Evaluating Peer-Operated Crisis Care Alternatives

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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

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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

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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.

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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

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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

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Existing Respites

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<table>
<thead>
<tr>
<th>Respite Name</th>
<th>State</th>
<th>Guests</th>
<th>LOS</th>
<th>Model</th>
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</thead>
<tbody>
<tr>
<td>Stepping Stone Peer Support &amp; Crisis Respite Center</td>
<td>NH</td>
<td>2</td>
<td>1-7</td>
<td>Peer-run</td>
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<tr>
<td>Sweetser Peer Support &amp; Learning &amp; Recovery Center</td>
<td>ME</td>
<td>3</td>
<td>3.5</td>
<td>Peer-operated</td>
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<tr>
<td>Georgia Peer Support and Wellness Center</td>
<td>GA</td>
<td>3</td>
<td>Up to 7</td>
<td>Peer-run</td>
</tr>
<tr>
<td>Peer Support, Wellness, and Respite Center of Bartow County</td>
<td>GA</td>
<td>3</td>
<td>Up to 7</td>
<td>Peer-run</td>
</tr>
<tr>
<td>Peer Support, Wellness, and Respite Center of White County</td>
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<td>3</td>
<td>Up to 7</td>
<td>Peer-run</td>
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<tr>
<td>Rose House Hospital Diversion Program by PEOPLe Inc. (Milton)</td>
<td>NY</td>
<td>4</td>
<td>1-5</td>
<td>Peer-run</td>
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<td>Rose House Hospital Diversion Program by PEOPLe Inc. (Putnam)</td>
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<td>Peer-run</td>
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<tr>
<td>Voices of the Heart, Inc.</td>
<td>NY</td>
<td>2</td>
<td>1-3</td>
<td>Peer-run</td>
</tr>
<tr>
<td>Foundations: A Place for Education and Recovery</td>
<td>OH</td>
<td>3</td>
<td>3-5</td>
<td>Peer-run</td>
</tr>
<tr>
<td>Keya House</td>
<td>NE</td>
<td>4</td>
<td>Up to 5</td>
<td>Peer-run</td>
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<tr>
<td>2nd Story Santa Cruz County</td>
<td>CA</td>
<td>8</td>
<td>8</td>
<td>Peer-operated</td>
</tr>
<tr>
<td>Alyssum</td>
<td>VT</td>
<td>2</td>
<td>14 +/-</td>
<td>Peer-run</td>
</tr>
<tr>
<td>Respite Name</td>
<td>State</td>
<td>Funders</td>
<td>Budget</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Stepping Stone Peer Support &amp; Crisis Respite Center</td>
<td>NH</td>
<td>NH State General Funds and Federal Block Grant</td>
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<tr>
<td>Sweetser Peer Support &amp; Learning &amp; Recovery Center</td>
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<td>Sweetser and their Endowment of Mental Health and United Way</td>
<td>$308,500</td>
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<tr>
<td>Georgia Peer Support and Wellness Center</td>
<td>GA</td>
<td>Georgia's Department of Behavioral Health and Developmental Disabilities (GBHDD)</td>
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<td>Peer Support, Wellness, and Respite Center of Bartow County (Milton)</td>
<td>GA</td>
<td>GBHDD</td>
<td>$325,000</td>
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<td>Peer Support, Wellness, and Respite Center of White County (Putnam)</td>
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<td>GBHDD</td>
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<td>Rose House Hospital Diversion Program by PEOPLe Inc. (Milton)</td>
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<td>Rose House Hospital Diversion Program by PEOPLe Inc. (Putnam)</td>
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<td>Voices of the Heart, Inc.</td>
<td>NY</td>
<td>NYS Office of Mental Hygiene, Warren and Washington County and Private supporters</td>
<td>$150,000</td>
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<td>Foundations: A Place for Education and Recovery</td>
<td>OH</td>
<td>Stark County Recovery Services Board (Canton)</td>
<td>$160,000</td>
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<td>Keya House</td>
<td>NE</td>
<td>State Division of Behavioral Health</td>
<td>$266,000</td>
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<td>2nd Story Santa Cruz County</td>
<td>CA</td>
<td>SAMHSA Mental Health Transformation Grant</td>
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<tr>
<td>Alyssum</td>
<td>VT</td>
<td>State of Vermont</td>
<td>$369,000</td>
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</table>
In the continuum of care
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.

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Referrals to other providers

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clubhouses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management/ACT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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

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

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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

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What programs need to be effective

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Research and 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.
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.

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Individual outcome measures

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Program context measures

Recovery-oriented environment
Relationship measures
Satisfaction

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System level measures

- Reports of services provided
- Cost
- Hospital utilization
- Other service utilization

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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
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  

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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

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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”.

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Discussion & Questions
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