one subscale score for hopefulness. No significant between-group differences were found for the other measures.	Adequate. The analysis relied primarily on self-report. The sample was restricted to outpatients, and there was a nonactive control group. The researchers did not examine other predictors of empowerment and patient self-advocacy.

[a] Articles are in chronological order by the three types of intervention. Abbreviations: ACT, assertive community treatment; BRIDGES, Building Recovery of Individual Dreams and Goals; HARP, Health and Recovery Peer; WRAP, Wellness Recovery Action Planning

[b] Various threats to both internal and external validity were considered in each study's rating of "limited" (study had several methodological limitations) or "adequate" (study had few or minor methodological limitations).

[c] Multiple publications based on the same randomized controlled trial are described in the same row.

and colleagues (28) compared patients randomly assigned to standard care, ACT, or ACT with peers and found that patients of peers had significantly more time in the community and significantly less inpatient time than those in the other two conditions. Reflecting the inconsistent findings in this literature, two other studies showed no significant differences between those who received peer support services and those who did not in hospital admission rates, length of stay, hospital readmissions, symptomatology, or a range of outcomes related to functioning (29,30,47). One was an RCT (judged to be limited in design) comparing teams that had all-peer case management versus standard case management (29,30). The other was a correlational study comparing patients of case management teams for homeless individuals that did and did not have case management positions occupied by peers (47).

There was more consistency among the three RCTs (published in six articles) (31–35,40) and one correlational study (48) in the service type of peers delivering curricula. One RCT that was published in three articles (31,32,34) built upon a promising single-group, pre-post treatment study (48). The researchers found that individuals who received WRAP—an eight-session, peer-led, illness self-management program—reported greater reductions in depression and anxiety symptoms and greater increases in perceived recovery, hope, quality of life, and self-advocacy compared with those who received treatment as usual. Similarly, an RCT evaluation of Building Recovery of Individual Dreams and Goals (BRIDGES)—an eight-week class taught by peers that addresses mental illness treatments, recovery, job readiness, communication, and assertiveness—found greater improvement among program participants than among those in the control group in perceived recovery and in some elements of hopefulness, empowerment, and assertiveness with providers (33,35). Finally, Druss and colleagues (40) conducted a small RCT evaluation of the Health and Recovery Peer (HARP) program—a six-session, peer-led, medical self-management intervention that is conducted using a program manual. The authors found greater patient activation and rates of primary care visits at six months postintervention for those in the program compared with those who received usual care. The authors also found notable (but not statistically significant) improvement in medication adherence, quality of life related to physical health, and physical activity. Although all four studies in the service type of peers delivering curricula found a service benefit, the impacts of the specific WRAP, BRIDGES, and HARP programs cannot be separated from their peer delivery in these studies.

Discussion

The purposes of this review were to rate the level of evidence of peer support services using the criteria established by the AEB Series and to describe the effectiveness of peer support services. Conclusions about peer support services depend on the degree to which effectiveness can be judged from studies with moderate evidence. The criteria established by the AEB Series state that moderate evidence has value in contributing to the consideration of effectiveness. On the basis of these criteria, results for the effectiveness of the peers added and the peers delivering curricula types of peer support services are encouraging (but clearly not definitive). These conclusions differ from those in the recent Cochrane review of peer support services, in part because that review excluded quasi-experimental trials and studies involving peer-delivered curricula (12).

Table 3

Quasi-experimental and correlational or descriptive studies of peer support services for individuals with serious mental illnesses included in the review[a]

Study	Sample description and intervention	Outcomes measured	Major findings	Study rating and explanation[b]
Quasi-experimental				
Peers added				
Felton et al., 1995 (41)	104 participants; case management teams versus case management teams plus non-peer assistants versus case management teams plus peer specialists	Self-image and outlook, treatment engagement, social support, quality of life, life problems, housing instability, income, family contact	Over the 2-year study, clients of case management teams plus peer specialists reported gains in quality of life indicators, reductions in some major life problems, and more treatment engagement, compared with those in the other two groups. There were no differences in outcomes between teams with nonpeer assistants and those with standard case management.	Limited. Participants were not randomly assigned. The small sample and an over-representation of clients in the case management only condition may have limited generalizability.
Klein et al., 1998 (42)	61 participants with co-occurring mental and substance use disorders; intensive case management teams with peers versus without peers	Crisis events (for example, emergency room visits), number of hospital days, social functioning, use of community resources and social integration, quality of life	Participants with peers had fewer inpatient days, better social functioning, and some improvements in quality of life indicators at the end of the intervention.	Limited. Participants were not randomly assigned, and the sample was small, limiting generalizability. The analysis relied on self-report data.
Chinman et al., 2001 (43)	158 participants; peer support services added to standard care versus a matched control group in standard care	Number of hospitalizations and hospital days	No significant between-group differences were found in outcomes 6 months after the service start date.	Limited. Participants were not randomly assigned.
Min et al., 2007 (44)	556 participants with serious mental illness and substance use disorders with a history of hospitalization; teams with case management versus teams with case management plus a peer worker	Days to first hospitalization; percentage hospitalized over 3 years	Participants on teams with peers had more time in the community and less inpatient use.	Limited. Participants were not randomly assigned. There was possible bias from case manager referral of certain participants to the study.
Schmidt et al., 2008 (45)	142 participants with a recent hospitalization; case management team versus case management team plus peer	Client contact, percentage with crisis center visits and number of visits, percentage hospitalized, number of hospitalizations and hospital days, outpatient mental health service use, medication use, substance abuse, housing stability	No significant between-group differences were found in outcomes measured at the 12-month follow-up.	Limited. Participants were not randomly assigned.

111

Table 3

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Study	Sample description and intervention	Outcomes measured	Major findings	Study rating and explanation[b]
van Vugt et al., 2012 (46)	530 participants in 20 ACT teams; teams without peers versus teams with peers	Level of functioning, met and unmet needs, working alliance, number of hospital days, number of homeless days	At 1- and 2-year follow-ups, clients of teams with peers had better psychiatric and social functioning, improvements in met and unmet needs related to their personal recovery, and fewer homeless days than clients of teams without peers. Peer presence was associated with an increased number of hospital days.	Limited. Participants were not randomly assigned to the comparison group. Clients of teams with peers were more severely ill than clients of other teams. Some clients of teams without peers had contact with peers.
Correlational or descriptive				
Peers added				
Landers et al., 2011 (15)	35,668 participants with a reimbursed community mental health service; those with a peer support services claim in the past year versus those without	Percentage with a hospitalization or crisis stabilization	Compared with participants without peers, more participants with peers used crisis services, but fewer had a hospitalization.	Limited. The study was restricted to Medicaid enrollees. The research design was cross-sectional.
Peers in existing roles				
Chinman et al., 2000 (47)	1,203 participants who were homeless; homeless outreach teams versus homeless outreach teams with peers	Quality of life, homelessness days, social support, symptoms and mental health problems, alcohol and drug problems, days worked	No significant between-group differences were found on outcomes over a 12-month period.	Limited. Participants were not randomly assigned.
Peers delivering curricula				
Cook et al., 2010 (48)	381 consumers of psychiatric services; pretest–posttest comparison of participants who received the WRAP curriculum	Recovery management attitudes and abilities	At the end of the intervention, participants reported significant increased hopefulness for recovery, awareness of early warning signs of decompensation, use of wellness tools, and awareness of symptom triggers. They also reported having a crisis plan in place, a plan to deal with symptoms, a social support system, and the ability to take responsibility for their own wellness.	Limited. The research design was a pretest–posttest comparison with no comparison group and a nonrandom sample. The analysis relied on a self-reported, nonvalidated instrument to measure dependent variables. There was a short follow-up time period.

[a] Articles are in chronological order by research design and type of intervention. Abbreviations: ACT, assertive community treatment; WRAP, Wellness Recovery Action Planning

[b] Various threats to both internal and external validity were considered in each study's rating of "limited" (study had several methodological limitations) or "adequate" (study had few or minor methodological limitations).

The Cochrane review found few differences in psychosocial outcomes and in outcomes related to psychiatric symptoms and service use between individuals who received services from peers involved on mental health teams and individuals who received services from professionals employed in similar roles. Our judgment of effectiveness also would be more mixed if only the most rigorous RCTs were considered. Out of the four RCTs judged adequate, two reported null findings (both for the peers added service type) (26,27), and two reported positive findings (in the peers delivering curricula service type) (31–35).

Although the peer support services discussed have demonstrated promising outcomes, research is still needed to show their effectiveness with greater confidence—that is, with a higher level of evidence. Research is needed that has greater specificity (for example, to distinguish various peer support services from each other), consistency (such as in service definitions and outcome measures), and follow-up of outcomes over a longer term. For example, studies of specific recovery programs led by peers (such as WRAP, BRIDGES,

and HARP) have not been able to differentiate the contributions of peers from the effects of the overall program, even though a peer's ability to promote beliefs about hope, recovery, engagement, empowerment, self-efficacy, self-management, and expanded social networks (49,50) is what has been "proposed as the central tenets of recovery" (49). One way to disentangle these effects would be to compare the outcomes of these programs with those obtained when the curricula are delivered by a paraprofessional without a psychiatric illness.

Stakeholders must develop commonly accepted peer support service definitions, types, values, standards, models, manuals, training curricula, and fidelity measures. National standards for certification and licensure of peer providers would create further standardization. This type of formalization of peer support has been questioned for its potential to undercut the informal, mutually supportive nature from which peer support originated. However, it could be possible to create standards and certification for some types of peer support services and not for others that peers and clients would like to keep more informal.

The many variations of peer support delivery could be explored with greater consistency and specificity. It is important to address variables such as setting (for example, traditional case management, psychosocial clubhouses, and outpatient treatment teams), service delivery mode (for example, groups, individual meetings, and drop-in meetings), background of peers (for example, those with serious mental illness versus those with less impairment), functions (for example, having a unique role in a system versus having a role similar to those of nonpeers), and levels of service delivery structure that range from informal support to specific program curricula. Attention also needs to be paid to well-documented implementation challenges, such as ill-defined roles and resistance among staff (19,51). Given the level of evidence to date, the research agenda moving forward should ask not only, "Do peer support services work?" but also, "Under what specific conditions do peer support services work?"

Evidence for the effectiveness of three types of peer support services for individuals with serious mental illnesses: moderate

Evidence for the effectiveness of peers added to traditional services and of peers delivering structured curricula was positive, albeit from studies across the range of methodological rigor. The contributions of peers, especially peers delivering curricula, are unclear. Across the service types, improvements have been shown in the following outcomes:
- Reduced inpatient service use
- Improved relationship with providers
- Better engagement with care
- Higher levels of empowerment
- Higher levels of patient activation
- Higher levels of hopefulness for recovery

Future research should determine what outcomes are the best indicators of impact and what valid and reliable tools are needed to measure these outcomes. For example, it may be helpful to use illness self-management and other recovery-oriented measures rather than relying only on traditional assessments of symptoms and functioning (45). Engagement might be another effective indicator, because engagement with services is fundamental to the efficacy of evidence-based programming for individuals with co-occurring mental and substance use disorders. Research suggests a valued role for peer providers in this area.

Finally, there is a need to expand the knowledge base of cultural competence in the delivery of peer support services. Given the significance of disparities in the receipt of mental health services, implementing effective culturally responsive care is of critical importance. Most of the studies reviewed did not specifically evaluate the impact of race, ethnicity, or sex on the effectiveness of peer support services. Tondora and colleagues (52) have implemented a clinical trial to examine the effectiveness of a peer-based service that includes cultural modifications for African-American and Latino populations. Forthcoming results may indicate whether these modifications were effective in promoting cultural responsiveness.

Conclusions

On the basis of the evidence standards established for the series, we conclude that each peer support service type (peers added to traditional services, peers in existing roles, and peers delivering curricula) achieved a moderate level of evidence (see box on this page). However, the three types differed in their documented effectiveness. Across the range of experimental rigor (RCT, quasi-experimental, and correlational or descriptive studies), there was more evidence in support of peers added, for which eight of 13 studies found a positive peer impact, and in support of peers delivering curricula, for which four of four studies found similar impact. There was less support for peers in existing roles, for which one of three studies found positive outcomes. Across all studies in this review, only one showed a worsening of one outcome—that of hospitalizations (46). These findings are important, given the stigma often associated with mental illness (4).

This review of peer support services has implications for several audiences. For policy makers and insurers, the service types of peers added and the peers delivering curricula appear to be important and emerging interventions in the spectrum of mental health and recovery services. Given that most of these studies show positive outcomes and that there has been only a single negative finding, we recommend that purchasers consider coverage of the peers added and the peers delivering curricula types of peer support services. The proliferation of effective peer support services means that many payers (such as state mental health and substance use directors, managed care companies, and county behavioral health administrators) may want to consider adding peers to covered

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services. Several states already cover peer support services with Medicaid funding (17).

For consumers, families, and treatment professionals, the increasing availability of peer support services in the traditional mental health system can enhance current services, and we recommend that consumers inquire about these services as part of their care. Within systems that often have too few resources, peer support services place a premium on developing relationships, on guiding patients through fragmented systems to the needed treatments, and on promoting development of a full life beyond illness management. Adding peers to clinical teams can make the teams more successful, and it is recommended that clinical leaders consult the available sources of information about how to do so (51).

Finally, for researchers, it is vital that future studies keep up with the growth of these services for mental and substance use disorders to show with greater confidence whether and how they have an impact. These implications interact, in that as more peer support services are deployed and used by consumers and families, there will be greater need for and enthusiasm about continued research—which, in turn, could fuel more provision of services. Over time, with greater use and research, peer support services have the potential to help mental health services fulfill the promise of recovery for those with serious mental illnesses.

Acknowledgments and disclosures

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS/

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Background on Policy Issue
States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:
- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing
Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
    Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Debra Miller
Director for Health Policy
Council of State Governments

ACADEMY
OF PEER SERVICES

We Learn. We Share. We Thrive.

COURSE CATALOG
SEPTEMBER 2014

TERM	BEGINS	ENDS
1	01/21/14	04/07/14
2	05/12/14	08/04/14
3	**09/08/14**	**12/01/14**

TABLE OF CONTENTS

CERTIFIED PEER SPECIALIST CORE COURSES

Action Planning for Prevention and Recovery

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

There are many different types of self-help plans, including relapse prevention, wellness, advance directive, and crisis management plans that are created by people for their own use in different stages of recovery. The Wellness Recovery Action Plan (WRAP™) is a popular example of a self-help plan. This course contains an overview of self-help plans, the elements of a plan, the process of creating a plan, and strategies for working with others on creating a plan for themselves. Similar to the integrity of having a lived experience of recovery before becoming a peer support provider, there is value and integrity in creating one's personal self-help plan before attempting to support others in that process.

Creating Person-Centered Service Plans

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

This course builds on the Introduction to Person-Centered Principles with the purpose and elements of a service plan and roles peer providers can play in helping to incorporate recovery-oriented person-centered (ROPC) approaches into the service planning process. The course includes examples of creating service plans that meet regulatory, quality, and funding requirements while also following ROPC approaches. Examples and principles shown in this course that are drawn from the New York State PROS (personalized recovery oriented services) handbook apply equally in all behavioral health settings that are implementing ROPC approaches.

CERTIFIED PEER SPECIALIST CORE COURSES (CONTINUED)

Documentation for Peer Support Services

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

Documentation is a universal skill for all types of service delivery. Documenting services contributes to service continuity, maintains accountability, and substantiates payments for services. This module introduces participants to common documents used when delivering peer services. By the end of the course, participants will be able to write an effective progress note using a standardized format and develop an incident report.

Essential Communication Skills (Active Listening and Reflective Responding)

SEAT TIME: **6 HOURS**
PREREQUISITE: **NONE**

In this course, participants will learn engagement strategies, i.e., preparing, attending, observing, and listening, and will analyze reflective responding techniques, i.e., response to content, response to feeling, response to meaning, and personalized response. Finally, participants will apply communication skills by evaluating video vignettes for effective communication techniques.

Human and Patient Rights in New York

SEAT TIME: **1 HOUR**
PREREQUISITE: **NONE**

This module helps you obtain a basic understanding of human rights protection in New York State. The content is designed to assist you in identifying the primary functions of the New York State Division of Human Rights. The module provides directions on how to access documentation to file a complaint and explains the rights of persons served in inpatient and outpatient settings in New York State.

Introduction to Person-Centered Principles

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

Traditional mental health care has been system-centered, focusing on what is needed to sustain the organization (funding, staffing, policies and procedures, etc....). Person-centered principles begin instead by getting to know and deeply understand each person to determine what is most important to each person as the basis for a collaborative working relationship. By the end of the course, participants will be able to identify and give examples of three fundamental values and five strategies of person-centered practices and how they relate to supporting a person in gaining or regaining hope and wellness.

Olmstead: The Continued Mandate of De-Institutionalization

SEAT TIME: **1 HOUR**
PREREQUISITE: **The Rehabilitation Act and the Americans with Disabilities Act (ADA)**

This module exposes the learner to the continuing mandate of deinstitutionalization known as the Olmstead Act. The module discusses the Olmstead vs. Lois Curtis ruling that stated segregation in institutions constitutes discrimination based on disability. Further, this module describes the "integration mandate" of the Americans with Disabilities Act (ADA) that requires public agencies to provide services in the most integrated setting possible according to the needs of any qualified individual with a disability. New York's state plan is also reviewed.

Peer-Delivered Service Models

SEAT TIME: **4 HOURS**
PREREQUISITE: **The Historical Roots of the Peer Movement**

This course describes peer support and its origins, the difference between peer support and peer-delivered services, a framework to categorize and organize supports and services across a wide spectrum of behavioral health settings, and the research studies that led to naming peer support an evidence-based practice. The course includes ways to advocate for more peer support and peer-delivered services in one's community that embody the spirit and values of authentic peer support.

The Goal Is Recovery

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

The concept of mental health recovery is controversial and has been misunderstood by people who provide services, people who receive services, and family members of those who receive services. Peer providers are often caught in the crossfire of misunderstandings between these different groups. This course provides a context for the controversy by examining the evolution of the concept of recovery, exploring how recovery is being used in current practice, and offering a glimpse at what the future may hold as the body of recovery-oriented knowledge, whole health support, and person-centered practice continues to grow. Participants will apply what they learn by preparing a series of Recovery Narratives for different audiences that will be posted to the Academy of Peer Services Discussion Forum for feedback from others in the course.

The Historical Roots of the Peer Movement

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

The goal of this course is to present key developments in the history of peers helping peers. Social and political factors played a role, but the movement would never have happened without its leaders. The course introduces the learner to the some of the rich traditions of the peer support movement.

The Importance of Advocacy & Advocacy Organizations

SEAT TIME: **2 HOURS**
PREREQUISITE: **NONE**

In this module, participants will examine the importance of advocacy and explore techniques to develop and access advocacy resources. Participants will explore the various types of advocacy and develop an advocacy plan for a given peer case, receiving feedback on items that should be included. The module will also provide access to advocacy supports and resources available in New York State.

Trauma-Informed Peer Support

SEAT TIME: **5 HOURS**
PREREQUISITE: **NONE**

Trauma-informed peer support can counter the impact of trauma on people in recovery by reducing the effects of unresolved and secondary trauma and supporting healing. In this course, participants will identify examples of traumatic events and peer responses, examine the prevalence of trauma and its impact on physical and emotional wellness, analyze principles of trauma-informed practices and their application in peer services that support recovery, and evaluate cultural considerations and the effect of trauma on how we view our cultural experiences and the lens in which we view the world.

ELECTIVE COURSES

An Overview of Peer Wellness Coaching

SEAT TIME: **3 HOURS**
PREREQUISITE: **Introduction to Person-Centered Principles**

Health and wellness are important for people who have been diagnosed with mental and substance use disorders. Health disparities are prevalent; however, wellness oriented peer approaches designed and delivered by people in recovery can help individuals realize their full potential while living longer, more satisfying lives. The goal of this course is to examine health and wellness in the peer community and review how the peer support Wellness Coaching model can help people improve their quality of life.

Community Organizing

SEAT TIME: **5 HOURS**
PREREQUISITE: **Development of Community Assets**

An experienced community organizer presents common community organizing approaches, strategies, and values used to support social change for people in recovery. Participants will review the role of the peer specialist as a community organizer, defining community organizing and why it is important to people in recovery. Participants will examine four community organizing approaches commonly used by organizers in the peer support role: Direct Action Organizing, Consciousness Raising, The Highlander School Model, and Civil Disobedience, and will formulate their own community organizing approach to support a mental health issue, applying strategies learned within a given exercise.

Development of Community Assets

SEAT TIME: 7 HOURS
PREREQUISITE: NONE

Participants will develop assets which already exist in the community and utilize them effectively in their roles as peer specialists. The course explains what community assets are, where they can be found, and how to gain access to them using the Asset-Based Community Development (ABCD) model. After identifying and organizing key assets of the ABCD Model, participants will construct a community asset map for their localities using Google Maps.

Harm Reduction

SEAT TIME: 4 HOURS
PREREQUISITE: NONE

This course presents harm reduction principles for reducing the negative consequences associated with substance use when supporting peers in recovery. It relates the history of the movement that became Harm Reduction and its development and reviews the principles and key features of harm reduction. Participants will analyze how and why harm reduction works in different situations when peers exhibit at-risk behaviors and will identify interventions in harm reduction consistent with the Stages of Change Model.

History of the Community Mental Health System

SEAT TIME: 5 HOURS
PREREQUISITE: NONE

Reformers have worked to improve treatment and conditions for people with mental health conditions throughout history. Each reformer's vision began with high hopes and good intentions. Many reformers reached their goals. However, a variety of challenges and barriers clouded some achievements, with ideas regressing or relapsing over time. The steady appearance of new visions and dedication of reformers have built on prior successes and resulted in progress toward a recovery-oriented system. This interactive course explores the people, politics, values, and roles responsible for reforming the system from asylums to permanent home addresses. The course's focus on reformation supports the critical role of peer supporters for improving today's mental health system.

Housing Related Peer Support Services

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

Housing is a critical element for recovery. This module describes housing programs offered through the NYS Office of Mental Health, Homeless Housing Assistance Program (HAAP) & the Department of Housing Urban Development (HUD). Participants will learn the distinctions between programs and the process of obtaining housing from application to bedroom for the tenant. Participants will also become familiar with the role of peer staff and the unique support they offer in the sometimes difficult process of obtaining and maintaining housing. Advocacy is often required in the housing process, so participants will gain understanding of The Fair Housing Act and how it can be used to affect discrimination. This housing programs and resources described in this module address New York State and the process/paperwork may vary according to County and/or region.

Individual Placement and Support (IPS) Model of Supported Employment

SEAT TIME: **2 HOURS**
PREREQUISITE: **NONE**

This course provides an overview of the evidence-based practice of the Individual Placement and Support (IPS) Model of Supported Employment. Participants will explore the role of employment in supporting peer recovery, identify the eight foundational principles of the IPS Model that support peers seeking employment, and hear stories from successful peers.

Insurance Parity

SEAT TIME: **1 HOUR**
PREREQUISITE: **NONE**

In this module, you will learn about mental health parity and benefits laws. The module defines mental health parity and specifically discusses Timothy's Law. In addition, the New York State parity law is reviewed and activities are provided to help you better understand the types of individuals and conditions covered under parity law.

Integrated Dual Disorder Treatment (IDDT)

SEAT TIME: **2 HOURS**
PREREQUISITE: **Harm Reduction**

Integrated Dual Disorder Treatment (IDDT) is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. In this module, participants will explore how IDDT addresses substance addictions and mental illness, leading to better outcomes than treating these disorders separately or in separate places.

Motivational Interviewing

SEAT TIME: **3 HOURS**
PREREQUISITE: **Essential Communication Skills (Active Listening and Reflective Responding)**

Motivational Interviewing (MI) is a collaborative process wherein both service provider and peer work together on an issue the peer is experiencing. During the conversation, the service provider helps the individual strengthen his/her motivation to change and increases his/her commitment to change. While MI is a complex process that requires training, coaching, and practice, parts of it can be used effectively in the peer support role. For example, the principles and spirit of MI can easily be incorporated into practice. In this course, participants will explore MI principles and its spirit, as well as peer readiness for change and change talk.

Peer Leadership

SEAT TIME: **4 HOURS**
PREREQUISITE: **Peer-Delivered Service Models**

Building on Introduction to Person-Centered Principles, this course shows the contrast between a traditional (system-centered) intake and assessment process and one in which the person is the focus of the process through recovery-oriented person-centered (ROPC) approaches. The course provides examples of creating a welcoming environment and the roles that peer support providers can play in giving hope and offering an orientation to the recovery process.

Person-Centered Intake and Assessment

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

Building on Introduction to Person-Centered Principles, this course shows the contrast between a traditional (system-centered) intake and assessment process and one in which the person is the focus of the process through recovery-oriented person-centered (ROPC) approaches. The course provides examples of creating a welcoming environment and the roles that peer support providers can play in giving hope and offering an orientation to the recovery process.

Psychiatric Advance Directives

SEAT TIME: **4 HOURS**
PREREQUISITE: **Human and Patient Rights in New York**

Maintaining autonomy in decision-making is a concern for most people. One way people can convey their preferences for medications, service providers, hospitals, and other important aspects of their wellbeing is by developing a psychiatric advance directive (PAD). New York State has laws that provide for the use of PADs, including some enforcement of the individual's wishes. As a peer provider, understanding how PADs work and the advantages and disadvantages of having a PAD are important to helping others make informed decisions. This module provides foundational information about PADs and how you as a peer provider work with others to make decisions about having a PAD. You will also learn how to help someone complete a PAD and distribute it to their supporters and service providers. NOTE: This module is not legal advice. You should always obtain legal advice from an attorney.

Recovery Centers in New York State

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

Peer Recovery Centers offer an option for people in New York State who are actively working on recovery. Unlike a Drop-in Center where people go to find refuge from the world, a Recovery Center is where people find their "spark of life" and work toward a successful return to the world. The course features interviews with program directors and staff of current recovery centers in New York State, with links to additional resources for anyone who might be interested in forming their own Peer Recovery Center.

Recovery though Psychiatric Rehabilitation Principles

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

The goal of this course is to provide an overview of the principles of psychiatric rehabilitation and the role of psychiatric rehabilitation in recovery. The course gives a historical look at the evolution of psychiatric rehabilitation and highlights how the principles of psychiatric rehabilitation have influenced the recovery movement and the effect the lived experiences of those in recovery have had on the evolving field of psychiatric rehabilitation.

The Rehabilitation Act and the Americans with Disabilities Act (ADA)

SEAT TIME: **2 HOURS**
PREREQUISITE: **NONE**

This module focuses on the Rehabilitation Act, the first major federal legislative effort to secure equal access and treatment for people with disabilities. The various sections of the Act are defined and examples of protections under those sections are provided. The module also covers the Americans with Disabilities Act (Titles I through V) as well as the ADA Amendments Act. Several resources that help you identify the implications of these Acts are provided throughout the course.

Social Security Entitlements

SEAT TIME: **2 HOURS**
PREREQUISITE: **NONE**

Course participants will examine the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefit programs administered by the Social Security Administration (SSA). They will explore the applications and appeals processes and apply SSA eligibility requirements within given peer cases.

Stigma and Self-Disclosure

SEAT TIME: **4 HOURS**
PREREQUISITE: **NONE**

Self-disclosure is a natural part of all relationships, but the stigma associated with mental health or addiction conditions makes self-disclosure of these conditions complicated. Peer support providers are called upon to be open about their experiences. This openness is what makes peer support unique from other professional services. For professional practitioners with mental health or addiction histories, the decision to disclose their own experiences with their clients can be especially complex. This course explores self-disclosure and stigma from different perspectives with strategies to weigh the pros and cons that can be used by peer support providers, professional practitioners, and the people they support.

Supported Employment Specialist Core Competencies

SEAT TIME: **3 HOURS**
PREREQUISITE: **Individual Placement and Support (IPS) Model of Supported Employment**

Using the Individual Placement and Support (IPS) Model, participants examine the role, skills, and competencies of the successful Supported Employment Specialist in assisting job seekers in finding and maintaining employment, thereby supporting them in recovery. Participants identify the core competencies of the Supported Employment Specialist within the following areas: Initial assessment, disclosure, employment planning, benefits counseling, job development, working with the State Vocational Rehabilitation Department, and providing follow-along support.

Written comment prepared for
NYC Human Resources Administration

Prepared By:

Esther Lok
Federation of Protestant Welfare Agencies
esther@fpwa.org

Mark Misrok
National Working Positive Coalition
markmisrok@gmail.com

Alison Yager
HIV Law Project
ayager@hivlawproject.org

Submitted By:

New York HIV Employment Network
c/o Federation of Protestant Welfare Agencies
281 Park Avenue South, New York, NY 10010

The New York HIV Employment Network, convened by the Federation of Protestant Welfare Agencies, HIV Law Project and the National Working Positive Coalition, includes direct service providers funded by various state and city labor, education and welfare agencies, and was formed in June 2014 with a common goal to promote employment, education and vocational rehabilitation and to remove disincentives to work for people living with HIV/AIDS (PLWHA). We thank the NYC Human Resources Administration (HRA) for this opportunity to submit written comments on the 2014 Biennial HRA Employment Plan.

Background

Public policies that marginalize PLWHA as unemployable or unable to work reinforce stigmatization and poverty that undermine HIV health and prevention outcomes. While not all PLWHA are able to work, some seek an opportunity to enter the workforce, and develop financial independence via living wage jobs that are responsive to and supportive of an individual's health status. Some research studies have shown that PLWHA who work or participate in vocational rehabilitation are significantly more likely to adhere to their medication and have better physical and mental health outcomes than those who are unemployed. This is good for individual health and public health.

PLWHA participating in HRA's HIV/AIDS Services Administration (HASA) Program frequently face challenges to accessing accurate information about HASA transition-to-work policies, as well as resources and supports for returning to work/education/vocational rehabilitation. Program policies must made available for participants to make well-informed decisions about employment, and HASA staff must be prepared to consistently provide accurate, accessible information about program policies and employment resources. Because the HIV/AIDS epidemic disproportionately impacts low-income communities of color, it is imperative to improve the economic security of these populations by providing connections for those who are able and seek to transition to work to the comprehensive range of available employment supports and vocational rehabilitation services.

Response to Proposed Changes in HRA's Employment Plan

We are encouraged by HRA's commitment to eliminate the "one size fits all" approach to employment programs. We believe acknowledging factors such as work history, education level, language proficiency, and disability status, and finding ways to address them would impact the success of a client in attaining sustained employment.

Currently, only individuals living with HIV who are symptomatic are be eligible for HASA and receive employment services that are not subject to the same work requirement of cash assistance recipients. This means many individuals living with HIV, who are asymptomatic, would be required to work 30-35 hours a week. We recommend HRA/HASA to relax its eligibility criteria by allowing all low-income persons living with HIV to receive HASA benefits, and access to employment services, resources and supports.

We support HRA's effort to maximize education, training and employment related services. Specifically, we recommend the HIV/AIDS Services Administration to expand and improve

the quality of its current offerings to include high quality job training, education and employment assistance opportunities for those who seek them. We also recommend that HRA take a proactive approach to improving coordination with other government-sponsored vocational rehabilitation and workforce development systems (e.g. ACCES-VR, Workforce1, Ticket to Work, and NY Employment Service System), as well as community-based programs, to make existing resources work better for PLWHA. Furthermore, we encourage HRA to also invest in preparing clients for living wage jobs rather than low-wage jobs, and help cultivate career pathways.

Additional Changes Proposed by the NY HIV Employment Network

We recommend that HASA revise its rules for transitioning to work to allow participants to earn more money and accrue more savings, and be assured of a reasonable trial work period, without losing benefits. Further, HASA must ensure expedited reinstatement, so that for those who aren't able to sustain employment, the return to HASA is quick and efficient. Additionally, we recommend that HASA create mechanisms by which administrators and staff receive community feedback about HASA programs to ensure that HASA employment (and other) programs and policies meet the needs of HASA clients.

Finally, HASA participants should be provided with information about working, training/education and employment services from intake throughout service delivery, with transition-to-work policies made accessible, and consistently communicated. For those who want to and are able to work, HASA can become a strategic and temporary resource to enable vocational progress and increased economic stability and independence.

We thank you for your consideration of these comments, and would welcome an opportunity to discuss them with you in greater depth.

TLC-PLUS

The Impact of Implementing a Financial Incentive Program for Viral Suppression on the Clinic Environment: Findings from a Qualitative Sub-study of HPTN 065

E. Greene[1], T. Gamble[1], E. Tolley[1], A. Pack[1], J. Stanton[1], J. Taylor[1], V. Shelus[1], J. Leider[2], W. El-Sadr[3] and B. Branson[4] for the HPTN 065 study team

BACKGROUND

The HPTN 065 (TLC-Plus) study assessed the feasibility and effectiveness of providing quarterly $70 financial incentives (FI) in the form of gift cards to HIV-infected patients on antiretroviral therapy (ART) who were able to achieve or maintain viral suppression (VS). VS was defined as HIV RNA<400 copies/mL. Nineteen participating sites in the Bronx, NY (BNY) and Washington, DC (DC) were randomized to the FI intervention and 20 sites were randomized to standard of care (SOC). A total of 39,359 FI gift cards were dispensed to patients with VS over 2 years at FI intervention sites. This qualitative sub-study was conducted for the purpose of exploring individual patient, provider and staff attitudes and experiences with the FI intervention. This sub-study complements the parent study, which will analyze the efficacy of the FI intervention using aggregate site-level data.

METHODS

The following qualitative data were collected by trained interviewers from diverse demographic backgrounds:

- Semi-structured in-depth interviews with 75 patients (aged 14-72) from 14 sites randomized to the FI intervention (all patients received at least 1 FI)

- Key informant interviews with 12 site investigators (SIs) [6 BNY, 6 DC] from 15 sites randomized to the FI intervention

- Three focus group discussions (FGDs) [6 BNY, 6 DC] with 12 site staff members representing 10 sites randomized to the FI intervention

All interviews were conducted in English, audio-recorded and transcribed. Transcripts were coded for major themes and analyzed in NVivo 10.0. Sub-themes related to implementation challenges and facilitators, description of implementation, and experiences in giving and receiving FI were extracted and examined to ascertain the impact of FI implementation on the clinic environment.

RESULTS

CHALLENGES EXPERIENCED BY SI AND STAFF

Timing of FI Provision The FI intervention was designed to be integrated into standard clinical care schedules for HIV management, which often include quarterly blood draws to monitor CD4 cell count and viral load (VL). As such, patients could qualify to receive FI as often as every 3 months, though some patients required less frequent monitoring. Despite these efforts to minimize disruption of care schedules, SIs and staff reported that the allowance of quarterly VL tests for FI qualification did not always align with clinical care, sometimes shifted the patients' priority to the FI, and resulted in busier clinics as patients adhered to appointments or visited more frequently.

> The study calls for its own needs in terms of CD4 and viral load draws. And meanwhile clinical care has sometimes different demands. Meaning that providers might not always see the need to send the CD4 and viral load on a given date that the patient feels that if they don't have their CD4 and viral load done on those dates, they can't get their incentive card. So there's some tension that isn't consistent between the study and the clinical care.
> – Site Investigator-02, BNY

SIs saw this increased engagement in care as a benefit, but acknowledged that it also increased demands on staff time and space and interfered with clinic flow.

> We experienced significantly higher patient volume because patients were showing up for their visits and also were wanting to be rescheduled every three months, whereas otherwise they might have begged and pleaded for four month visits or six month visits or even not have scheduled right every when they left the clinic at a previous appointment. So it was a challenge for us to deal with a shorter volume.
> – Site Investigator-01, BNY

Implementation Logistics Implementation of the FI intervention required determining patient eligibility and qualification for FI based on study criteria and VL results, disbursing gift cards to patients, monitoring and tracking gift card inventory, ensuring safe storage of gift cards, and tracking FI disbursement in paper forms and an electronic database. Study procedures were designed to be as streamlined as possible, ongoing training and support were provided, and sites were given the latitude to develop their own process of gift card distribution and staffing, but some SIs and staff noted an increased administrative burden, particularly in large hospitals or clinics with a high volume of patients.

> I think that there were issues around the gift cards and making sure we kept them straight and making sure nothing got stolen. That was a big stress among the providers, and that we kept track of them properly, the operational issues were not without attention and some degree of vigilance. It was an extra layer of activity on an already burdened system with inadequate staff to do it.
> – Site Investigator-11, DC

Enrollment Staff, more so than SIs, had difficulty dealing with patients who felt "entitled" to receiving FIs or who would become upset upon learning that they did not qualify for an FI. (See posters A-671-0004-00774 and A-671-0005-00765).

Confidentiality Concerns Some sites integrated the FI intervention procedures into their usual patient registration processes involving front desk staff. A few staff noted confidentiality concerns within these contexts related to discussing eligibility for FIs in semi-private areas such as clinic waiting rooms.

> We approach [patients] at the check-in desk. So you really don't want to use any language that is going to say they have HIV outright. So you're trying to use roundabout language to say, you're getting this gift card for taking care of yourself, adhering to your medication, and this is for looking at your result of your good blood work! You're not really saying anything specifically, but you want to be straight up and just tell them this, but you can't really.
> – Staff, FGD-02, DC

IMPLEMENTATION FACILITATORS

Systems and Processes While SIs and staff described challenges related to implementing the FI intervention, they also described a learning curve as processes were developed to improve logistics, clinic flow, and FI and patient tracking.

> The way the cards were distributed to the patients changed over time, because first [the study coordinator] was just putting them all on my desk, and I'd be left carrying those cards from patient to patient... because I was seeing several patients at once and they were not always HIV positive, I didn't want to carry a stack of cards with me into room after room. And what we started to do was just to clip the card to the chart of the patient that were supposed to be getting it. That way when I picked up the chart I picked it up specifically for that patient and would bring it in. So, the way in which we got the cards to patients evolved over time, by the end of it, it was just going off seamlessly.
> – Site Investigator-12, DC

Positive Patient Interactions SIs and staff generally expressed positive opinions of the FI intervention and indicated that the positive patient interactions they experienced due to the FIs helped to overcome implementation challenges or resistance to the program. (See poster A-671-0005-00765)

> The doctor didn't want to schedule things around the gift card distribution, that eventually when they realized how the program works and everything I think they were more careful in telling their patients, 'well I'll tell you when you can get your next gift card and then order your appointment at the front.' We definitely had a lot of support from the clerks that were out front also, often they knew the patients. So that absolutely helped with patients that gave trouble. And we worked with the nurses too... when they were talking to patients, doing patient education they would bring up the program.
> – Staff, FGD-02, BNY

Dedicated and Trained Staff Most SIs attributed smooth implementation to having well-trained and dedicated study staff.

> I can tell you that we were very fortunate to have the young ladies that we had work on our study here. And they did a great job. And I think they learned very much how to work with the flow of the clinic, work with the providers, and work with the patients so that it really became much smoother over time.
> – Site Investigator-02, BNY

PATIENT PERSPECTIVE

While SIs and staff were keenly aware of the changes necessary to adapt to and integrate the FI intervention into their care process, the majority of patients, when asked, noticed no effect on their clinic experience due to the FI program beyond the added benefit of receiving the gift card.

> I don't think [the FI program] has [changed my experience], because like I said, I never anticipated this program and I never expected it to continue a long at all. And now I am understanding that it has and even though it doesn't change the fact that the services have been very good. A blood test done, you know, accurately and it's been good. It's accessed. And I get served there well. From where I live, the access... is not too far to travel, and the services from them. So I'm comfortable here. – Patient, semi-private area male, 40 years old, DC

> [The FI program] made the visit a little bit more... I would say happier. Every time you got all comfortable when on my lab results, because I knew my history, my health history, and I knew that everything's pretty much on point.
> – Patient, semi-private area male, 24 years old, DC

CONCLUSION

Implementing the FI intervention posed some challenges for providers and staff, primarily:

- Integrating the quarterly FI schedule into the standard clinical care schedule for HIV management.

- Increased patient volume, as well as demands on staff time and space.

- Adapting to logistical and administrative processes required for managing the FI program.

- Dealing with difficult or demanding patients.

- Ensuring the confidentiality of patients while explaining the FI program to them.

However, SIs and staff noted several strategies used to mitigate implementation challenges, notably:

- Developing systems and processes over time to improve logistics, clinic flow, and patient tracking.

- Recognizing the positive benefits afforded to patients by the FI program and experiencing positive patient interactions.

- Educating patients and other providers and staff about the FI program and its requirements.

- Relying on trained and dedicated study staff to lead FI program implementation.

The positive experiences and strategies used to overcome challenges facilitated eventual smooth implementation of the FI intervention without patients perceiving any negative effects on their clinical care experiences. While the efficacy of the FI intervention remains to be determined through the assessment of the primary HPTN 065 study data, these qualitative results provide encouraging evidence as to the feasibility of implementing a large scale FI program in a clinical setting.

Additional findings from this sub-study are presented in the following three posters: A-671-0004-00749; A-671-0005-00765; A-671-0004-00774.

Health Care for the Homeless
MEDICAL RESPITE
RESEARCH

This document provides a comprehensive list of medical respite research and articles published in academic journals. Articles are categorized by topic. New resources will be added to this document as they are published.

REDUCED HOSPITALIZATION

Title: **The effects of respite care for homeless patients: a cohort study**
Author: Buchanan, D., Doblin, B. Sai, T., & Garcia, P.
Source: American Journal of Public Health, 96(7), 1278-1281, July 2006
Summary: OBJECTIVES: Homeless individuals experience high rates of physical and mental illness, increased mortality, and frequent hospitalizations. Respite care provides homeless individuals with housing and services allowing more complete recovery from illnesses and stabilization of chronic conditions.
METHODS: We investigated respite care's impact on 225 hospitalized homeless adults consecutively referred from an urban public hospital during a 26-month period.
The cohort was separated into 2 groups: (1) patients referred and accepted into the respite center and (2) patients referred but denied admission because beds were unavailable. All patients met the center's predefined eligibility criteria. Main outcome measures were inpatient days, emergency department visits, and outpatient clinic visits. RESULTS: The 2 groups had similar demographic characteristics, admitting diagnoses, and patterns of medical care use at baseline. During 12 months of follow-up, the respite care group required fewer hospital days than the usual care group (3.7 vs 8.3 days; P=.002), with no differences in emergency department or outpatient clinic visits. Individuals with HIV/AIDS experienced the greatest reduction in hospital days. CONCLUSION: Respite care after hospital discharge reduces homeless patients' future hospitalizations.

Title: **Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons.**
Authors: Kertesz, S. G., Posner, M. A., O'Connell, J. J., Swain, S., Mullins, A. N., Schwartz, M. and Ash, A. S.

Source: Journal of Prevention and Intervention in the Community (in press)
Summary: Medical respite programs offer medical, nursing, and other care as well as accommodation for homeless persons discharged from acute hospital stays. They represent a community-based adaptation of urban health systems to the specific needs of homeless persons. This paper examines whether post-hospital discharge to a homeless medical respite program was associated with a reduced chance of 90-day readmission compared to other disposition options. Adjusting for imbalances in patient characteristics using propensity scores, Respite patients were the only group that was significantly less likely to be readmitted within 90 days compared to those released to Own Care. Respite programs merit attention as a potentially efficacious service for homeless persons leaving the hospital.

Title: **Respite care for homeless people reduces future hospitalizations.**
Authors: Buchanan, D., Doblin, B., & Garcia, P.
Source: Journal of General Internal Medicine, 18(S1), 203, April 2003
Summary: BACKGROUND: Respite care provides 24 hour shelter for homeless people being discharged from a hospital. This allows homeless individuals to fully recover from an illness away from the difficulties of the streets or overnight shelters. Additional supportive services are often also provided in this setting. Although there are at least 22 providers of respite care to homeless people in the United States, no studies have explored the outcomes of these respite services. METHODS: We conducted a retrospective review of administrative data for all patients referred from Chicago's largest public hospital to Interfaith House, Chicago's only provider of respite services. All referrals meeting Interfaith House's eligibility requirements who were referred between October of 1998 and December of 2000 were included in the analysis. The referrals were separated into two groups. Individuals in the respite care group were referred and entered the respite care program (N=161). Individuals in the control group were referred but were not placed in respite care due to a lack of bed availability (N=65). The primary outcome of

the study was the use of health services within the County Health system during the 12 months after referral. RESULTS: At baseline, there were slightly more Hispanic patients in the control group (16% vs 6%). The respite care group had more patients with a diagnosis of trauma (38% vs 25%). During the 6 months prior to referral, the respite care group had slightly more ER visits (1.5 vs 0.9 visits) and hospital days (5.7 vs 5.2 days). Otherwise the two groups were similar in terms of gender, race, diagnoses, and utilization of services prior to the referral. During the following 12 months after referral, both groups had similar numbers of ER visits and scheduled clinic visits, however individuals in the respite care group had a 60% reduction in the number of inpatient days (P = 0.001). The absolute reduction in hospital days was 4.9 days per person after controlling for gender, race, diagnosis, and prior utilization of health services. CONCLUSION: Homeless patients who are served by respite care providers after hospital discharge spent 4.9 fewer days in the hospital during the following year compared to controls. This represents a significant savings to the healthcare system.

IMPROVED OUTCOMES FOR PROGRAM PARTICIPANTS

Title: Shelter- based convalescence for homeless adults
Authors: Thompson SJ, Bender KA, Lewis CM, Watkins R
Source: Canadian Journal of Public Health, 97(5):379-83, September/October 2006
Summary: OBJECTIVES: Homelessness is associated with increased hospital costs and length of stay, and medical or surgical conditions are typically complicated by secondary diagnoses of substance abuse or mental illness. Convalescence care to provide timely treatment has not been analyzed. This is a retrospective study of diagnoses and utility of shelter-based convalescence in a cohort of homeless subjects. METHODS: A 20-bed shelter-based unit providing up to 3 months stay post hospital discharge, or for treatment of addictions or for those too ill to remain in the general shelter was studied. Charting was by the use of an electronic health record developed for the project. Demographics, reason for admission and outcomes are retrospectively described. RESULTS: 140 men had 181 admissions from July 2000-April 2003; 23.8% were post hospital discharge, 57.4% were from the general shelter. Average length of stay was 40 days. 83.4% were treated for a medical or surgical condition, 83.6% for psychiatric disease and 29.8% for addictions. Medication adherence was >80% in the majority. During admission, 20% obtained a new health card, 43.6% a new drug card, 89.3% received transportation to appointments, 60% applied for housing and 24.3% obtained housing. CONCLUSION: A shelter-based convalescence unit can provide health care to homeless persons, treat medical and mental illness, ensure adherence to treatment regimes, decrease substance abuse and assist with housing.

PROGRAM DESCRIPTION

Title: It takes a village: a multidisciplinary model for the acute illness aftercare of individuals experiencing homelessness.
Authors: Gundlapalli A., Hanks, M., Stevens, S. M., Geroso, A. M., Viavant, C. R., McCall, Y., Lang, P., Bovos, M., Branscomb, N. T., & Ainsworth, A.D.
Source: Journal of Health Care for the Poor and Underserved, 16(2): 257-72, May 2005
Summary: Homeless individuals are often uninsured and are more likely than the housed to utilize acute health care services and experience longer hospitalizations. Currently in the United States, there are fragmented services available for the aftercare of these patients to ensure continuum of care, promote healing, and avoid re-entry into the acute care system. The Fourth Street Clinic Respite Program was created to address these issues. Patients are referred to the program from local hospitals and other service providers. Based on the acuity of illness and need for nursing care, patients are admitted to one of four programs: (1) Shelter-based Day Bed Program, (2) Temporary Emergency Housing (Motel) Program, (3) Tuberculosis Housing Program, or (4) Nursing Home Program. Aftercare patients receive medical, social, and behavioral health services and are discharged to local shelters when stable. The aftercare program provides a safe refuge for recovery from acute illnesses for those experiencing homelessness.

Title: Medical Respite Care for Homeless People: A Growing National Phenomenon
Authors: Zerger, S., Doblin, B. & Thompson, L.
*Source:* Journal of Health Care for the Poor and Underserved, 20(1): 36-41, February 2009
Summary: The first known respite care facilities for homeless people emerged in the mid- 1980s, but recent trends in health systems and services have driven their rapid proliferation across the country within the past decade. This report is the first attempt to describe these respite programs comprehensively.

NYU Furman Center

State of New York City's Housing and Neighborhoods in 2013
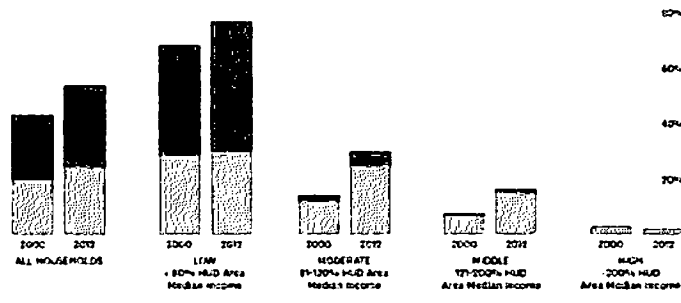
Renters and Their Homes

Rents are high and rising.
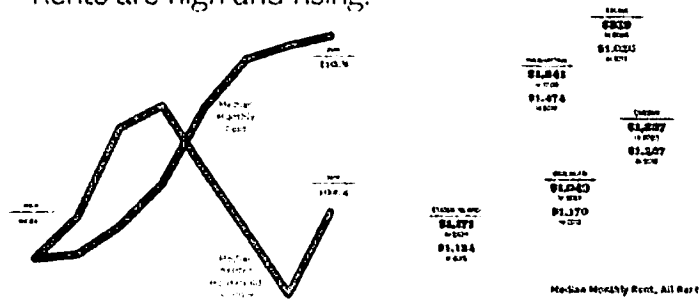
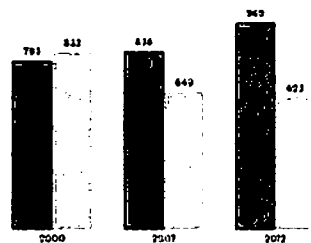## Low-income renters were much more likely to be rent burdened than other income groups.

77 percent of low-income households were rent burdened in 2012, with 47 percent spending over half of their income on rent.

The number of rental units affordable to lower-income New Yorkers has decreased.

622,746

The number of NYC rental units affordable to a three-person household earning $37,978 in 2012.

969,224

The number of NYC households earning at or below $37,978 in 2012.

**NYU
Furman
Center**

**State of New York City's
Housing and Neighborhoods
in 2013**

Home prices increased in every borough between 2012 and 2013.
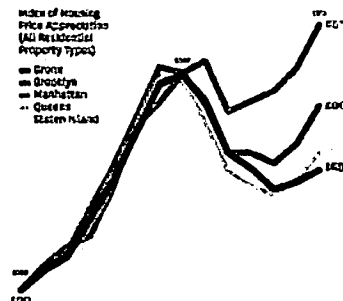
The average sales price of condos and rental properties with
over 5 units or more have both surpassed their pre-recession peak.

Foreclosure starts continued to be elevated in 2013 but were still below peak levels.

**Foreclosures were concentrated
in many of the same neighborhoods
as they were in 2009.**
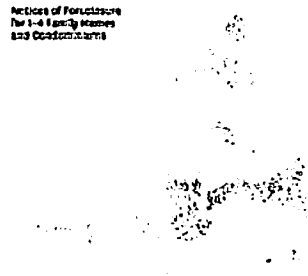
Monthly mortgage payments for newly purchased homes became more affordable between 2007 and 2013.

**A three-person household earning 80% of the area median income
could afford monthly payments financed with a conventional mortgage
for 5% of home sales in 2007 and 27% of home sales in 2013.**

**However, the maximum price of a single-family home or condo affordable
to a three-person household earning 80% of the area median income in 2013—
about $338,000—would require a down payment of nearly $68,000.**

CASE STUDY

December 2014

Technical Assistance to Improve Patient Outcomes in the Crescent City Beacon Community

I. Executive Summary

Before Hurricane Katrina hit in 2005, New Orleans already had some of the worst health care statistics in the country, with high rates of infant mortality and chronic diseases like heart disease, diabetes and HIV/AIDS. The hurricane shattered New Orleans' already weak safety net, forcing clinics and hospitals to close, and dislocating some 4,500 physicians. New Orleans's health care system was in shambles, putting its already vulnerable citizens at significant health risk.

Rebuilding the New Orleans healthcare system offered an opportunity to address some of the issues that plague many communities moving away from hospital-centered care, and investing in, patient-centered, community-based health services.

The Crescent City Beacon Community (CCBC) – a network of community health centers and other primary care practices serving more than 50,000 patients – is one of 17 "Beacon Communities" around the country funded to leverage technology to transform local health systems and improve care for low-income families. The Louisiana Public Health Initiative, which led the initiative, brought in Primary Care Development Corporation (PCDC) to help the CCBC practices reshape how they delivered care and worked with their communities.

From December 2011 through March 2013 the PCDC provided technical assistance to the Crescent City Beacon Community. To implement a quality improvement initiative at each of CCBC's 16 primary care practices, PCDC's technical assistance strategy focused on the implementation of the following five interrelated interventions geared toward improving patient outcomes in primary care settings:

- Care management and care team protocols

- Risk stratification of patients
- Population-based disease registries
- Transitions of care best practices
- Clinical decision support systems

These five interventions are drawn from the chronic care model -- an approach to the management of chronically ill patients that seeks to improve outcomes for patients by shifting the healthcare delivery model away from what is essentially a "reactive" system (responding mainly when a person is sick) to one that is proactive and focused on keeping a person as healthy as possible.

PCDC's Learning Collaborative included a blend of remote and in-person training and coaching to ensure intensive learning and incorporation of that learning into daily sustainable operations in each practice. Specifically, we conducted four in person learning sessions in New Orleans for the community, and one learning session remotely, or "virtually," through Internet-based technology. We also held weekly teleconferences with each site to guide and ensure continual progress. This approach delivered current and innovative subject matter expertise, enforced periods of activity and implementation, placed strong emphasis on self-assessment, and most importantly, promoted sustainability of operational changes after project completion.

Goals for the project beyond implementing the five interrelated interventions included:

- Improving process measures related to the delivery of care
- Increasing the use of care plans
- Developing written policies and procedures and job descriptions
- Establishing systems for encouraging patient self-management and education

Long-term goals included improved clinical outcome measures for diabetes (DM) and cardiovascular disease (CVD) patients. CHCs reported process and clinical outcome measures to LPHI quarterly throughout the project.

All the centers involved in CCBC finished the project with the ability to track outcome measures for their DM and CVD patients. When healthcare organizations gain the ability to track their processes and clinical outcomes powerful positive changes can take place. The clinics in the Crescent City Beacon Community have made enormous strides through their work on the Beacon project, and we look forward to seeing continued improvements for patients and staff.

II. The Primary Care Practices at the Beginning of the Learning Collaborative

One of the critical pieces of this project was determining each practice's varying levels of patient-centered medical home, health IT, and care management capabilities and skills as they related to the five interventions. Determining "readiness" early in the process ensured that PCDC could use the best intelligence and data to structure a comprehensive program that addressed core concepts, activities, support levels, and technology capability.

PCDC assessed each site using an assessment tool it created for the project, and combined the results with data gathered by CCBC and LPHI prior to project start with results from a PCDC designed "practice profile" administered to all sites.

This assessment enabled PCDC to determine and address each practice's capabilities in the areas of quality improvement, care management, population health management, transitions of care, and clinical decision support (see assessment chart).

Almost three quarters of the centers had a weak grasp of care management and did not employ any systematic or standardized way of addressing the needs of their high risk, chronically ill DM and CVD patients. Over half of the centers did not use a coordinated or planned approach for the care of their DM and CVD patients.

The quality improvement activities of centers varied. A few centers had robust quality improvement systems and processes in place but more than half of the centers had no quality improvement team at all. Of those with quality improvement teams, less than half of those teams met regularly, and less than half received or reviewed reports of performance or improvements from their providers and care teams.

Providing coordinated care also challenged centers. Without a health information exchange, and few reliable systems or established processes for communicating with hospitals and specialists, many of the centers had trouble receiving specialist reports

Measure (from PCDC assessment tool results)	January 2012 % of centers
Have care manager job descriptions	25%
Conduct previsit planning	25%
Use care plans	25%
Follow-up with patients who do not keep appointments	37%
Use registries to identify patients who might benefit from educational resources	12%
Have risk stratification protocols	25%
Train staff on risk stratification protocols	18%
Provide care management for DM patients	31%
Provide care management for CVD patients	18%
Train all staff on use of CDS tools	12%
Include providers in decision making about use of CDS tools	18%
Maintain written protocols for referrals	43%
Established quality improvement (QI) team	43%
QI team meets regularly	37%
Provides feedback to QI team on improvements	31%
Receives notifications from the ER about patient admissions	0%
Receives notifications from the inpatient department about patient admissions	0%

and did not receive notification or information when patients were seen in the emergency room or admitted as an inpatient in the hospital.

In addition, all the centers faced organizational challenges not directly related to the interventions of this project that had the potential to impact the effectiveness and outcomes of the project.

A large proportion of the centers had competing priorities and were facing multiple demands on their time. Some sites were planning to seek recognition as NCQA Patient Centered Medical Homes, or were already in the middle of the process, while also working on the CCBC project. While some of the themes and interventions of the work in the two projects overlapped, the schedule for the work frequently did not, and the type of work was different CCBC focused more on operationalizing interventions and building sustain-

ect. PCDC also observed issues in many centers related to standardized data collection. In many centers, clinical staff were not always recording data in structured fields and had not received training on where to document correctly in their EMR resulting in inaccurate and incomplete data reports for those centers.

Lastly, many centers had high rates of staff turnover, unfilled positions and staff with demanding workloads who were hesitant to take on new roles such as providing care management or setting aside time from patient care for meetings.

III. Summary of Strategy and Project Activities

PCDC's Learning Collaborative included six phases: a pre-work period, five learning sessions, and five action periods. At the end of the project LPHI offered all the

Curriculum Outline

Phase 1	Pre-Work Project Planning	Site assessments Gap Analyses Work plans		Dec. 2011-Feb. 2012
Phase 2	Learning Session One	Quality Improvement Care Management I	Activity Period 1	Mar.-Apr. 2012
Phase 3	Learning Session Two	Care Management 2 Population Management Risk Stratification	Activity Period 2	May-Jun. 2012
Phase 4	Learning Session Three (virtual)	Transitions of Care	Activity Period 3	Jul.-Sept. 2012
Phase 5	Learning Session Four	Clinical Decision Support	Activity Period 4	Oct.-Nov. 2012
Phase 6	Learning Session Five	Sustainability and Spread	Activity Period 5	Dec. 2012
	Extension Period	Centers set own goals related to above intervention areas	Activity Period 6	Jan. 2013-Mar. 2013

able change, while the PCMH recognition preparation focused more on producing reports and correct documentation to submit for recognition.

We noted challenges relating to health information technology (HIT) capabilities of the centers. Some centers began this project, which had optimization of a center's HIT as a goal, without an electronic medical record (EMR). One center, an ambulatory care site that was part of a hospital, did not have the ability to modify their EMR. Other centers had begun or were planning to implement an EMR during the CCBC proj-

centers the option of continuing to receive technical assistance from PCDC for an extended three month period (see curriculum outline above).

The sequence of learning sessions and action periods was specifically designed to commence with topics that were considered foundational to the project, followed by topics that would build on that foundation. PCDC also worked with LPHI to coordinate the timing of specific topics such as transitions of care with the roll out of the Health Information Exchange in the Crescent City community.

Phase 1: Pre-work

PCDC launched the project with a presentation to the executive leadership of the centers that reviewed the initiative objectives and the corresponding work that would be required of their staff. At this kick-off, PCDC emphasized the need for consistent protected time for staff to attend meetings and complete project work. (PCDC believes that lack of executive buy-in is a leading cause of project failures, so we spend significant time ensuring that the centers we work with will have this support.)

At the launch, we asked the executive leadership of each site to designate a "change team" to lead the process improvement work of the project. This team would meet, participate in the weekly calls with PCDC coaches and follow up on tasks related to the changes or improvements their centers were implementing. To ensure that all levels of the organization were "bought in" and to increase the chances that changes and improvements would be sustained and spread throughout the organization, PCDC recommended that a multi-disciplinary cross-section of staff members be chosen for the change team, ideally including administrators, medical assistants, front desk staff, nurses, providers, and the medical director or clinical lead. In the end, most change teams ended up comprised of a cross section of medical center staff.

The executive leadership kick-off was followed by on-site visits from PCDC coaches to all sixteen practice sites. Following the assessment process, PCDC used the data gathered from the assessments to compile gap analyses, recommendations, preliminary work plans and goals for each practice.

Phase 2: Quality Improvement Care Management I

Phase two of the project kicked off with a learning session that focused on quality improvement and care management, two principles/concepts that were seen as essential for the practices to understand at the outset of the project.

PCDC's team facilitated all learning sessions. The sessions encouraged the development of new ideas, highlighted existing best practices around a topic, and created a supportive environment for healthcare professionals to share experiences and knowledge with each other. To that end, all learning sessions involved a mix of presentations, activities, and group exercises in which sites were guided to think creatively about the productive ways to implement interventions to meet the goals of the project.

Topics included an overview of the chronic care model and its relationship to quality improvement, the role of the care manager, health coaching, care management activities, and "Plan-Do-Study-Act" (PDSA) cycles as a way to test change, and change management.

Phase 3: Care Management 2/Population Management/Risk Stratification

Approximately eight weeks later, phase three began with the second learning session. The focus of this session was evidence-based guidelines and an introduction to population management as a method for providing better care for chronically ill patients.

Presentations and activities helped the centers to grasp concepts related to these areas and to understand how to operationalize population management through the implementation of tools such as disease-specific registries, and the addition of new personnel such as care managers. The session also emphasized the "care team" model as a way to better manage the multiple levels of care that need to be delivered to chronically ill patients. Presentations from the EMR vendors allowed the sites to see concrete examples of how to set up registries in their particular systems.

Phase 4: Transitions of Care

The third learning session was conducted virtually, through the use of Internet-based meeting technology. All sixteen sites logged on from their centers and used webcams if available. Topics and activities for this session included best practices related to transitions of care. PCDC designed activities to aid the sites' change teams in exploring and applying ideas related to new work flows and processes that would be needed to

most effectively use the new Health Information Exchange system that is being implemented in their Beacon community. This session began phase four.

Phase 5: Clinical Decision Support

Phase five of the project began with a learning session on clinical decision support (CDS). This topic brought together and built on topics that PCDC had been working on with centers for most of the project. These included improving the flow of the right information to the right people at the right time in the work flow as a way to drive improvement in the targeted clinical measures. For example, through the work at this session, a center may have identified that to have an impact on a selected measure, it should implement a registry system so that Medical Assistants can take required action between a patient's visits.

Throughout the project, PCDC focused on improving staff's use of their health information technology to enhance their delivery of chronic care management. We facilitated project leadership and the change teams in thinking about what operational changes would affect targeted clinical measures, and planning how to address these changes in their Electronic Medical Record systems. They quickly grasped the variety of CDS tools that existed and how using these features at the appropriate time in workflow could assist them.

In this phase of the project, nationally-recognized CDS subject matter expert Jerry Osheroff, M.D. (TMIT Conuslting LLC), joined PCDC to collaborate on the development of strategy for the implementation of CDS in the centers. Dr. Osheroff attended the learning session and facilitated an activity that PCDC and he co-developed. This activity helped centers to identify gaps in information flow related to a particular clinical or process improvement.

Phase 6: Sustainability and Spread

The last and final learning session focused on sustainability and spread of the changes and improvements that the centers had made over the course of the Beacon project. Each organization created a "storyboard" that focused on an intervention implemented during the Beacon project that they believed had had the most impact on their ability to deliver high quality care. Pictures, graphs and examples of what they had done were included on each storyboard. Other organizations had a chance to view the storyboards during the "gallery walk" where they could ask questions and learn about the new ideas and approaches adopted by their colleagues.

Other activities at the learning session focused on "lessons learned" by each center during the project and brainstorming ideas to "make the new way unavoidable" or in other words, to make the new changes sustainable. The centers completed a sustainability dashboard that showed them how to measure and track interventions and processes that they wanted to maintain after the project ended.

Phase 7: Extension Period

In December 2012, LPHI offered the centers the opportunity to continue receiving technical assistance and coaching from PCDC for an additional three months. Fourteen out of sixteen centers chose to continue. No new topics were introduced during this time frame and most centers chose to use this time to meet goals they had set for themselves earlier in the project but had not yet completed. The extension period included four bi-weekly coaching calls with the centers, the development of an individualized transition plan and a final site visit from the coaches.

PCDC considers the extension period to have been particularly valuable for organizations with fewer resources and /or multiple competing priorities. Centers benefited from the extension period's narrow focus, the reduced number of goals to work towards, and the absence of new topics. Bi-weekly meetings were well received and allowed centers time to meet on their own to complete work.

Coaching

In addition to the five learning sessions, an essential component of PCDC's technical assistance strategy for the CCBC project was weekly or bi-weekly coaching calls with all 16 sites. PCDC assigned one of its consul-

tants, or "coaches," to work with each site throughout the project. This enabled PCDC to customize the work for each site while still keeping all centers moving through the learning session topics and activity periods in parallel.

PCDC supplemented the coaching calls with on-site, in-person visits throughout the year, amounting to a total of five in-person visits including the assessment visit at the beginning of the project. The extension period provided extra coaching calls and a sixth site visit for those centers that continued the project.

A guiding philosophy for the PCDC team was to "meet the practices where they were," meaning that an explicit effort was made to work with each site individually to identify barriers and challenges to meeting the project's goals, and construct plans that took these challenges into account. (LPHI strongly encouraged this approach, too.) PCDC's coaching calls and site visits enabled the coaches to engage participants and understand the unique challenges, patient populations and culture of each practice as well as to assist in guiding, monitoring and managing progress.

PCDC also partnered with LPHI designated project officers for each site. Leveraging LPHI's existing relationships with the practices, and their geographical proximity, LPHI's project officers complemented and enhanced PCDC's work, and assisted in finding solutions, brought in EMR vendors when needed, and helped to keep the practices informed about the project. The project officers also communicated to the practices about other aspects of the Beacon project that were outside of PCDC's scope of work.

Project Structure and Approach

PCDC created a detailed curriculum that included project phases specifically sequenced for maximal effectiveness. This curriculum served as the foundation for our approach to the management of this project. Basic tenets of the chronic care model were discussed with the centers at the beginning of the project so that center staff would understand the goals of the operational changes and health information technology work that followed.

For example, our approach to teaching the implementation of a registry was first to talk about shifting from a "reactive" model of care for chronically ill patients to a "proactive" approach. Centers were asked to think about why this would be a good approach and what benefits for patients and health center staff might result from this shift in approach. Once a center agreed that this model made sense to them and was something they wanted to try, we then moved on to discussing what a registry is, how they would set one up in their centers, and how they would use it. Assuring understanding and buy-in of the bigger concepts and model came first, the tools, processes and operations changes followed.

PCDC Staff/Team Process

PCDC consulting staff come from a variety of backgrounds including clinical, operations, HIT, teaching, and public health. The PCDC project lead was a clinician who has extensive experience working in community health centers that serve an uninsured and Medicaid patient population. Coaches were assigned to specific centers based on their content expertise (i.e. a center who might be undergoing an EMR implementation concurrently during this project was assigned someone who had experience with this process, a coach with previous hospital experience was given the only hospital ambulatory care center involved in the project, etc.) Each coach was given four centers that were assessed as functioning at different levels.

The PCDC team met internally for two, one-hour meetings every week, except for the two to three weeks immediately before the learning sessions when the team met more frequently to develop presentations, and create exercises and activities for the learning sessions (6-9 hours). The routine weekly internal meetings were divided between project updates and sharing of issues that coaches were encountering at the sites (meeting #1), and preparation for the learning sessions (meeting #2). In addition, when coaches encountered issues with their sites they would meet one-on-one with the PCDC project manager to discuss possible approaches to the problem or to collectively

reach out to LPHI for assistance.

Additional support for many aspects of the project came from a designated project coordinator who managed administrative tasks, and handled preparation for the five learning sessions including coordinating scheduling with LPHI, making sure the PCDC team had all needed materials and technology for each learning session, turning draft exercises and activities created by the team into finished products, and traveling with us to New Orleans to effectively "stage manage" each session and ensure that the team kept on schedule and had the support they needed to deliver and facilitate the sessions. The coordinator was also responsible for producing aggregated data reports from all the assessment tools, as well as preparing reports from the evaluations distributed after each learning session and at the end of the project.

Additional project management support was provided by a PCDC senior team member who was also a coach on the project. This set up meant that the project lead had their own support from someone who was intimately familiar with the project, in addition to PCDC's executive sponsor, and could consult with them as needed for strategic guidance or to brainstorm solutions for any issues that arose.

The PCDC team project lead and the LPHI team met bi-weekly throughout the duration of the project.

IV. The Primary Care Practices at the End of the Learning Collaborative: Significant Improvement

PCDC would not normally expect to see improvement in clinical outcome measures in the short space of a year (the duration of this learning collaborative), however, there have been improvements in clinical outcomes for a majority of the centers involved in this Beacon community project, particularly in the diabetes measures. Most centers chose to focus first on implementing interventions to improve diabetes care and this focus is reflected in these results. PCDC worked with the centers to help them replicate the operational changes they made with DM patients for their CVD and other chronically ill patients.

CCBC Outcome Measure Performance:
Baseline to Current (baseline is from before PCDC began working with centers)

	Q2(5/3/11) to Q9 (2/29/13)
Diabetes: A1c testing	△
Diabetes: A1c control (< 8%)	△
Diabetes: Lipid Testing	△
Diabetes: Lipid Control (<100 mG/dL)	△
Diabetes: Blood Pressure Control (< 130/80)	▽
Ischemic Vascular Disease: Blood Pressure Control (< 140/90)	◁▷
Ischemic Vascular Disease: Complete Lipid Profile	△
Coronary Artery Disease: Drug Therapy for Lowering LDL-C	△

Blood pressure control for diabetic patients proved to be particularly challenging and both PCDC and LPHI observed conditions that may have affected the lack of improvement on this measure:

- patients not being able to access and pay for prescription medications to treat hypertension

- sites needing to learn from other sites what evidence based best practices are most effective for their patient population

CCBC Outcome Measure Performance: Q8 to Q9

	Q8 to Q9 April 2013 submission
Diabetes: A1c testing	△
Diabetes: A1c control (< 8%)	△
Diabetes: Lipid Testing	△
Diabetes: Lipid Control (<100 mG/dL)	△
Diabetes: Blood Pressure Control (< 130/80)	△
Ischemic Vascular Disease: Blood Pressure Control (< 140/90)	◁▷
Ischemic Vascular Disease: Complete Lipid Profile	◁▷
Coronary Artery Disease: Drug Therapy for Lowering LDL-C	△

Results from PCDC's assessment tool that was administered in the beginning, middle, and finally