Transformation Transfer Initiative Final Report: New York

Interview conducted on: June 9, 2021
Interviewee: Tracey Wilson, Mental Health Program Specialist, Sustained Engagement Support Team

1. *When did you launch your 2020 TTI, and how long has it been operational?*

There are two different sites where this project is taking place. One is up north in our Saint Lawrence Psychiatric Center, and the other is in New York City at our Kingsboro Psychiatric Center. The northern facility, Saint Lawrence, launched much earlier than Kingsboro—in October of last year. Kingsboro just launched this week.

2. *How has COVID-19 impacted your project? What adaptive practices or efforts have aided you in overcoming these challenges?*

As noted, the Kingsboro program just launched this week; this was mostly due to the pandemic and subsequent staffing issues. This Center is in Brooklyn, and it was impacted strongly by COVID, experiencing both client and staff illnesses.

We also saw a lot of our outpatient clinical staff being reassigned to inpatient duties, because we had to help clear units in the community hospital. Anybody who was in one of the community hospitals for mental health reasons was sent to our state psychiatric centers so that they could turn those beds into medical beds. These processes required a great deal of shuffling of staff throughout our system. Thus, the clinical work shifted and became more of managing people while we were facing with this crisis. Accordingly, we could not take on a new project at that time, which led to the major delay in implementation for the Kingsboro Center.

Additionally, there were restrictions on outside agencies coming onto our state facility campuses. Part of our project has been contracting with peer agencies so that we could have peer specialists working with our clients. This part of the programming was delayed; only recently have we been able to have the peer agencies we are contracting with come on site, fill out all the necessary paperwork, and get onboarded.

In order to respond to these challenges, the biggest and most obvious change we have implemented has been to shift to telehealth. We are changing the way we interact and deliver services by working with a large percentage of our client-base primarily by telephone and also, in some cases, by video.

3. *How many individuals have participated in your TTI at time of this interview?*

For Quarters 4 through 1 (from the October 1 through March 31) we had 14 individuals enrolled.

4. *How much has been paid in incentives at time of this interview?*

In that same time period, we have paid out $235.00 in incentives.

5. *Have there been changes to your key partners and/or target population?*

St. Lawrence did expand their partnerships to some extent. This site was initially working with only individuals discharged from inpatient units of both the state and community hospitals. They have expanded to individuals who are discharging from emergency rooms, as well, in order to achieve a larger cohort of individuals. They have also expanded to some of the more rural hospitals they were not going to be working with initially.

We had a lot of challenges getting people to agree to be a participant in the project. Accordingly, we keep trying to cast the net a bit wider to see if that helps to pique more interest in the program. As noted, we only have 14 participants, and the majority of people who have been approached about the project have declined. We are trying to really get to the bottom of why there is so little interest and change our approach to try to achieve a bigger buy in.

6. *Do you plan to make incentives a part of your behavioral health system moving forward? If so, how will you achieve sustainability?*

There is not a plan to do so right now. While our project did include the incentives, the large majority of the funding went to peer support agencies that we contracted with to support clients. We are leaning more toward considering the ability to continue utilizing such a peer support service moving forward. If we find that the peers are really making a difference in the level of engagement, and helping people to navigate the system and stay out of the hospital, then those are things that will likely try to continue with. Due to the pandemic and budget restrictions, we are currently experiencing a hiring freeze and we are not taking on any new contracts. We do not know how long this hiring freeze will last. It is challenging, and we have to wait and see when we can bring on more peers.

7. *Do you have any meaningful anecdotes regarding your programs that you can relay to us? (I.e., testimonials from participants, creative solutions)*

Recently, we have noticed that the few participants who really do seem motivated to engage with a peer and are excited about participating in the project are individuals who connected with us much earlier on before their inpatient discharge. Thus, there was an ability to build rapport and form a relationship before the transition back into the community.

Early on in our project, though, the inpatient staff we were working with were not giving us the heads up early enough that people were going to be approaching discharge, so we were not afforded the opportunity to form those relationships and offer that warm handoff the way we would have liked. This has highlighted the fact that the participants who got that extra time and that warm handoff have benefitted much more from the program thus far.

As noted, the large majority of the individuals we have approached have said they are not interested in participating. The more we dig into that, it might be about our approach and about how this project is being presented. We are going to try to shift our delivery and focus more on how can help in terms of accessing benefits or getting basic needs met such as food and clothing. We will focus less on the end goal of getting connected to treatment, because that has been in forefront of our messaging thus far—and it might be alienating some people. Rather than focusing on the treatment engagement, we will try to focus more on the engagement with the peer specialist. We will then use that relationship as a bridge to other treatment opportunities.

8. Do you see the incentives working to help individuals make follow-up appointments?

The incentives have not seemed as though they are the reason people are signing on. The people who have signed on seem to be more motivated to work with a peer. The participants want that additional support of navigating the complex systems of social services and Medicaid and that type of thing.

It is also interesting to look at the appointment attendance rates of those who enrolled in the program and those who declined. They are largely the same. The individuals who are participating have an attendance rate of 85%, while those who declined are attending their appointments 88% of the time.

9. What has this federal investment given your state system that would not have happened without it?

The greatest value to us has been the ability to utilize peer-to-peer supporters who have lived experience to try to facilitate our highest return into the community and to try to help bridge that gap and navigate the complex system of mental health and benefits. We have a very difficult time hiring peer specialists within New York State because of the way our civil service system is set up. Thus, many of our clinics do not have any type of peer representation, which is unfortunate. This is always something we are trying to change, but it is more of a budget issue than anything else.

10. How will you use any residual funding?

We will most likely funnel residual funding into the peer support specialists. Depending on what we see with the incentives—if there is a turnaround in how people respond to those—there is also the potential for us to try to continue some of those as well. But our strongest focus will be on continuing to encourage the involvement of peer specialists and individuals with lived experience.