Evaluating Peer-Operated Crisis Care Alternatives

Laysha Ostrow, M.P.P.
Johns Hopkins Bloomberg School of Public Health
Presentation to Columbia University/Nathan Kline Institute, September 2012

Outline

- Review of the model of peer-run and -operated crisis respites
- Characteristics of existing respites
- Peer-run respites in the continuum of care and community
- Sustainability: Shifting funding from state/county funds to Medicaid reimbursement
- Research and Evaluation: Results of survey of existing respites
- Recommendations on evaluation

Background

- Hospitalization for people experiencing a psychiatric crisis is often traumatic, costly, and does not provide recovery-oriented services.
- Alternatives to hospitalization are needed.
- Mental health consumer/survivors have created alternatives to hospitalization, called peer-run crisis respites.
- There are 13 existing respites

Ostrow, 2012

What are Peer-Run Crisis Respites?

- Peer-run respites are crisis alternatives with the intended outcome of diverting hospitalization
- They are staffed and operated by peers who have professional training in providing crisis support to build mutual, trusting relationships
- Peer-run respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis

Ostrow, 2012

Models of Peer-Run Respites

- Peer-run indicates that the board of directors is at least 51% peers
  - peers staff, operate, and oversee the respite at all levels
- Peer-operated (hybrid) indicates that although the board is not a majority peers, the director and staff are peers
  - Attached to a traditional provider

Ostrow, 2012

Peer-Operated Respites as an Adaptation

- "We call peer-run "pure" and peer-operated "hybrid"
  - There is implicit judgment in this language, but it's most important that the services and the people providing them reflect the values
- Traditional providers are trained in hierarchical power dynamics in treatment – this is what they know (whether they are aware or not)
  - Psychiatrists on staff or consultation for peer-operated respites should be selected carefully and offered training in peer support modalities and shared/supported decision-making

Ostrow, 2012

Existing Respites

Ostrow, 2012

Respite Name	State	Guests	LOS	Model
Stepping Stone Peer Support & Crisis Respite Center	NH	2	1-7	Peer-run
Sweetser Peer Support & Learning & Recovery Center	ME	3	3.5	Peer-operated
Georgia Peer Support and Wellness Center	GA	3	Up to 7	Peer-run
Peer Support, Wellness, and Respite Center of Bartow County	GA	3	Up to 7	Peer-run
Peer Support, Wellness, and Respite Center of White County	GA	3	Up to 7	Peer-run
Rose House Hospital Diversion Program by PEOPLe Inc. (Milton)	NY	4	1-5	Peer-run
Rose House Hospital Diversion Program by PEOPLe Inc. (Putnam)	NY	3	1-5	Peer-run
Voices of the Heart, Inc.	NY	2	1-3	Peer-run
Foundations: A Place for Education and Recovery	OH	3	3-5	Peer-run
Keya House	NE	4	Up to 5	Peer-run
2nd Story Santa Cruz County	CA	8	8	Peer-operated
Alyssum	VT	2	14 +/–	Peer-run

Ostrow, 2012

Respite Name	State	Funders	Budget
Stepping Stone Peer Support & Crisis Respite Center	**NH**	NH State General Funds and Federal Block Grant	$353,180
Sweetser Peer Support & Learning & Recovery Center	**ME**	Sweetser and their Endowment of Mental Health and United Way	$308,500
Georgia Peer Support and Wellness Center	**GA**	Georgia's Department of Behavioral Health and Developmental Disabilities (GBHDD)	$354,000
Peer Support, Wellness, and Respite Center of Bartow County	**GA**	GBHDD	$325,000
Peer Support, Wellness, and Respite Center of White County	**GA**	GBHDD	$325,000
Rose House Hospital Diversion Program by PEOPLe Inc. (Milton)	**NY**	Orange County	$270,00
Rose House Hospital Diversion Program by PEOPLe Inc. (Putnam)	**NY**	Putnam County	$290,000
Voices of the Heart, Inc.	**NY**	NYS Office of Mental Hygiene, Warren and Washington County and Private supporters	$150,000
Foundations: A Place for Education and Recovery	**OH**	Stark County Recovery Services Board (Canton)	$160,000
Keya House	**NE**	State Division of Behavioral Health	$266,000
2nd Story Santa Cruz County	**CA**	SAMHSA Mental Health Transformation Grant Ostrow, 2012	$478,650
Alyssum	**VT**	State of Vermont	$369,000

In the continuum of care

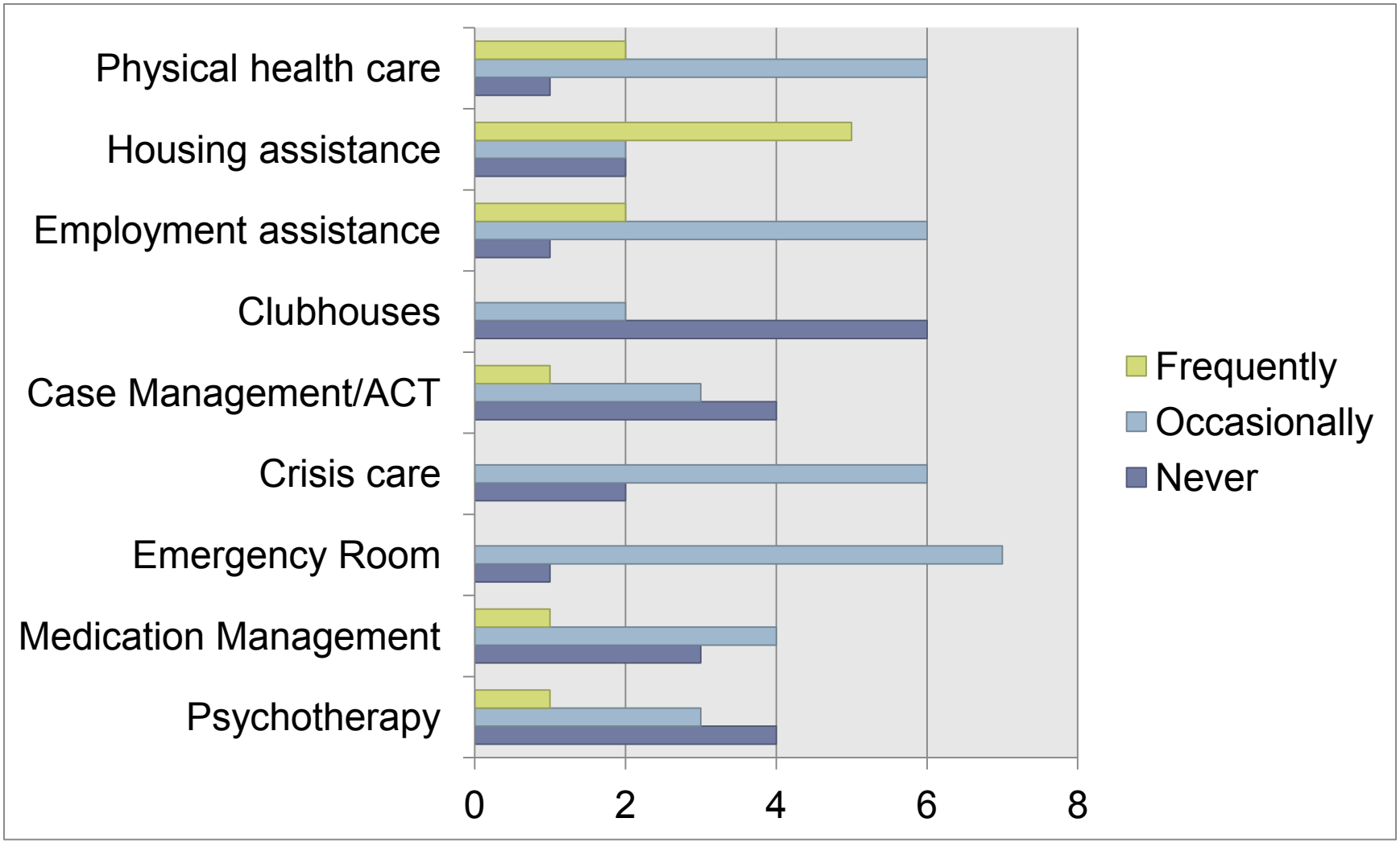
Ostrow, 2012

Alternatives or Adjuncts?

- 8 felt that their organization's activities were an *alternative* to hospitals and ERs
- 2 saw their activities as a service that can be used *in addition* to hospitals and ERs.
- When comparing peer run respites and inpatient and ER…
  - 2 thought people should *only* use peer run respites
  - 7 thought people should *mostly* use peer-run respites, but sometimes use hospitals and ERs
  - 1 thought people should use both *equally*
  - None thought people should mostly use hospitals and ERs, and sometimes use peer-run respites

Ostrow, 2012

Referrals to other providers



Ostrow, 2012

Referrals from providers

- All respites reported that other providers either occasionally or frequently refer people to their services. None reported that providers never refer to them.

Sustainability

Ostrow, 2012

Reimbursement

- Peer-run respites are not Medicaid reimbursable at this time, but future funding could eventually come from a combination of state revenues, block grant dollars, Medicaid, and Medicare.
- Respite directors were asked whether they would be willing to accept Medicaid reimbursement
  - 6 respondents were willing to become Medicaid providers, but had concerns
  - 4 were unwilling to become Medicaid providers

Concerns about Medicaid reimbursement	Responses
Do not want to have to justify medical necessity	9
Afraid cannot remain advocates if part of an insurance company network	7
Detract from our mission of focusing on recovery, and make us focus on money	5
Not enough financial staff to manage the billing	2
Do not want to participate in Medicaid's requirements for quality and performance measurement	2
Do not have computer systems secure enough	1
Do not want to be audited by an insurance company	1
Do not want to go through the application process	0
Do not have enough administrative staff to handle the paperwork	0

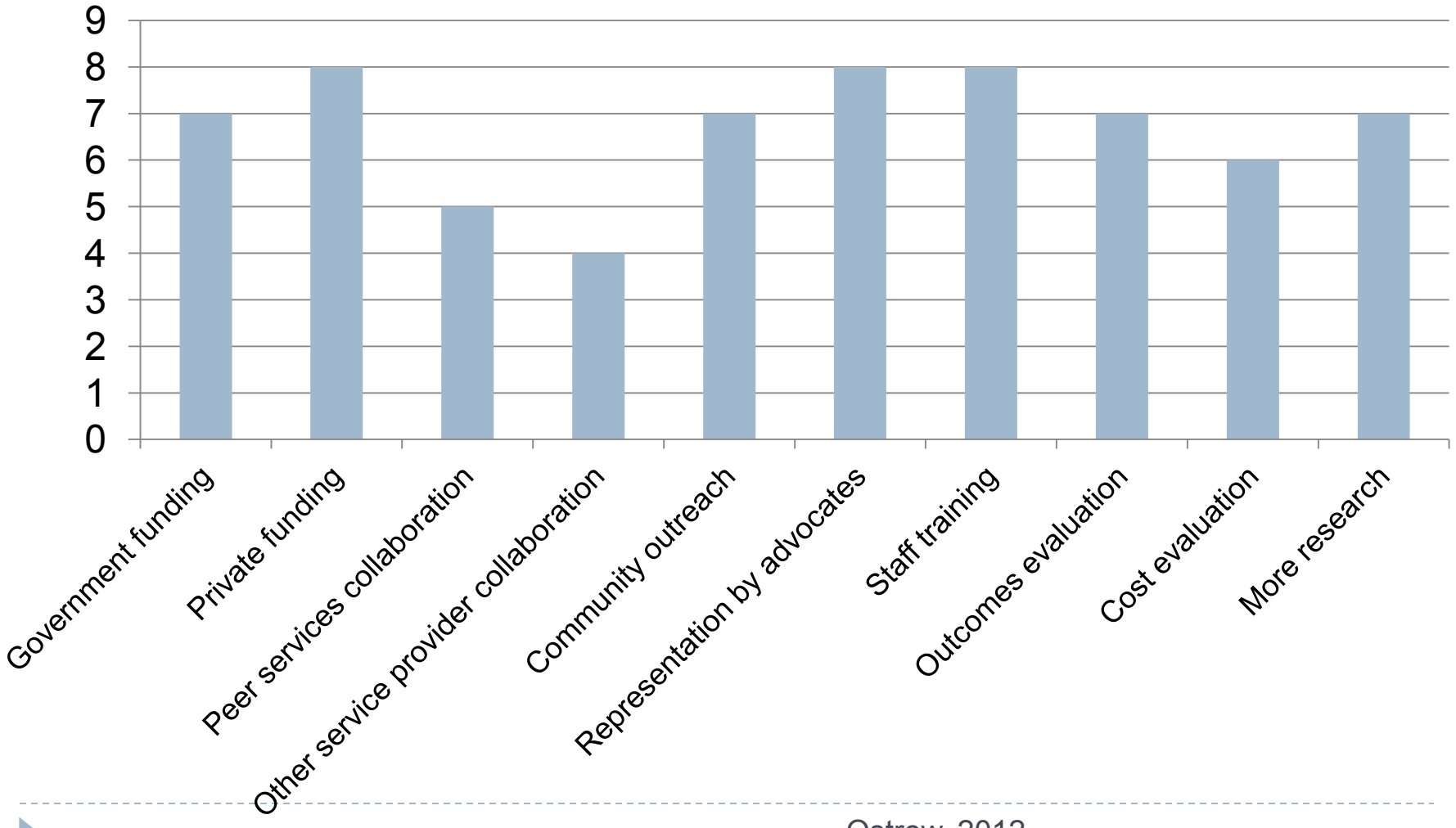
Ostrow, 2012

Other concerns

- Medicaid required clinical/medical supervision
- Medical model language is “demeaning and inaccurate”
- Rates may not be acceptable for funding needs
- There are issues because of the values and principles of the consumer/survivor/ex-patient/peer movement
- Taking Medicaid brought up issues around forced and coercive treatment

Ostrow, 2012

What programs need to be effective



Ostrow, 2012

Research and Evaluation

Ostrow, 2012

Research & Evaluation

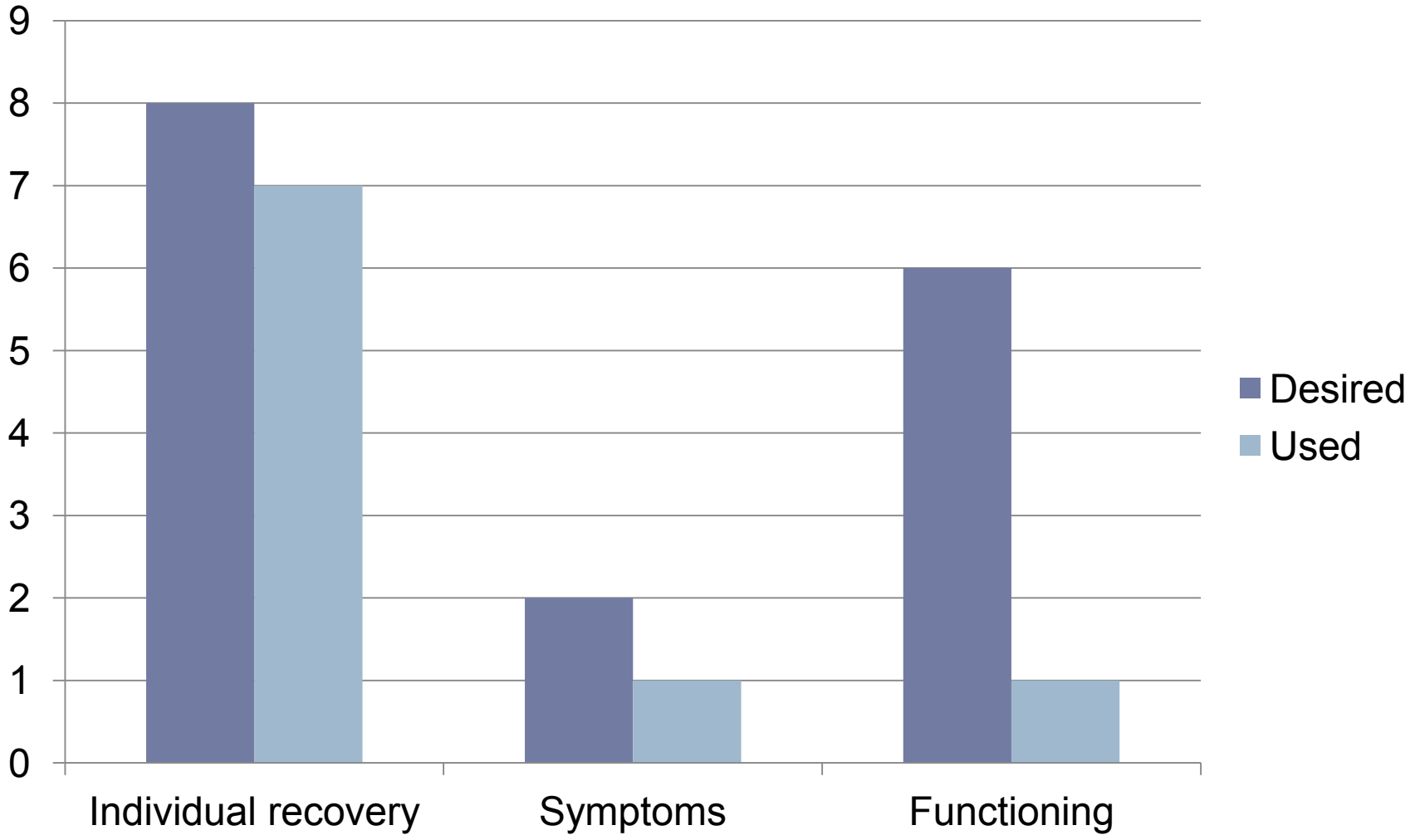
- Evaluating peer-run respites is an important next step in their development and implementation
- They must be evaluated for cost, outcomes, and cost-effectiveness if they are to succeed
- To date, there has not been large scale, multi-site, quantitative evaluation of organizational processes, utilization, outcomes, or costs
- The intended outcomes are not the same as traditional services
  - Transforming systems means transforming how we conceptualize effectiveness

Ostrow, 2012

Existing respites' evaluation

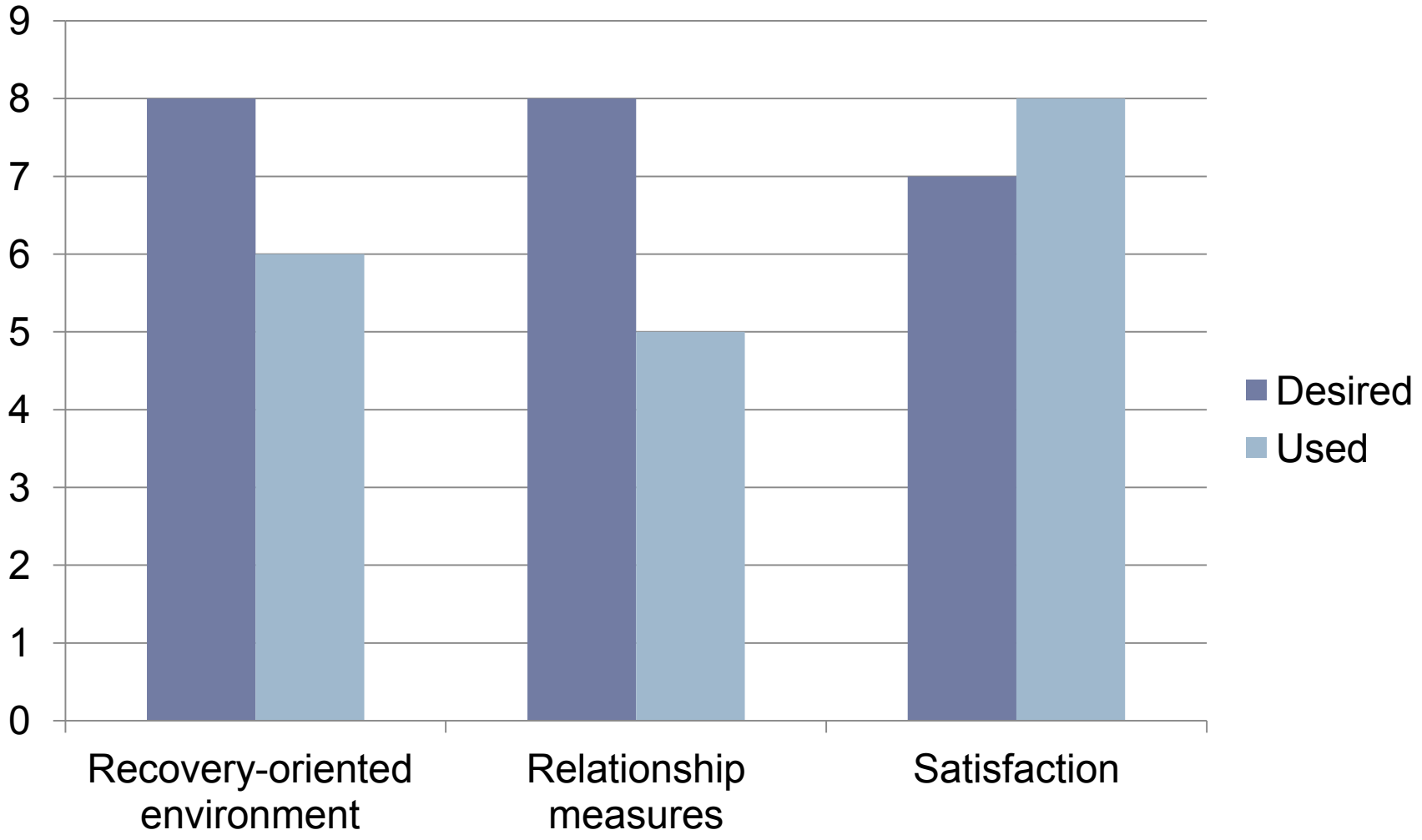
- All programs have been evaluated at least once, except one that has only been open for two months.
- One had been evaluated twice, and six had been evaluated 3 or more times.
- Only one respite had participated in an evaluation where there was a comparison group.
- All of the directors wanted their program to be evaluated in the future.

Individual outcome measures



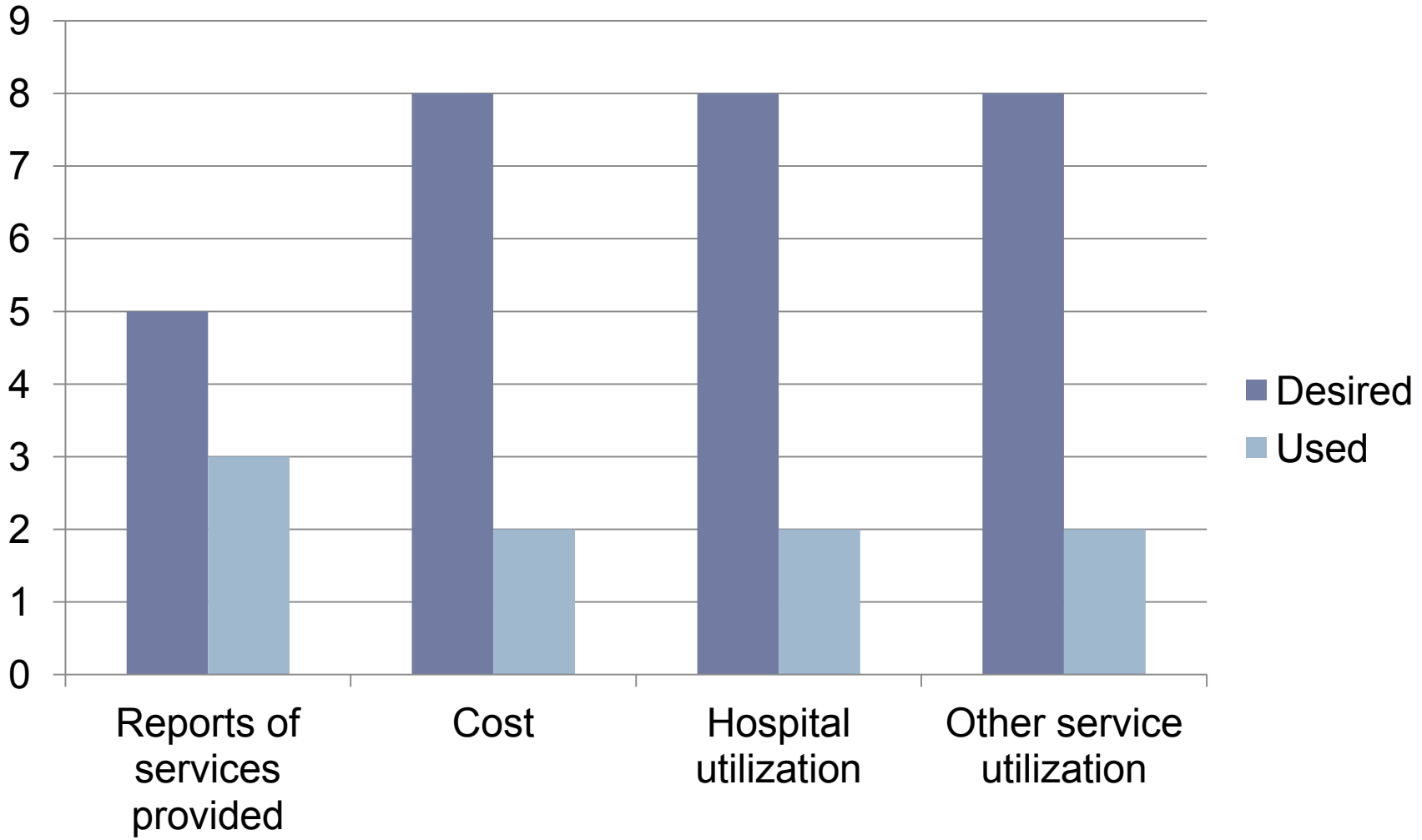
Ostrow, 2012

Program context measures



Ostrow, 2012

System level measures



Ostrow, 2012

- The greatest disparity was in system level measures
  - These are the measures that policy-makers are most interested in
  - Success in these kinds of measures will lead to greater sustainability

Recommendations on Evaluation of Existing Respites & Parachute

Ostrow, 2012

Research Teams

- Principal Investigators: “Psych survivors” or “Allies”?
  - “Bias” and insight are two sides of the same coin
- Interviewers should be peers
  - As with any interviewers, training is essential, but if interviewers are trained in peer support previously, there could be more issues with interviewing technique
- Consumer input on measurement selection, data analysis, and interpretation/dissemination of results
- Recommend having an economist on research team

Research Design and Measurement

- Recall concerns of "ethics" of randomization in COSP study
  - "Hospitals are not an EBP" – but neither are respites
- Cost-effectiveness will be essential
  - Given equal outcomes, the lower cost alternative is the better choice
- Re-hospitalization rates and other service use
  - Hospitals are driver of health care costs; medications are also driving costs
    - "Coming off drugs" movement vs. unmet treatment need debate
    - Not our place as evaluators to make judgment about medication use as good or bad – but important to measure and correlate with reduced/increased service use and other outcomes
  - Need cooperation of local systems in tracking data – advise having your own data person who can access these data

Research Design and Measurement, ct'd

- The creation of alternatives to hospitals is because of survivors' experience with force/coercion/oppression of institutions
  - To show that respites are a better alternative, force and coercion are essential to measure
    - Possible validated measure is the McArthur Coercion Scale
      - Would have to be adapted to replace "hospital" with "respite" to make comparisons
- Satisfaction measures are easy to administer, but have become a folly of mental health services research
  - Satisfaction research is known to be biased positively
- Recovery measures not relevant
  - The goal of crisis care is addressing immediate issues. Recovery is a life-long process and I would not expect valid changes in scores; especially issue of regression to the mean and crisis being "rock bottom"

Discussion & Questions

Ostrow, 2012

Laysha Ostrow, M.P.P.
NIMH Pre-Doctoral Training Fellow
Johns Hopkins Bloomberg School of Public Health
lostrow@jhsph.edu
410-929-2737

This research supported by NIMH grant T32MH019545