NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
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Continuous Engagement between Community and Clinic Treatment Teams

On January 24, 2020, the Department of Health and Mental Hygiene (DOHMH) held a meeting with mental health providers to present DOHMH's ideas about a new program model and elicit feedback from attendees. In compliance with applicable laws and rules, attached please find a transcript from the meeting.

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

STAKEHOLDERS MEETING

42-09 28th Street
Long Island City, New York

January 24, 2020
1:09 p.m.

Reported By:

Elbia Merino

A P P E A R A N C E S:

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DR. HARRISON: Welcome, everybody. I'm Myla Harrison. I'm the Assistant Commissioner in the Bureau of Mental Health in the New York City Department of Health and Mental Hygiene. I'm thrilled that you are all here. We invited you here so we could get information from you all about some ideas that we've been having regarding a new program model.

So we are not going around to hear everybody in the room. It's not that kind of meeting. But this is a chance for you all to weigh-in on questions we are going to pose and ideas that you might have to help us shape a program.

I'm going to give you some background. A little bit of kind of why we are here and why we asked you to be here. And then I'm going to, you know, open up the floor. We have somebody taking notes. So when you are speaking, give your name before

you actually tell us something. That way, we'll have it transcribed.

So thank you again, all, for coming. I know we did not give you a whole lot of notice for being here, so we appreciate you being here. So I'm, again, information gathering for the Department of Health and Mental Hygiene on the new program model. That's why I asked you all to come.

So what we're going to do, I'm going to give you some background. I'm going to talk a little bit about our ideas for our program model and then we are going to pose some questions for you all. Make sense?

So some background. We have just undergone a thirty-day mental health review that the health department and the police department were together asked to do by the mayor after there were some incidents in New York City with people who may have had mental illness, certainly were homeless, and

were disturbing in many ways.

So as part of that review, we had a number of goals. And one of those goals was to increase the referrals that were coming into the health department specifically for our Single Point of Access program, SPOA. And even for AOT program, our Assisted Outpatient Treatment program.

We know that we don't capture all the New Yorkers with serious mental illness who would likely benefit from the higher level care that those programs monitor and offer. One of the ways we are aiming to increase referrals is to do training out in the community, out of the hospitals. Anybody that wants to know more about the service systems and what we do and how we are doing it, we are going out there and offering training to do that.

We are also aiming to increase the referrals we get to our Co-Response

Teams, which are our police and social work care teams, as well as our newer HEAT team, which are our Health Engagement & Assessment Team. And there are new teams coming on board for HEAT response through some of the other mayoral initiatives that are going on in the City.

We also will have a goal to improve the retention of people in the service system. So this is the idea, that I think anyone who is a provider around the table knows, that people fall through the cracks in between different parts of a program. You are leaving an inpatient you are leaving an emergency department.

Any time there's a transition, it's pretty easy to lose people. And you know, the idea is what can we do better to keep people, you know, within the system. We know that a number of the people who are more challenging to stay in our services or

engaged with us are likely to be homeless. Maybe they're in the shelter system. Maybe they're street homeless.

So we are working more closely with our colleagues in the Department of Homeless Services so that we can do a better job connecting people, staying connected.

We are also, through this idea of improving retention, thinking through a new program model. The third goal from our thirty-day review is to decrease the people who are lost to follow up. It's somewhat similar to the first goal. One is that retention.

So if they're in treatment, kind of keep them in there and helping them stay in the system. But also, again, what can we do to lessen the chance of somebody being lost at follow up. And we are doing some back-end data matching between folks that we know

about who, you know, have a high risk for violence, for instance.

And knowing where they in the shelter system so that we get some back-end matches so that we can see if somebody slept in the shelter the night before. So there's a system called HHS Connect, health and human service connect. It's a city-wide system. So we are using that as just one way to use technology to help prevent the loss of people; just as an example.

We've also been talking with our colleagues at the State Office of Mental Health, PSYCKES specifically, in order to add more information into PSYCKES when people are in non-Medicaid types of services. For instance, our Intensive Mobile Treatment teams, which are our newer treatment options, are not billing Medicaid. So they -- if someone is on IMT, that would not show up. If

somebody is in our Single Point of Access system in between, not yet in treatment, they're not currently showing up.

So we've been talking with our colleagues and are planning to share other information and build out PSYCKES so it's a more robust way for a provider who has access to PSYCKES to know someone maybe had been discharged from an ACT team, for instance, or is on an IMT team. So we are looking at some new flags for some additional information to add to that.

So those are some of the big items that came out of our thirty-day review. We worked closely with our colleagues at Department of Homeless Services, HRA, correctional health, health and hospitals, police department and fire department. I think those are the big ones.

So speaking about background, what do we have now? What are our existing

mobile treatment teams? What's the capacity? What are we looking at? So there are existing assertive community treatment teams in New York City. Each of those teams essentially serve sixty-eight people at any given point in time. And it's a ten-to-one client to staff ratio.

We have forensic assertive community treatment teams. There are five of those. We've got shelter partnered ACT teams that are run by the Office of Mental Health. They're not in contract with the Department of Health and Mental Hygiene. There are ten of those in our system. Those are all new in the last two to three years or so.

And as I mentioned, we also have Intensive Mobile Treatment teams. The Intensive Mobile Treatment teams have a different staffing per client ratio. So an Intensive Mobile Treatment will serve essentially no more than

twenty-seven people at any given point in time with an 8.5 FTE, full-time equivalent, staff ratio. It's a much more intensive model.

Our Intensive Mobile Treatment teams are really all about engaging people our system have failed for that point in time. They will do anything to help engage and to help offer you, in a very person-centered way, the kind of care and help you need wherever you are at that point in time.

The goal of IMT is not to discharge you. When people are successful in some of our models, we'll say, "Okay. Good. You can go on to this next level." And there's another gap in care. So we are bringing on -- we have seven current IMT teams. We are bringing on four more teams through some of the other City funding that we've gotten recently. Something I wanted to make

sure we all know about.

So in addition to our mobile treatment teams, we also have mobile crisis teams. And our mobile crisis teams -- essentially, there are nineteen mobile crisis teams city-wide serving adults. Sixteen of these are hospital-based and have mental health clinic within their system.

And just to give you some sense of, you know, who we are serving, we've got for calendar year 2018 -- you are not actually seeing this added up. There were about twenty thousand referrals into mobile crisis teams city-wide. Many other referrals are coming from psychiatric emergency rooms, as well as from out patient departments. Again, outpatient mental health providers as well.

In order to get mobile crisis teams, for the most part, if you are a friend or family or a loved one, you are a calling NYC Well. And then the

folks that operate them, are only allowed to have internal referrals as well. And more than half of the mobile crisis team visits are with internal as well.

In New York City, we had to work with our colleagues at the state and had to put in a crisis plan, crisis services plan, a year and a half ago or so we submitted one. As part of our crisis services plan to the Office of Mental Health, we said that we were moving toward a two-hour response time for mobile crisis team. It is not acceptable to not -- to have it more than that.

So in New York City, you have up to forty-eight hours if you're a mobile crisis team operator. And the average is over seventeen hours. I don't know of any crisis that can wait seventeen hours.

And as we start talking about even a two-hour response, people want to

know "Well, who can even wait two hours?" The idea is not that you are waiting two hours, it's that you are responding within two hours. We know that there are providers now in mainly Manhattan, but some of the Bronx as well, and some of you are here with us today, where we've been able to get through a more rapid mobile crisis team response time as well. Which helps people in the community sort of, you know, allows for less stress at different points in the system if you can respond quickly.

When we get to a two-hour response time for the whole system, we will have more challenges thinking about when an outpatient provider is using mobile crisis. Which many times, is more of an outreach function than a mobile crisis function. So we're going to have to be thinking about what that means to the providers who are using that now when that's not how

it's going to be moving in the future.

You should also know, if you don't already, that the Medicaid Managed Care Plan will pay for mobile crisis visits. There are four types of visits they will cover. And they expect the three-hour response time. We want to do better than that. But they want three-hour response time at the stage of managed care, Medicaid.

The program we are thinking of, we've given a name and the name is not as important as we are hoping it will do. We are thinking of calling it CONNEC2T. And CONNEC2T stands for continuous engagement between community and clinic treatment.

So the idea is, we need to improve participant functioning with regard to participating in the community, with their families, at work. We need to build resiliency and maintain people within community settings.

We know we still do not have

enough treatment capacity for the highest level of need. People with serious mental illness where their traditionally not ending up coming to your clinics. We still have three hundred or so people on a waiting list for our ACT or a list of shelter partner ACT. So all of those teams essentially still have waiting lists.

So there is a great need for additional treatment services for people with serious mental health. And we know that we don't just want to build more ACT teams. We are thinking the aims of this program will be a seamless continuum between outpatient and field-based mobile treatment. Where we would have full integration with mental health and substance use treatment. In addition to resources to address social determinants of health.

So we also know that we have not really integrated mental health and

substance use in New York City in our mental health providers' community. What that means is we are not taking care of the individuals who have needs. We are asking them to go somewhere else, too. And that's not ideal. From an individual perspective.

So we are thinking the target population will be adults with mental health and substance use needs. They have histories of violence, substance involvement and/or homelessness and/or failed connections with treatment.

So some of the strategies we are thinking about is the flexibility of mobile care with additional resources and efficiencies of a site-based clinic. So that all clients can be seen in the clinic and in the community.

So right now, if you are on an ACT team, you are seen on your ACT team. You can't really get to the clinic.

Your ACT team won't get billed if you are seen in a clinic. If there's a group for you to go to and benefit from the clinic, it's not going to get paid for. If you are transitioning down from an ACT team, yes, you can get seen for fewer visits on your ACT team. But again, it's not ideal. It's short-term. And not everybody works at that level of need.

So this idea of flexibility and additional resources in order to have this happen, is what we are thinking about strategically. We know through our work on our intensive mobile treatment teams, that emphasis on engagement and rapport building is critical.

As I mentioned earlier, integrating mental health and substance use is a priority. We want to be able to address social determinants of health. That may include issues around criminal justice

involvement, employment, education. Those sorts of things.

So we see the clinic as the sort of the -- sort of the epicenter, but with this critical component of flexibility to have people seen in the community. But the clinic could then have individual and group capacity, treatment capacity, socialization and structure. And again, not everybody can come to a clinic. Not everybody is ready for that.

This is just a kind of visual of what I've already said, where, you know, the clinic would be thought of as an epicenter or kind of a central location. But the individual clients could be seen in their home or on the streets if they're street homeless. Or a coffee shop if that's where they'd rather be seen. If somebody ends up hospitalized, that there's connections between the hospitalization. Again, if somebody

is sheltered, living in a shelter, that there's connections there. If there's any involvement with the justice system, that we stay connected there as well as any other community sorts of capacity.

So this is really a way to think through how to think about the service model that we are talking about. Also, how to think about the individual. Any individual that we are seeing, what their needs are and how to get those needs met.

So if there are people ready to engage in clinic services on site, they can come do that. But if they're not ready, if they're not comfortable with that, that the team will go to them. We also envision that there could be -- we thought about the idea of a tiered approach. These are some of the things that I'm going to ask questions about. I'm kind of peppering it with some thoughts.

Where if somebody is new into the program, they're more likely, perhaps, to be seen in the community. So maybe eighty percent of the time they'll be seen in the community. Twenty percent of the time, perhaps, they're seen in the clinic in the first part of the person's treatment. Perhaps in six months. Again, this is all just speculative. Then that would transition with more on-site services over time.

And then due to the flexibility of this model, we think that more people could be served than on a traditional ACT team. Perhaps a hundred people can be served. We also think that there will be more flexibility to what those individuals needs are. So less than, "Oh, wait. My billing model is I need six visits in a month," even if that person maybe needs more than that, maybe needs less than that. There's not a lot of flexibility

there. This will allow for more flexibility.

Mainly, when I think about that inflexibility, it's specific to an ACT team and the way the Medicaid rates are with an ACT team. We can talk a little bit more about of some of those ideas when we go forward.

This is a slide to remind me to tell you that the idea, the way the program would be accessed, would be through our single point of access. So it's still for that, you know, higher level need. And that right now, we review about four thousand referrals a year to our single point of access for ACT. In fact, for IMT and for non-Medicaid care coordination.

And our clinical staff are making appropriate -- are making eligibility determinations and assignments based on somebody's needs, managing referral lists, and not -- and frequently

suggesting alternate levels of care.

So I am going to pose some questions. And I've got probably more questions than we are going to get through. But we are going to try because we have a lot of time, I've kept you captive.

Before we start the questions, just to say -- I mean, we have this room until 4:00. It's about 1:30, so we have plenty of time. If we end up with lots of conversation and people are needing a break because it's hard to sit for -- I don't know that we'll be here for two and a half more hours. But if you need a break, let me know. We'll look in an hour or so and we'll see how people are doing.

So questions first around the program model. So just to give you a preview, we are going to talk about the model. We are going to talk about the target population and treatment. And then we are going to talk about

the staffing. And last, funding and implementation. So sort of a few different categories.

So program model, there's lots of questions here. I can read one of these questions or based on what I've said so far, I'm happy to hear your feedback on what you would do to recommend improving the current continuum with clinical and nonclinical services for the current population, for instance. Or how we could integrate social determinants in our mental health model. This is your chance to say, "Oh, okay. New model. How might I do that? What might that look like? What would make it better? What might work?"

Again, say your name.

SPEAKER: Ellen Tabor. I'm the associate chief medical officer for ICL. But I'm also on an ACT team in the Bronx. And I also work with one and a half IMT teams. So I have

experience with patients in both the ACTS, in Brooklyn particularly and the Bronx. There are two issues that are not up there, but I wanted to bring up.

One of them is consent and sharing of information. We could do a lot more for people if we didn't have to get their consent. They often -- I think everyone here is nodding -- I see a lot of nodding, so I can tell they stopped there. That any kind of integrated care depends upon the fact that we can share information. And the level of consent that is required in the average setting are picked up by everyone in the community and is so deficient that it prevents us from providing the care that could be much more easily provided if we just said, "We are all taking care of this person and we need to know and you have to tell us."

That's my first issue. But I'm

going to actually stop there because maybe we can discuss that. Or you are just taking notes?

DR. HARRISON: I mean, this is for you to give us information. So we are not going to be asking you questions. This is not -- we are not telling you anything. You are telling us. If there's something that needs more clarity, we certainly will.

SPEAKER: My second issue is AOT. Most of our people have AOT. However, AOT also requires consent for release of records. You can't always get it. There's a strong desire of the courts, and AOT offices themselves, that AOT be voluntary. Which is an oxymoron, in a way.

I mean, AOT is for people who are not adherent, who have not been able to -- despite even they're best intentions, to be able to participate in programs that were for a long period of time. And yet, when they

refuse their injections, for example, we are often told by AOT that we cannot just bring them to an emergency room. That they have to show some other sign of danger. So there's confusion in the AOT office that prevents them from getting maximal efficacy of that program. Even when the --

DR. HARRISON: Anything about the model we proposed?

SPEAKER: I think it sounds great. But I think it's going to be limited by the kind of people that we are taking care of who don't come to clinic. I think that our ACT people -- they're hard to find. And IMT even more so because they're often street homeless. We do a lot of diligent searches and we are not often rewarded with success.

So it's a great -- it would be wonderful to have a central place. I think we'd all love it. But -- I

think that's what we are all striving for. That we can get people off the ACT team, making room for more people. And then moving them into a clinic situation, but I have not seen that happen.

DR. HARRISON: Just to clarify, since I want to make sure people aren't misthinking this based on this comment. This proposed model would be both field-based treatment and the clinic. So it's not just the clinic side. This is not to necessarily take people off of your ACT team, this is to offer a different kind of model.

SPEAKER: If I can add to that -- from Visiting Nurse Service of New York. I represent a few directors. We do have ACT teams, shelter ACT, IMT crisis teams, a children's clinic. We don't have an adult clinic, which is where this might be a good introduction for us.

But I want to add to your point,

that the population we serve in these programs are more community-based than clinical. And we think about the model and the shifting from eighty/twenty to maybe for clinic.

I think we have to be cautious with that and see how it plays out. And maybe more years into the investment of this type of program before we can get to that phase if it's really truly community-based. It's a great idea. I think it will take us a little bit more time.

DR. HARRISON: I know there's other hands. But just a follow-up question then, since you are saying it might likely take more time to get a transition back into a clinic for somebody. Any thoughts on how much time? Not that we need time -- know time, but thoughts of what that might look like?

SPEAKER: Not time, but a piece of --

DR. HARRISON: Just say your name.

SPEAKER: Oh, sorry. Deborah Zicht from the Jewish Board.

So I have a community ACT and a shelter ACT program. And mini clinics. I don't know about a time frame, but a piece that might help with that connection is if you had some people who were able to -- that the staff were able to be partly on the ACT team and partly in the clinic. Because you can really -- I mean, I've seen this from an adolescent program that we had. That had people who were able to do both clinic and outreach.

And the clients, once they got connected with those folks, were much more willing to then get into the clinic if they knew that somebody from that team was part of that clinic as well. It was less threatening to them. It was more welcoming. And if they know that they could kind of go back and forth but with some of the

same people, that might be a way to have some retention.

DR. HARRISON: Continuity of staff between the two.

SPEAKER: Yeah.

SPEAKER: If I could just make a clarification, that's exactly one point. I mean, we are talking about the both ways, by directional flow of people. So yes, at some point they will move the treatment from the community into the clinic, but also the other way around.

So it's not just changing. Instead of vertical system, you are progressing from one to another, it's more horizontal way. According to your times and needs, you are going to be moving in or out or whatever way you want to be going.

DR. HARRISON: Just say your name so --

SPEAKER: Vladimir Gasca. I am part of the group and mental health.

DR. HARRISON: So someone behind you has had a hand for a while.

SPEAKER: Nadjete from SUS. So this model is ideal. We have the Certified Community Behavioral Health Clinics, which operates in this matter. The clinic, you have staff in the clinic, but the staff can go out and provide the services. And it's not just clinical services, but you also have services that address social determinants.

So when someone cannot come in, you have a peer that can go out to do the service. And also with Telehealth, you have the provider that's giving the service. The nurses going out, they can give injection also in the community because the nurse can go out and see the person.

And you have people who come in, they may not be ready for -- to see the psychiatrist, to get prescription yet. But they're coming for a peer

group. Or we do a peer group at a shelter or at a residence if we have enough people.

So we have the service now. People are doing the services in the community. We are embedded in some hospitals where you have peers that are engaging people from there and from the hospital. Trying to say which clinic they want to be connected to, to escort them to the clinic through the intake process. We have similar programs like that.

It's the utilization of the program and people being aware of where the programs are. What is the process? How do you get someone into the program? And maybe we partner with the ACT teams. So there's a process.

People who don't need all the service but just need the IM, they're a great candidate for the CCBHC team because you have a case manager still

that doesn't need to do the full six visits. You have a peer specialist on the team. Depending on what the person needs, you have all those services.

Some of them may never need to set foot into the clinic. Because all their service is being provided in the community. Because they don't have to come to the clinic to get an intake completed. An intake specialist can go to them and complete intake with them in the hospital. Wherever the person is.

So they are going out to do the service. They bring them and depending on your preference. So we have the model now and there are UCC BACs in the City. And I think they have capacity as well.

DR. HARRISON: Just a follow-up question on that, since you mentioned social determinants. What are -- maybe just for your CCBHC team, what

sort of work are you doing around the social determinant?

SPEAKER: Housing, when someone comes, we do the HRA 2010e. We do prepare them in terms of interview. We do escort people to housing employment. We have employment training, vocational training. People are going back to school. Working with people to get jobs.

Health, physical health because physical integration is also part of the process. Psych rehab. The peers that are doing the engagement. Peer support services.

So you have the whole parameter of services that you are providing. It's not just medications, it's all those other elements. Elements that are often the priority of the people. And medication is the means of getting to that. That's the first thing people say, "I want a job. And I haven't used since yesterday, but I need a

job." How do we work with that person to get their resume ready and get the process going?

SPEAKER: Hi. Carolann Slattery from Samaritan.

We have, obviously ACT and mental health clinics and CCBHC. I will tell you that the way the model that I'm reading, you are saying is staffing has to be really looked at on the front end. Because staffing versus the regulatory body of OMH, definitely don't coincide if you want this model to be productive and fluent.

Also, with the clinical and nonclinical services, I noticed with our ACT clients and shelter clients, because we have obviously a lot of shelters as well, the clients need to be educated. They're not consistent, as you said, with their medication. But they're also not educated.

I think if you look at staffing patterns and not just look at social

workers and the doctors and the peer, we were able to integrate like art therapists and different type of targeted case managers. And we took a little bit of the site rehab services and a little bit of our health home, type of look model, and we combined that model. And that's how we were able to get the clients to buy into the CCBHC model if you want to say. But kind of the new model you are looking at.

I think the client, if you even mandated the injectables, show they can skirt around it. I think when you talk about going back and forth with leases, that's in the wind somewhere. Because that would be a fantasy, I'd love it.

I think the target population is -- you say adult services and you say seriously, you know, mental illness. I think you need to really finite that into what type of mental

illness you are talking about and what type of pathology. Because you have some persistent illness clients that are so low functioning that when you have that AOT order that comes into outpatient, you've already set them up for failure. Because they can't even be productive in an outpatient-type of model, and they get lost in the shelter system.

So I would break it down into your target populations to find what type. I would break it into regulatory body versus the type of staffing pattern that you are going to do. And I will tell you that a majority if the clients, even on the ACT team and in the CCBHC, they don't have insurance.

So even getting them on the insurance and getting the information that is needed to be able to move forward for Medicaid, is very cumbersome. We have individuals that strictly work in that with the clients

and getting the paper work that's needed. I think it should be broken up that way.

DR. HARRISON: Let me ask you a follow-up question. When you say regulatory and staffing, what -- do you have some specific suggestions? I'm not sure I'm following what you are --

SPEAKER: If you look at 599 rights or you're looking at the ACT rights, they have the doctor and really the social worker on the front end. That's really within the first thirty days, having to be very robust and getting these assessments done and getting all these criteria done, or you are out of compliance.

If you really want true engagement, like you said, and retention, you need to change that staffing pattern the first couple of weeks. And use a different type of staffing pattern that you might have

to extend thirty-day to maybe a forty-five day clearance.

So instead of putting waivers in and stuff like that on your model, maybe have a different type of -- you know, what I mean, attached to it. Like they did for Act and 599. We're supposed to come up with the integrated outpatient service. Which is what you're waiting for, anxiously. So I think that has to come up first.

DR. HARRISON: One other quick question then. Since you're bringing it up, which is great. If not physicians and social workers, who are you thinking is useful in those engagement types of --

SPEAKER: When we looked at the data in our OMH, in our article thirty-one and versus our ACT and versus our CCBHC, the clients and the services that were really more helpful were the targeted case managers and peers. I use peers very loosely

because we've had a lot of problems with peers. So I think different types of peers. Put it that way.

When you look at those types, like care coordinators, when you look at those individuals, their language and their delivery with the client is more on a one-on-one basis. Us, physicians and the social workers, their program is a different model. Even if they come from wanting to engage, their engagement is much different.

The client, we found the first forty-eight hours, seventy-two hours was really critical. We started a model in our Jamaica clinic where we had Uber systems going to and from with peers and social workers. We were going to the hospital picking up, and also the client. and then in the middle of the night, doing follow up calls.

That follow-up call, within the first couple of days, really got them

to buy in. Because when they wanted to use or they were having some histrionic episode, we were able to speak to them and drop them down. Having an Uber pick them up and turn back to the clinic or the shelter, wherever they have to meet.

DR. HARRISON: So anything else? Okay. So you had your hand up. Apologies to the people behind me.

SPEAKER: That's okay. I'm -- (inaudible) -- I'm with the Behavioral Health Plan in Kings County.

It's an interesting model, what you have proposed. So again, it's a question for you. But again, I'm having -- this is -- we are really looking at it's not a mobile crisis kind of model. It's not an ACT model. It's not a clinic model. It's not a CBS model.

We are looking somewhere in between. Something is on the skating rink. I don't know which one it is.

But you are putting something on the skater to do this kind of model. OnTrack program has similar kind of work model.

Where you really, you know, it's not really fully medication management. Twenty percent would be medication management. But again, looking at the patient as a whole, you know, looking and working with them in a more recovery oriented model.

They don't accept substance use as a criteria yet, which I really think that should not be. Because we are trying to expand -- we are trying to use a model to, you know, we want to move to substance use program. Patients that -- I think they have patient therapist.

So how do we take that kind of model to kind of deliver this kind of program because they do home visits. They go with the patient to buy medication. They get everything,

whatever needed. Including vocational therapist. And family meeting, family therapy. Everything is involved in that model.

Is this model we are looking for more of a twenty-four/seven kind of coverage or just Monday through Friday or seven days a week?

DR. HARRISON: Tell us what you think we need, what's important.

SPEAKER: This is all very high-risk population we are talking about. These are the kind of patients who are ending up in the emergency room setting. Not getting the right care and keep on rehospitalization. Like I said, it's a very high-risk population.

And also, they've been recycling or cycling between incarceration to a program to a shelter. And again, the social determinants are very -- there's very poor social support for them. There's no roof for them.

There is, you know, they don't get proper food. They're involved in certain things that end up, you know, they cycle.

So again, the model -- the care or the staffing model should be different. And we really need to be there for them. And how do we do that? Because mobile crisis starts at nine o'clock in the night, different shift. I don't think that's a twenty-four hour model. I think it actually does some work, but I'm not sure how much it is. It is really something -- you are coming up with something so --

DR. HARRISON: So these are great points. Which then reminded me of something I didn't say when I talked about mobile crisis earlier, but you reminded me. Thank you.

I talked about a two-hour response for mobile crisis. It's part of our plan, we also said and expected

twenty-four/seven mobile crisis team response as well. Separate from what we are talking about here. But I just want you all to hear that. Because in addition to our response, we need to figure out as a city how we get to the overnight responses as well. Because crisis don't end at 8 p.m. or 10 p.m., or whatever.

SPEAKER: One clarification also, I think -- very important point you made. We act, in fact, the issue of homelessness. Because we are going to be working with a lot of people who are going to be very difficult to find. In that sense, it will be different than the population that is working on.

DR. HARRISON: There's still more input.

SPEAKER: Sheryl Silver at the Bridge. We have three community ACT teams, three shelter ACT teams, forensic ACT team, outpatient mental

health clinic.

One point of clarification. The shelter ACT teams that is we operate, are none have ever been full. So I don't know about the waiting list for them. Not even close to capacity on one of them, the one in the Bronx.

The other question I had, I guess it's a point of clarification. You said one hundred people would be served. Are these going to be newly formed clinics?

And for clarification too, the whole referral through the SPOA. We had a recent situation where it took two weeks to figure out a referral on a Manhattan ACT team. And there are hundreds of people waiting for services. It's -- the system that's in place is incredibly inefficient. I don't know all the inner workings. Because oftentimes, the response we get, even at my level, "We are discussing internally. We'll get back

to you." Which I mean, collectively, myself and our AVP, we have thirty years of ACT experience. I think we can probably add to the conversation. So that that's oftentimes the response we get.

I'm just concerned that the SPOA will take on even more responsibility in making clinical determinations for people that they really are not clear on, and how that's all going to kind of work itself out in practice.

DR. HARRISON: So we were not necessarily thinking that these were coming -- that there's -- those hundred or so people were coming from existing clinics. They would be new people coming. They may come from the clinic. But they are people who are coming to us from emergency rooms and inpatient units, who need that level of care. But -- so I hear you. And so --

SPEAKER: It will be a distinct

program of one hundred people? Is that what you are thinking?

DR. HARRISON: Yeah. You want to say something Jamie?

SPEAKER: I think the point you get at, I think the sticking points in SPOA assignments, in the case you are referring recently, are largely around catchment areas. Which I think is related to the ACT model and its reliance on successful field-based visits since we have to limit the geography. So that's feasible.

Nearly all of the delays in ACT are about like "Does he live in Manhattan? Does he live in Brooklyn? Does he live in Manhattan? Does he live in Brooklyn?" Right. That's basically what those back and forths are. The determination and level of cares are usually very quick. And the average assignment is very fast. You know, within two days, when the person's residence is really known.

And so I wonder how this new model and what your ideas are for focusing on folks who are moving a lot. Right? And that's a big challenge.

We've developed IMT specifically for that situation where people are really transient. That's great, but IMT is a really small scale intervention. Right? That's not scalable city-wide scale. So we're looking for a more scalable way to serve people who may be moving a bit more than typical.

SPEAKER: We've been told -- I don't know what the IMT teams, we don't have one. But we've been told probably over the last six months that criteria have to do with level of dangerousness in the community. Which is not -- or I guess not the violence in the community, rather than some people who just on the ACT team cannot get any traction after years and years and years. They're still homeless.

They're going from borough to borough.

We have one staff person dedicated to literally going to three different boroughs trying to find this person, which is fully past our ability to go and depending on a viable way. But that could just be a capacity issue. So there had to be another criteria listed now for IMT. That's what I told my staff. I don't know if that's accurate or not.

SPEAKER: I don't want to get sort of bogged down in that. I want to sort of think about how do we better serve people who move a lot.

SPEAKER: Right. And we thought the IMT was --

DR. HARRISON: We are coming up -- thinking about this new model. To continue to deal with the gaps that we know we have still, currently. This isn't about improving IMT. This is about a new way to think and how we would do that.

SPEAKER: It would have to be borough specific, right?

DR. HARRISON: Do you want to suggest that? For it to be borough specific? No? Yes? Some say yes.

SPEAKER: It would be hard to get them. I mean, you'd have to get a lot of staff to get people.

SPEAKER: Yes, maybe with collaborative. Depending on where they are and kind of working collaboratively.

SPEAKER: If we have some kind of a medical record that has a universal identifier so that we could -- not Medicaid dependent like PSYKES, which is good as far as it goes. But some way that we could find people through a searchable medical record that was, I hate to say -- but it was secure enough that we would not worry about confidentiality.

But open enough that wherever that patient landed, we could find where

they have been before. And who's talking car of them? Who do we call? Where is their ACT team or their shelter or their last two shelters. And so on.

SPEAKER: Hi. I'm Jason Hershberger with One Brooklyn Health. I think to really creative a model -- and I don't know what the instances were that sparked the review. But as I was listening to it, the problem -- is my problem, I thought this might help someone, is the gap between inpatient and outpatient.

All my clinics tell me that about half the people refer to them from an inpatient no-show. So I lose half the people between inpatient and outpatient. I think the system that we've designed is kind of a fail first. We give everyone a five-day appointment. Half of them show up, half of them don't. The ones that don't, we think about a mobile crisis

referral. Trying to do a mobile thing afterwards is a failure.

So this model might be interesting if it were focused on sort of that inpatient to outpatient discharge moment, where we could refer them at the time of discharge. Which I guess this is my suggestion, make sure that the time to fulfill an acceptance is really, really short -- days get smaller and smaller and smaller. It's not something we can wait two weeks for work. If we refer, sort of same day or next day acceptance. And then you know, I've -- I get six hundred people a year.

SPEAKER: Deborah Zicht. I did speak.

Going back to, I think you were saying, about in terms of also viability. Right. So like fiscal viability. So with the -- like with the shelter ACT teams right now, they're not fiscally viable because we

have a large population of people who are transient. They're in and out of the shelters. You are spending, you know, for every one visit, you are having at least one visit that is, you know, looking for somebody who isn't where they -- where you think they are.

So you may be doing four hundred visits, but you are only getting paid for two hundred visits. If this model is targeting even more of a transient population and more high risk, you really have to think about what the payer model would be, and whether it should be something on a per visit session base or whether it should just be a flat out -- a flat fee or a flat, you know, pay.

You know, more like an on-track model that just has a particular amount of money that comes through. It's not on how many visits you actually have. Because I don't know

how it would be able to be maintained by programs.

SPEAKER: Just to piggyback on Jason. In terms of the drop between inpatient and outpatient programs, the -- if the program has the ability to copy some of the pathway whole model where you have a staff member that goes into the hospital, then someone comes in within two days of them coming, there's a staff there to engage them.

To explain the clinic, get their information where you're being discharged with the day of the appointment, that they can agree to take the person to the appointment and they know where the person is. Who is another person they can contact if this person doesn't show up. Because most of the time, the phone numbers don't work when you are trying to reach them. It's no longer in service.

But if you have someone who has built that connection, as soon as they come in, you know they're going to come out in the next three days. So that there's someone dedicated to those unit that go and make a connection and -- between the inpatient and outpatient clinic and with the CCBHC same day access. So that should be included.

SPEAKER: Jodi Romano. I'm from Health and Hospitals, Elmhurst.

I was just thinking, you know, I love the idea of the community work because we have such a hard time getting some of our patients to connect back with us at the hospital. One of the suggestions that I have is if that there is a way to incorporate Telehealth into this.

I think that, you know, the way that we engage a lot of people is by promising help with the social determinants of health. So we'll say,

"Okay. We are going to do the HRA 2010." Well, we need a psych eval to do that. If there was a way that we could go into their home and call into the psychiatrist -- we have a CPEP so there's always a psychiatrist in the hospital.

We could do realtime assessments that way. The patient never has to come to the hospital. I just think it would be -- it would open a lot more opportunities for us. We can also do, you know, social work sessions with patients through Telehealth.

If we have case workers that went to the home with laptops, that there would be a way to sort of Skype in to do a Telehealth type of session. I just think that opens a lot more opportunity for us, especially with the shortage of psychiatrists.

And the staffing problems. If you want to do a program that's open twenty-four/seven, it's a lot easier

if we only have to staff people, you know, a few people to go out into the field but everybody else can be at the hospital or somewhere else.

SPEAKER: Tracy Gard, the Jewish Board.

Just piggybacking on what the folks are saying about the transition of inpatient to outpatient. We actually piloted a very small, really a project to do just that. A very short-term model. Within thirty days of, you know, getting someone connected within those first thirty days.

We did it up in the Bronx. We actually partnered with four hospitals. So as -- and with an insurance company. And as somebody was ready to be discharged, our licensed clinician would go on to the unit, work with the individual and then have a few visits with them out in the community to really connect

them.

We were actually very successful with the ones we were able -- to people's points -- the ones that we were able to have that first connection with. I think over, I want to say nearly half of them were successfully able to make it to their -- to whenever they were being discharged to.

But it really did take a lot of working with them and working around ambivalence and what are their worries about getting to that appointment. I think a lot of times we think about it being more concrete issues that's preventing them from getting there. But actually, it wasn't so much that.

And like I said, it was successful in terms of from an engagement perspective.

SPEAKER: Since we are talking about a very high-risk population, we need to think about do you need an

internist or a medical practitioner to really take a look at this. They're really going to be medically involved also.

Another thing I'm thinking based on what we are hearing, do you really need a hub; like a Brooklyn hub, Queens hub? So that it's not just assigned to Kings County or to SUS or some program, but it's just a place where you can have a Telehealth in the same area, but at the same time, it will be given to go all over rather that asking Kings County why did you take it down?

I don't know. Or do we want to make the five boroughs better, do you want to make it as a hub and people will come in and come there. I think that's the only way you can do it to address the staffing issue. Because everybody has staffing issue. That can be a different model, which we can propose.

Another thing is with the integrated license. You can get integrated license where you can have patients, you know -- the county will be on the district for integrated license where we can have mental heath clinic. Medical linked to a mental help clinic. And also we can integrate substance use into the program. How do you bring that licensing to it and make sure that you have everything in one place for these kind of patients.

SPEAKER: We have some of those. I'm Vladimir Gasca, Director of Psychiatry, Elmhurst.

We have a few already running IOS services. And I think it's exactly the condition that you describe. All three different kinds of needs, plus there's social determinants. We also want to stress the on-track model that's been successful. Maybe we can also learn. We are very happy to see

the patient's engagement. They have the continuity of staff going to their homes and providing services at the facility.

And for our ACT teams, something that happens with us, I think it's secondary effects of not having psychiatrist. We bring some of the patients from the ACT teams to the clinic and we see them there. It's not really supposed to be, it's supposed to be at the clinic. But for the ones that are in transition, it's working really well. So some of those that are actually going, it makes this is a very good transition.

SPEAKER: I think the -- I just want to add to it. I think the flexibility of the program is always help. Because what I hear, most of the programs are very rigid. You cannot move out of this place. This is a grant. You cannot do this. You are hired even though you don't see

patient, you don't come out of the program.

Those are things that need to be broken up between the regulatory agency. And we don't challenge that kind of programming. We just live with it, with the old model of care. If you want to change, you need to break up those kinds of things.

DR. HARRISON: You have a comment.

SPEAKER: Jeff Goldberg. Long Island Hospital. I think the -- I just want to reiterate. I think the importance of the Telehealth, Telepsychiatry component can't be underestimated in terms of what you could leverage. Because if you are thinking of coverage, twenty-four/seven, seven days a week, and juxtapose that to the workforce shortage of psychiatrists and mental health professionals, that can be a big difference to make.

In terms of the integrated

substance and mental health treatment training and supervision, you have to think about bringing on case ACTs, bringing on peer recovery advocates NPs or PAs that have the certification in Suboxone and Buprenorphine. I think would be important.

And just looking at the bigger picture in terms of -- I'm sure there are certain outcomes or deliverables that you want for these hundred patients, right? So I don't know if, you know -- I mean, you are bringing it here as an idea. But this could be something, once if you firm it up, where you could put it out to bid. In terms of maybe there's a specific organization that would take that on. And much like, you know, they've done with the, you know, Pathway Home and things like that.

DR. HARRISON: I'm going to move us to the next topic. We can always come back. But I think we've heard a

lot of really great comments.

So target population and treatment engagement. We might have gotten to some of these things with the earlier conversation. This is for you guys thinking about the kind of -- some folks talked about it, the kind of people that would be best served by this kind of model. Who in your own programs might, you know, work in the model like this.

I think we've gotten to -- currently manage people who have on-site/off-site need, essential eligibility criteria. And so the thinking through prioritizing ACT or IMT program. I'm throwing in a lot of questions. But again, we are getting a little more specific now.

So who might really be a good candidate for this type of program? And/or who do you think you are seeing in your settings where you are working that might qualify for that -- high

utilizing.

SPEAKER: Again, who don't have a home, living on the street, getting incarcerated, not taking care of their medical health or their mental health. Almost twenty percent of population is in that area, in that group.

SPEAKER: If I can add? So you know we have a Pathway Home team. And we do some of those thirty-day visits for plans. The population that we struggle with, we did great work, but the clients who are actively using substance use and have and are homeless not going in and out, are the most disengaged group.

We've had an escort take them to a pharmacy to pick up the medication to take them back home and they've fled the pharmacy without their belongings. That happens. I'm just throwing this out. I don't know what the solution is. I'm more interested in the IOS model because that's something we

haven't done. Trying to -- these are the members who are in denial and really don't want help and are going in and out of the system.

We are trying to think about how do we engage that population. That's the toughest population. I'm not saying that they're for this program. But I would love to think about how --

SPEAKER: ICLactually has a facility. I don't work at it, but I do love it. It's call the Hub and it's in Brooklyn. It's on Atlantic Avenue if you're familiar with it. If you're not, you should check it out. It's brand new and it's got everything. It has family services.

They have the social -- they meet the social needs by having food, they actually have a CSA. We have clothing for people who might need it. People can bring their children. We have the PROS program for the patients who are suitable for that. We have three ACT

teams that work out of there. We deliver patients' medications. I usually have a bag with me full of stuff. I have -- if anybody would like some. We give shots wherever people will accept them.

A hub model is a terrific one. And we have two different primary care clinics that are partnered with CHN there. People feel very comfortable and they're coming in and getting whatever it might be. So the clinic model is fantastic. The more expansive the services, the better.

How do you get people to walk in. I think that's ultimately the question. Who escorts them? How do we do the proper outreach for them? But that model is probably worth studying for more agencies in the City.

SPEAKER: Can do they work with homelessness people?

SPEAKER: Yeah. Well, we have the

ACT teams. We have shelter ACT teams out in East New York, Bushwick, and one more ACT team that works out of -- We also have the Brooklyn IMT team. It doesn't work out of our hub, but it's not too far away.

SPEAKER: I guess that speaks to this model as having the clinic as an article thirty-one clinic as an epicenter and maybe that's the part that could be more flexible. Where it could be a PROS program. It could be an 822, as that epicenter to then provide these services out of, kind of depending on where --

SPEAKER: One of the things that the way the hub was designed -- it's less than two years old. It was meant to be a community center, so the doors are open. Whatever you might need, you can walk in and get. If you are homeless and need to shower, you can have a shower. I think it's very nonjudgmental. There's no staff

bathrooms. It's very person-centered and we -- we do have an outpatient clinic there.

SPEAKER: Looks like a living room model.

SPEAKER: I will tell you, we have outpatient clinics based in our shelters. So we have 822s and we have ACTs and so we do have -- we have satellites. I will tell you, like you said, the population is very difficult to work with. People think oh, you have an outpatient clinic in the shelter, they just come right there and it's all happy-go-lucky.

It really is not. Just engaging them from the bed to go five hundred feet is like, you know, painful. You know. So I do think like incentives, and we talk about this all the time, when the ACT shelter based team -- I remember sitting in the meeting with OMH -- I mean DHS and OASAS. And everyone talked about how we are going

to get funding for this and is ACT viable and stuff, which we all know shelter ACT is not.

That incentive word came up. And for some reason, it got pushed back in the back of the room and no one acknowledged it again. And these clients, to be engaged, they need to have some incentive. Just coming from their bed down the hallway, they need an incentive. You know, they'll just walk away.

I will tell you, the amount of assessments we get, we'll get forty-five assessments in one month or referrals in one month for one shelter. And if maybe ten of them actually pan out, it's great. So I think when you look at this model, you really need to look at not just a hub, but what are the really -- how are you breaking down the engagement criteria.

And again, what type of clients you are going to be accessing.

Because the substance use disorder population is a very hard population. You give them their medication -- and we don't see them for thirty days. You know, and then they just disappear and on the street.

The IOS license, we have it in all of our clinics, thirteen of them. It's not as great as everyone thinks it is. Because there's a lot of loopholes working with OASAS and OMH, collaborating together on that IOS license.

So I hope your model has both regulatory bodies talking to each other and communicating, which I don't -- I pray happens. Because that's -- I think that's the biggest barrier you are going to come across.

DR. HARRISON: So one further follow up question to that. What would incentives look like? What are successful incentives? And then we'll get to you.

SPEAKER: So we looked at incentives where we have little stores that we put into the shelters, that we put in there. So if you come to your appointment, you can go to the store and pick something up. If you --

SPEAKER: What kind of stuff do you have?

SPEAKER: Everything.

SPEAKER: Everything. Chips, clothing, food. MetroCards are a huge incentive for them.

SPEAKER: 7-Eleven, movies, right. Exactly like that.

SPEAKER: Cigarettes?

SPEAKER: We do have a Pathway Home also and we try to help with the clothing.

SPEAKER: The Pathway Home can be a little bit more inventive. You know, like rock climbing. Again, back to the point that somebody is engaged and they want to have a membership, it gives you flexibility.

SPEAKER: Six to nine model, it's not. And there's no such thing as worrying about how we're getting paid because it came through CVC and funding -- you wouldn't have a problem either.

DR. HARRISON: We'll get to the funding at the end. Before you go, Jason --

SPEAKER: Jason Hershberger, again. OBH. It sounds to me like this model is trying to bridge the mobile treatment and the clinic. So you have to have people that sort of get that zone cone, on the edge of a clinic, person. I would recommend that you focus on people that are close to the clinic here.

So the inpatient discharge, you get a fifty percent chance of showing up at the clinic. It's close. The emergency room discharge, has a five percent chance of showing up at the clinic. They're so far away, it maybe

a waste of resources.

So I would focus on people that have been set up to succeed with maybe a little extra help. Then maybe a transitional period like date of discharge, ninety days. Transitional care.

DR. HARRISON: So you are saying this just as a transitional program, not as a full treatment going on?

SPEAKER: Not forever. I would do it like trying to tie someone. A big outcome, the discharge rate here -- the successful discharge criteria is, in my mind, would be full integration to an outpatient program.

SPEAKER: We are actually doing that now through the OBHP benefit. So you can -- and that's exactly the agreement and it works very well. I think though, I think just for clarification if I understood it.

This is really focusing on very specific group out of people who may

fall into that large group. But it's history of violence, criminal justice involvement, homelessness, so it's more than just that sort of in between. Even if we extend out OMH, we have a longer period of time for preadmission work. But this model is talking about something much longer than that, it's a continuous care post-admission.

And then part of the question is, how long is that period of extended engagement to go out there. And that's the question I think probably until we do it, we will not know.

SPEAKER: Two things. One, the connection -- possibly the connection with additional safe haven beds would be the huge boon to this. The other thing though, you know, part of our ACT step down, we -- the goal is to really help integrate people into their communities of choice.

So to expect someone who, you

know, wound up getting housed -- and of course everyone knows that housing is on the outer boroughs, like as far out as you could possibly get. So someone who is living in the Northern Bronx, to expect them to come to a hub that we create in the South Bronx, doesn't seem to be in line with the recovery model and a focus on integrating into their communities, unless they're choosing to travel that far.

So would there be a consideration of taking the funding that wherever this is coming from and pushing it out into clinics that are existing throughout the City and neighborhoods, wherever they might be, that allows for them to have flexibility of this type of service that we can -- because I mean, we are we push all the time for people to step down from ACT. And we are not successful because the services that they go to, or that are

available to them, are not what they want.

But this seems like it could potentially be that bridge, and no pun intended, but that could be dispersed throughout the boroughs into the existing places where people live.

DR. HARRISON: So we had a push for at least one per borough; if I heard from behind me. And now you are saying more neighborhood-focused. I don't think we were thinking of creating whole new clinics. This is not like we are going to build a new clinic. Right.

So I was thinking you are working in existing clinics for a model like this. Which, I think, is what I heard you suggest. But not all of them. Right, because there's just going to be so much to go around. But certainly thinking through maybe a more neighborhood-focused idea.

SPEAKER: Jessica Klaver from

CASES. We have an outpatient mental clinic, health home care management, six ACT teams and IMT team.

And so just in terms of the population, I was thinking that we do kind of clinically clearly have these in betweeners, in a way. So thinking about the ACT population we have, there's a lot of clients in our ACT teams that I think can and do come on site and can make it in to clinic-type based services, like on-site services.

That may change. So they may for some time make it in and then all of a sudden, they disappear. So we would need the capacity to go and find them. But to some extent, they could engage in a clinic-type service.

And then also, in the clinic side, we have people who, you know, are kind of -- stopped coming in. And we get very worried about them. Some of them we make local crisis referrals and to have a bit of a capacity to go out and

kind of find them and re-engage them.

So there is a clear population that's sort of somewhere in between ACT and clinic. And when we graduate them from ACT to the clinic, it's really quite extreme. It's like we are going to see you six times a month in the community and it's going to be very much in the community. And then all of a sudden, you have to come to the clinic.

So there's a population that I think is already in between that could sort of be targeted. I know the ACT teams sometimes know that someone -- an ACT client can come to the clinic get their injection and see a psychiatrist. But they don't step them down because that person is also benefiting from the wraparound services of the ACT team and maybe they're in the middle of getting housing or they're really engaged with the substance use counselor on the ACT

team.

So to then have to send them to a clinic where all that treatment is going to be slit up, is something the ACT teams don't want to do and the client doesn't want to do. And so I think especially around housing and some of the social determinants, the clinics can have a more capacity to do that. We can really target these kind of in between populations.

SPEAKER: There are two questions. Again, you know, when I hear everybody talking, you can see that there's a lot of programs. A lot of clinics. A lot of things that we do for a patient. I just don't know, do we really look into the root cause why these patients are not getting well. Where is the "why"? Why we need to do this program. I think if we understand that, then maybe we will get a better understanding of what it is we need to do. Because it looks

like there's programs available, and there's still that population we are not able to connect to treatment. They're failing in that one.

You know, we have peer counselors. We have behavioral analysts. We have doctors. We have social workers. Name it. All the license -- we have the whole group of people working for the patients. But still patients are failing. So we need to understand why. And the other thing is, do we have data to show what kind of group of -- again, what is the person or patient we are talking about, so we can make a meaningful work around looking at that kind of -- you know.

SPEAKER: I'll say that not necessarily patients are failing, but we are failing.

SPEAKER: That's what I'm saying. We have so many programs, but still nothing --

DR. HARRISON: I think, just to

share a little bit more on the impetus for this, we still have people on the wait list. Yes, there's lots of innovative stuff going on and there's still more people who need it than capacity for it. This is, in part, capacity building. But not doing something that we know may have challenges of being successful.

So I guess capacity building with a high likelihood of success. So that's some of the -- that was some of our thinking. We also did not want to just expand to more ACT teams. There are real Medicaid issues right now. And ACT team expansion was not in the cards. Okay?

So we are -- not quiet at the root cause. But why we are sitting here with you is because we have to do something else. And we want to do it better. We want to be thinking about individual's needs. We want to be thinking about person-centered care.

We want to be thinking of how you can get somebody substance use needs at the same time as you are giving them everything else. So we know those things aren't working so well now. So those were some of the thoughts.

SPEAKER: This is Nadgete from SUS. In terms of capacity, I don't know for clinic providers, we have slots. We are not at capacity. We have higher rate of no-shows and clinics have bleeding and we have food or service, people who need the service. So it's really how -- because we haven't maximized what we can really offer. But the way we are offering it is not in a way that's appealing or attractive to the people who need it.

So really addressing that gap so we can really maximize what we have before adding a new clinic or whatever. Because the service is there, but they're not being utilized

to a full capacity.

SPEAKER: Deborah Zicht from Jewish Board.

So I think one of the pieces may be missing in here is the client voice. Right. So why don't we -- as this woman over here behind you was saying, in terms of assessing like why are we doing this and what would be most helpful, why not go and ask the clients who we know are the high utilizers in the emergency room.

So they get asked questions in the emergency room about what would make it helpful for them to get into services. We ask in, you know, when they're, you know, maybe a few months out of getting out of prison, what would make it most helpful and useful to you. I mean, I don't know. I don't know exactly where.

But we do a lot of asking us folks who provide the service, and we don't do a whole lot of asking the people

who receive the service and who are trying to get to receive the service. I think that needs to be a part of this discussion.

SPEAKER: Sort of along the lines of what you're thinking of, ICL. That two things have come up a lot. One is that all the programs have exclusionary criteria. And I think that sometimes we try to fit people too narrowly. People who are not easily engaged too narrowly into some kind of a frame work that is going to be really hard for them.

It seems like -- I think we turn off people sometimes by making certain kinds of demands; behavioral, clinical, whatever. The other thing that I'm just going to say, I know what you said about we can't really -- the ACT model is not sustainable. But sometimes when you throw money at problems, they get better. Because if you can increase the ratio, you know,

have more staff -- I don't know if that's increase or decreasing but have a staff ratio of seven-to-one instead of ten-to-one, what more could we get done.

The acknowledgement that we don't have enough psychiatrists and we don't have enough peers, I think that that can be addressed sometimes just with money. And I know -- we want to use the resources we have creatively. But sometimes you have to say, you know, we can't.

The state needs to acknowledge it. Programs need to acknowledge it. That maybe we're not paying programs and people enough to make this work rewarding for them. Not these people, obviously, but people -- other people, who can conceivably be -- it could have professionals engaged where we're trying to engage patients if we made it attractive to them.

SPEAKER: Also, you have to

license people who are waiting for the person -- for the person who needs service to be referred to the first line of contact. Then you have the bachelor level person who is doing the first engagement, doing the assessment, to be able to send them.

But how much training and support or how much is left to that bachelor level person to begin the engagement? Target case managers, they're bachelor level people that go out and are supposed to really build that relationship. And we're talking about people with severe mental illness who may not have been in treatment.

So paying attention to that full cart of work or who really has a heavy load and is not well-compensated, doesn't have the adequate training but their responsibility is huge. We just looked at -- do a good job enough to get them to the clinician. And the clinician and the clinician will take

care of the rest. So we do have that large cohort that needs to be assessed as well.

DR. HARRISON: Any other ideas on this topic? Because I can move us along. These are great inputs.

Okay. So we talked around this a little bit, but the idea of staffing. If we are creating this program we've been talking around, sort of a clinic hub with a field-based team, what should the staffing look like? What about peers?

SPEAKER: The one comment that I'm hearing everybody -- I think whatever we decide, we shouldn't told that there should be one licensed social worker. One this. I think we need some flexibility, especially as we develop this, to be creative. You do want these license submissions, but you might find in one borough you don't need that or you may need more of something else.

So just knowing from contract-based stuff, we just get very, you need this, this, this, this, and it cannot change. And if we really want change across years, I think -- I don't know how we will do this, but you have to think about making it much more flexible. Or making it flexible to change. It's not working out. We don't really need this. We got this. Can this work for this. And training the people you have to do different things perhaps.

SPEAKER: Absolutely.

SPEAKER: Our challenge with mobile treatment mobile crisis, it's hard to find the patients. So the clinic, to staff the clinic, you double-book patients in the clinic. You triple-book patients in the clinic. The staff is occupied one way or another.

In the community, we send a team out, we've got a thirty percent chance

of bringing them, which is great for baseball, but it's really inefficient from a staffing perspective. Whatever staff is kind of the mobile treatment arm, needs to be, I think, the least costly.

DR. HARRISON: The least costly or the most --

SPEAKER: Or the most skilled.

DR. HARRISON: Or the most funded, where it's not a revenue funding. No?

SPEAKER: I mean the -- running ACT teams for as long as I have, there's a very particular skill set that's required of people who are going out into the community to engage and see people and develop really meaningful relationships. And we can get them a little -- I mean nothing already, there's no way we can pay them any less.

And it is a different breed of person than typically is a clinic-based person. We've tried to

do -- once in a while, we get a good clinic person whose like "I'm ready for community work." And once in a while, it works. But it doesn't always work. It definitely takes a breed of person who is willing to go into neighborhoods.

And you know, there's the challenge that we face in staffing is finding people who are reflective of the communities that we are serving. Who have a deep understanding of the challenges, the multiple challenges of the people who -- not because they're choosing not to engage in services, but because of the trauma that they've experienced are unable to engage in services. So it's complicated and it's not -- I think a lot of effort and focus needs to go into the staffing of that portion of things. And the funding needs to be there to pay for them.

DR. HARRISON: And then it

involves training for staff. So if engaging, going out and doing outreaches is a different kind of work, what sort of training? What's needed? How do you --

SPEAKER: It's a clinical skill set that's needed. It can't be the level of the clinic.

SPEAKER: I also think you have to keep focus on supervision. People who go out there and need supervision or need support, I think we've struggled a lot with that. The peers that I didn't realize, when we sort of took on some of the programs that we've taken on with the peers, how much time the supervision was going to require.

It's different when you're supervising a social worker or something because they're bringing all of their own trauma with them. And so I think that you have to also take into account that you might staff it with peers, but then you have to staff

clinical people who are going to be able to supervise those peers.

SPEAKER: Marie Timal. I was actually going to talk more about supervision. But also, safety is a big factor. We have an ACT program. We have the Pathway Home program. And we are going out in the community, a lot of staff have some concerns around safety issues.

That's a training in itself. Making sure they're comfortable. Knowing what to do in certain situations. How do you get yourself out of a potentially hazardous situation.

SPEAKER: During the training, yes, we give clinical skills. We have to also get to people, doing their own work in terms of that safety that you are feeling. Is it because of your own biases? "I feel it's going to be dangerous here." Is it real or is it because of your implicit bias? And

all those other things that come into any training that we have to do, has to have that racial and equity lens in there to be able to see beyond the person. And understand and see also how we are showing up in the space and how is it that we -- when we engage, what are we bringing into our own work.

So we have to take the time with the staff who's engaged, whether it's a peer, social worker. All of us come with our own stuff. So during training to address our stuff ad be aware of it and know "This is me showing up. This is my own stuff coming in." And be able to have a space to check that and do the work. So that needs to be included in the training.

SPEAKER: I couldn't agree more. Just from doing more and more work with this population, how we supervise the staff. You know, it's -- they of

course need supervision around things like documentation and this and that.

And then around the clinical skills, there's another layer. You know, making sure they have basic competence with things like term reduction or motivational interviewing. Those things are kind of key in the engagement part before you get the treatment.

But what we really found is that people need to do a lot of work around their personal experience of doing the work. You know, it might be related to traumas that they've experienced in there lives that are coming back up. Or just more generally, what they're bringing to the table.

So it's almost kind of like we've doubled and tripled up the supervision of staff doing this kind of work and it's been really important.

SPEAKER: Grant Mitchell with Mount Sinai. Two quick points.

So one is I think we have to be careful if we have separate staff for the mobile, separate staff for the clinic, separate addiction staff. Separate means we are going to have the same issues that we are working against. I think it's clear that we have to have cross-training. And we got to make sure, I think function is one team. Even if their background training is in one area or another.

And the second is I advocate working in this proposition and how critical it is to have someone twenty-four/seven that actually knows the patient. This idea of functioning nine to five, nine to nine, it's critical the patient has access to someone who knows them. It doesn't have to be us. I mean, everybody can't be on call every night. But the second piece is having providers have access to someone who knows them. And that is a problem that results in

readmissions and failure because we just can't find out that this person's suicide ideation has been present for twenty-five years and they haven't acted on it, it don't necessarily mean that they wouldn't. So, staffing.

SPEAKER: I just wanted to add that working as one unit, the way the CCBHC model, where you have one treatment plan and everyone, the targeted case manager, everyone document what it is that they're working on with the person meeting together.

So they know that this is my responsibility. I'm helping them with this specific task. This is what the therapist is doing, and what the psychiatrist is doing. So everyone is working on one document and having a joint meeting and knowing who is outreaching and who is doing what. So it's one program, just with different arms. Like an ACT team.

SPEAKER: People having experience with addressing racial equity and staffing. Racial equity staffing, how is that being addressed or any suggestions on how to address those issues to integrate it to a team like this?

SPEAKER: Funding to hire. I mean, all of our great staff are being snatched up by MCOs. By -- you know, you name it. And the folks that I think we want most in our programs are incredibly desirable.

So why wouldn't they leave my ACT team and work for $15,000.00 more? You know, even though we have great benefits, doesn't matter. They're young and they want money to go out and have fun. $15,000.00 is a lot of money. It's a big challenge for us. It's a huge challenge.

SPEAKER: It's also just a pool of -- sorry. Go ahead.

SPEAKER: Jeff Goldberg of Coney

Island.

Again, in terms of the staffing, I don't know, maybe other people have the question, too, I'm still having a hard time conceptualizing, is this one team or multiple teams? Or it's really one -- connect one philosophy of how to approach this group of patients.

But is this a city-wide team that's going to be supporting all our existing services in terms of that you know clinic/community continuum? Or is it a conceived as a transitional team that's going to look at patients in the first ninety to hundred-twenty days?

Is it the mayor's top hundred mental health patients in the City? You know, we know that that was some of the impetus, you know, originally that formed this. Or is it for the ER or getting discharged from the ER or the inpatient unit. We haven't

mentioned correctional health services, where we know that these patients are set up for failure.

And I think depending on that, then you are going to staff it, you know, accordingly. So I'm still -- I guess maybe it's -- I don't think anyone -- you don't know the answer to that. That's why we are all here.

DR. HARRISON: You actually brought up lots of ideas that came up in this room. There's an answer at this point. We could say, "Well what about this?" Something we can think about.

If we had regional teams, maybe two in each borough. So not one per borough, but a couple per borough. Where there's an existing clinic as a base, how might you staff this if any one of those teams had to serve about a hundred people in the community and in the clinic. And then you know we had a couple of ideas.

SPEAKER: I'd like to see this kind of service sort of partner with what, you know, with what we have say at Coney with our ACT team and the ER. Where we know that these patients have difficulty and we are partnering and co-caring for the individual.

SPEAKER: I was going to respond a little bit, maybe to your comment. We struggle a lot with including diverse people in the areas that we need to serve. We make a concentrated effort to look at all the resumes to get people in the pool in. And we take a look at it.

I think we do a good job. We definitely hire people that are more culturally sound. We offer a lot of training. We cross-reference. The pool is not there. We -- kind of similar to the parachute model working with an MCO. Most of the staff we had were white. We had that conversation. We're working in areas where African

Americans are more. How are we going to deal with that? That's the population we are going to serve. What can we offer the staff? But if there is no pool of people to hire from, what do we do? It's a tough challenge, question. I don't think the graduate schools of social work are doing a good enough job in many areas to support this kind of work.

DR. HARRISON: I want to stick to the things that we have some control over right now. So if you did want to a recruit a diverse enough staff that was matching the communities you were serving, would higher salaries alone be enough or would that be a way to help them?

SPEAKER: It's possible. The pool I think is also tough because we are trying to look at it. They're all competing against each other.

SPEAKER: Then there's the piece of once you have those staff,

retaining them and also training them. And doing really some of the work that the woman who had to leave was talking about, of getting people to really do that self-reflective work and understanding who they are and what they bring no matter what their racial, ethnic, you know, religious background, gender, all of that.

What that means when they're doing that work. What that means to the client sitting in front of them. What that means to themselves. And that being an ongoing piece of supervision and the work that gets done in addition to getting that pool of folks in.

SPEAKER: I do think that this will correlate with your funding, I do -- the programs that we have that are funded through a grant, I don't want to use the word grant because that's time-limited. But where there's some form of you don't have to worry about

productivity, and that's not being the constant conversation with the staff administratively. I think that is a different type of retention with other staff.

You can give someone $5,000.00, they think it's so much. Even though when you break it down into what they get in a paycheck, it's nothing. But in their mind, they just got $5,000.00 more. So they'll skip to another agency for a very low pay.

It's when they're there, their job expectations and what you expect them to produce. How you are going to monitor that productivity. I think that level of anxiety causes them t jump ship also. Just like the electronic health record. You know, time-limited, twenty-four hours to get your note in. Stuff like that. So I think that's going to play a huge role.

What makes me nervous is your

structure model lets peers play a predominant role. We have -- we actually train peers and we have a training model and we take them out of our organization. I have to tell you, through OMH and OASAS, the peers and their -- because they're not really credentialed, they're not being monitored through licensing and stuff like that, I've seen really good and really bad.

They're coming with their baggage. And there's no time limit of if they're in recovery, when they're in recovery. The turnover of peers is very large in our organization and we are a very large organization. And the clients notice that.

So if you are going to use peers as a predominant role, I think your agency really needs to -- or your model needs to make sure that you are hiring the criteria of what you want that person to look like. The

experience that's attached to them. You know who is supervising them. The policy and procedures around them. And the training definitely has to be very concrete.

SPEAKER: In addition, there's a long view and short view. The short view is what's everybody has already said. There's a longer view, too. When you think about the stuff you get at medical school, which was founded here in New York to recruit people from maybe first generation college students, people that they would be taking care of, that started like in high school.

Recruiting people and skipping some of the hurdles that might have -- might not quite do as well. There's a lot of high schools in the City that have health tracks. If we can engage with them, they're already there, and provide them with volunteering and training experiences that would not be

a burden on the staff that are currently working.

But we might be able to develop a pool of people who know New York City and its population. Who might be very interested if the rest of the conditions were rewarding for them, and continuing that work after they left.

Regardless of that, by high school early college, which is a high school that you graduated with an associates degree for first generation families, immigrant families who never had those opportunities. They can get a job. They can go finish college later on. Or they finish college in two more years. It's another model for engaging the people in New York that we want to hire to work with other New Yorkers. That's the longer view.

DR. HARRISON: Any other thoughts on training?

SPEAKER: Taking deescalation.

Training determinants, deescalation. That's a very important part. I think I agree with being not the heavy -- the model should not be -- maybe should be peers. But again, we are talking about just very high risk, very complex kind of group of patients.

Having peers being the front line is going to be very hard. So there needs to be -- a lot of other disciplines need to play a role in this and also support the peers. Also, need to be trauma informed training for these kind of people. Because again, this group will be traumatizing so many different levels. Whether it's from sexual to physical to financial trauma, the other one. So how do we train people?

SPEAKER: If these are a particular group of people are very difficult to track or find in terms of thinking outside of the mental health

staffing, but in terms of community affairs offices of NYPD or, you know, people that do this kind of investigative work and you know, in a non -- you know, not looking to punish anyone, but to try and find people or discover people, you know, what other agencies in the City would sort of, you know, partner with this need.

DR. HARRISON: Does anyone have experience bringing in attorneys into your sites?

SPEAKER: Yes.

DR. HARRISON: Whoever said yes or -- can you speak to that? What that looks like if you are bringing attorneys into a setting so that your clients can --

SPEAKER: Currently, the mental health legal services provides that kind of legal rights. They're the ones who really support the patients in a new patient setting. In an outpatient setting, I'm not sure

whether we have anything.

DR. HARRISON: I'm thinking if somebody has issues with housing eviction, the justice system.

SPEAKER: High Line, we have an office there for patients.

SPEAKER: They'll come to see anybody who has eviction issues.

SPEAKER: Immigration issues.

DR. HARRISON: High Line. Who is funding that?

SPEAKER: I think it's the City.

SPEAKER: Or the state. Is it the state, High Line?

DR. HARRISON: So they're in clinic settings?

SPEAKER: At the hospital.

DR. HARRISON: Hospital settings. How about the nonprofits, do you guys have these groups?

SPEAKER: No.

DR. HARRISON: Would it be beneficial for individuals if there was a day a week where there was

somebody there that people could see?

SPEAKER: At least access where we can go and you know --

SPEAKER: I would just say I think for training, the system issues are really people coming from all different systems. Criminal justice system, we have bail reform now. Homelessness and DHS. I sit in so many different rooms with people who have a lack of knowledge in crossing over those systems. So that's kind of what I'm thinking in my head, how do you train or have the support there for them.

The other thing I would say, one thing worked with IMT, there was a real velocity around -- the original team actually participated in developing. This developing whenever and wherever, having people really be part in creating the mission.

It really does help to have one mission that people really believe in,

that really drives the work.

SPEAKER: Could you draw from adult perspective services for this initiative or are they really just follow --

DR. HARRISON: What do you mean?

SPEAKER: I mean, traditionally, the same issue called for vulnerable individuals. But traditionally, it meant the vulnerable and mentally ill, had to come under their group care. Unless they're elderly or --

DR. HARRISON: The last set of questions, and I don't believe -- they're really about funding and implementation. So let's talk a little bit about incentive. What would wrap around sort of the funding. What would need to be modified within any existing clinic, if they were going to do this, so it becomes welcoming and engaging for these particular clients.

What about the reimbursement for

this. If we are situating a program in a clinic knowing that the team is also going out into the community, what parts of that are potentially reimbursable and what parts are not reimbursable. We need to be thinking about other resources and what does that look like.

I'd love to hear your thoughts. And I think in particular with the Mount Sinai perspective. I'd love to hear that and what that looks like. What that --

SPEAKER: So that team is just -- it's really focused on transition. It's just inpatient psychiatry or CPEP. And it's really, anyone who is referred to our clinics, is really to engage them. It's really using the LBHP benefit. You are first basically are using the preadmission screening type.

And then thereafter, they may still function as part of the clinic

team. But it's really the engagement work. We are still testing out how to reimburse -- I mean, yes. We are billing now and billing it out under the clinic benefit under OPHT. The OASAS clinic has a similar off site with principals very much the same.

I mean if we think about it, our ultimate goal was, you know, it's a peer and asocial worker. It's not, you know, we are not having three doctors and four social workers that if we can get an X number of people, just like you, who don't show up, that we can get that number of people could, over the course of a year, would that hopefully be enough to meet the cost of those two.

Which theoretically is okay. We had, I think it's more us than our EMR, I think it's more than that. I think ultimately, we had such a large number of referrals and a lot of good success, that I think it will be very

close to being, you know, fully neutral. I think there might be a little bit -- we have a really good team.

So to everyone's point, it makes a good difference. I think it is really doable. We have a set, very defined, population. And it's really coming from people from a certain -- not just a place, but a certain state. Right. They've been identified as having some sort of acute crisis. Or they're immediately post-crisis because they've been stabilized.

So our team, even though they may be working with people who are homeless, it's much more broad. I think it's doable, but it really depends on how large the team is. A two-person team is doable. I think we are getting something like twenty to twenty-five, something like that. They're seeing them at least three, four times.

SPEAKER: I have a question. When you say viable revenue-wise, or even looking at revenue, OASAS allows community services to be built. Assessment and everything like that. OMH doesn't.

So when we contacted OMH -- because we were a CCBHC community, we were allowed to do that. But our regular article thirty-one, they said no. They said even if you do one group, even once outside of the model of the clinic, you have to make it quote unquote "a satellite." So they don't recognize community-based services.

So this whole model of yours, like I said, you really do have to speak to the regulatory models. OASAS wants it, loves it, embraces it. They want all of the services. You can do as much as you want outside of the community. Go for it. So it's, you know, back and forth on that.

I will tell you I have noticed clinics, staff people that you hire for clinic-based environment, really want to spend some of the time in the clinic. They don't like to be in the community. The ACT teams and your other local crisis teams, because they're higher community-based services, then they have a mindset.

But if I'm a case manager, a therapist or a peer, and you are hired within the clinic of this address, they will say, "When am I going to be in the clinic?" They want their schedule. So I think between revenue and staffing patterns needs to be looked in that area.

SPEAKER: Tracy Gard from the Jewish Board.

I guess I keep thinking back to what other folks have said about the on-track New York teams and how they really engage. And so when someone comes, they meet the whole team. And

you know, the team is there and then -- you know, it's a very -- so it sets the tone right up front. Like we are all here for you.

And so I think that would be a very hard thing to do in a clinic setting, but that idea of this is everyone who is here to, you know, we are all here together in this process. Rather than, the current set up is you can by an appointment, potentially one person at a time. And try to figure who is who and what the system is and who do I talk to for what. I think using the OnTrack model for engagement might be one way.

SPEAKER: I have a question. One thing that's part of the OnTrack model that doesn't seem to be part of this at all is IPS, the vocational system. And I know that for OnTrack and for -- at least for young adults, one of the real engagement lures is the combination of peers and getting a

job. And so that the supported -- supported vocational or educational component is one way to keep them engaged and "Oh, yeah. By the way, you have to have treatment, too." And that doesn't seem to be anywhere in this model, unless I missed it. So just a thought.

DR. HARRISON: To add in, I mean, other people brought it up as ideas. So we heard about it.

SPEAKER: Just want to reiterate to be welcoming and engaging. It's part of what people want, besides primary medical care. Sometimes that's more of a motivator than psychiatric care. The fluidity within space and that space could be both real and virtual.

As people's goals change for themselves, that they can still use -- at least the same institution and can build -- come to a place and see people they recognize. Whether

they're doing PROS or they're doing therapy, or whether they're coming in for groceries or see their primary care after. I think it's --

SPEAKER: The doctor was describing a program before, like reviewing room model. Is there any way you can share your data? I'm just thinking whether --

SPEAKER: Yes, I can.

SPEAKER: That model, is it preventing your -- other people much more engaged in that kind of model. Again, there's something available and we can duplicate because maybe they're seeing everything there. But a good model to take a look at.

SPEAKER: Yes. There was a presentation at IPS back in May. So I can speak to the people that own it and see about distributing it, yeah.

SPEAKER: I'm worry about the LBP community model. My understanding is that -- what I've done is twenty

percent usual revenue for a particular service. But in this case, you are recording two people going out in the community with a higher no-show rate. To me, it ends up being a financial loss, a non-sustainable way -- to us.

SPEAKER: That was our experience with it, yes. That the billing alone did not -- was not able to sustain it.

SPEAKER: It cost twice as much and you miss twice as many people.

DR. HARRISON: Do you know what --

SPEAKER: I think the way we thought about it is there's actual billing for the OBHP work. But part of what they do is really about keeping people coming to the clinic and you have additional visits to the clinic, theoretically. We have not completed our own analysis.

The other thing I'll share is that we also do our internal referrals, you know. So it's not just the people that are being referred. So it's that

team that knows if we're doing this pilot, the mobile crisis team now has a much wider catchment. The other outreach team is handling both when we finish the analysis.

It's only been about a year and a half we've been doing it. But in terms of engagement, people are coming in. I mean, that's really the most people.

DR. HARRISON: Right. So I think it sounds like there's going to need to be many different ways to think about different types of revenue streams for this kind of program. It's not going to be only LBHP. If you are seeing this person in the clinic, there's another way to do it. Just a thought.

SPEAKER: Also again, different -- you are talk about a different type of client, right? Because you are talking about the people who you can bridge to clinic. I think a lot of

the folks that we all talk about that we can't get are the people -- you can't even get them in the ACT team. You can't get them in the fact team. You can't get them in the six-pack team. You can't get them.

I'm curious about going back to your thirty-day review, these people who are alarming, right, the City and the mayor, whatever, to say we need to do something different, who are those folks? Are they people who are touching any services? Are they people who are only in the prison system? People who are in the homeless system? Are they people who have access to any mental health services ever? Who are we talking about?

You have to think about who are you trying to target. Are you trying to target the people who have not touched it, you know, the mental health systems at all? Or are you

trying to target people who are in and out of the mental health systems and trying to grab them in.

DR. HARRISON: I think we know from a few years with this particular mayor, and knowing where our gaps are in care, people in and out of all of these systems is still a big problem.

SPEAKER: Is there any connection with OMH, not necessarily before, not too recently, about the fact that there aren't really enough long-term beds? A lot of what we are trying to build here is for people who are so unstable. It's their illness, yes, the drug use. But really, it's their illnesses.

And I think it's important to acknowledge psychiatric illnesses are relapsing. And I think we are all doing -- working as hard as we possibly can. Some people aren't ready to be in any level of community services. If they are, it would be a

step down. I think state that had the transitional, South Beach has it as well, you live there, but then you went to transitional health there.

I think that that -- I don't know the data and outcomes, but it makes sense to me that sometimes we are pushing people very fast into a lot of unstructured time. That's very, very difficult for them.

DR. HARRISON: So interesting, when you say unstructured time, I didn't hear anybody mention useful things for people to do with their time. We didn't ask that question, but --

SPEAKER: But people did. They're talking about vocational. They're talking about education. People have brought up --

DR. HARRISON: Is that enough? Are those really -- I just wonder if that's something you guys think about or want to suggest anything about.

SPEAKER: I know in our ACT programs and the home health care coordination because of the non-Medicaid coordination grant, we do art group. Which we've stopped because of space issues. We do movie groups. We do lots of different things.

We can be created once we engage somebody. The challenge, of course, is to get people engaged. There's an opportunity to do many socialization types of activities. I'm sure everybody does.

SPEAKER: But you are still following that part rather than how to engage with what's in the communities.

SPEAKER: Correct. For the moment. And then going for a movie, for example, then they can go out on their own. The good thing about it is they own the group. They come back. They choose what they need to. They talk about the process. They talk

about the interactions they had with each other, too. But small groups. It's not --

SPEAKER: I mean the space thing makes me think a little bit more. I wonder to what extent there is any space available in clinic for any community activities like this. And you had to give it up. And what I think is so attractive about the ICL hub is like this space. Right. The built environment is really inviting.

SPEAKER: It's pretty attractive. I don't work there, but I love it.

SPEAKER: I just wonder if that's a lure and a gap and what could help that.

SPEAKER: People also having community connection relationships that they can leverage. And how would we do so with something like this. Or utilize some funding for that.

SPEAKER: I know another program that's through HRA, human resource

administration. We have -- we have New York Cares, I think. And they come in and do resume writings. So we've created partnerships. They come in on a Thursday, whoever comes in can, you know -- and again, we are thinking about integrating our programs and have everybody come not just for one specific program and offer opportunities.

You have to have the time and the space to kind of figure out what that might be. But yeah, that's one example. They do a winter coat drive with us as well for our clients. They used to do come every Thursday for resume writing group. It's great, right. They have a professional working in the finance industry coming in to talk to you and doing interviews.

SPEAKER: Maybe get -- again, going back to the regulatory things. So let's say our agency has a service,

but the client wants something and we don't have it, but your program does, can't they be seen in the two places. Which right now, no, they can't.

Can't you get this service here and that service there and the next service somewhere else because it works for the client, without having to worry about no, you can only -- regulations say you can only get this service in this place. And you know, there's a lot of obstacles to fluidity in terms of access to care.

SPEAKER: I would agree with that within our own programs. Because our client wanted to go, we can do one on one. But we couldn't -- unless we organized every day for every program. It defeats the purpose.

SPEAKER: Or if there are capped funds. So that if people have their own money, they didn't have a place that they had to spend it.

DR. HARRISON: So any last minute

thoughts? And it doesn't have to just be on this funding and limitation issue. Anything you think we ought to know as we are thinking about this model or anybody who hasn't spoken that wants to weigh in.

SPEAKER: Keith Martin.

You know, I've heard so many wonderful things and I think all of our agencies are doing spectacular things. And here we are getting ready to create yet another model. I think what we keep hearing this in the room that we have the resources to address the problem. But I think it's like taking what's available, and saying how do we improve upon where what already exists.

It's like we are going to throw more money at a problem that, I think the doctor back here said, the "why." What's the need for? What's the population that we are looking at?

So I guess I'm kind of struggling

with how to respond with it being inclusive in the discussion without tilting it back the other way. Because we have so many wonderful resources. I was at a meeting with OASAS the other day, as this young lady said, flexibility is what's creating all of the impediments that I think a lot of the resources in the room, can't access because of rules regulations, policies and procedures.

OASAS is talking about how do we remove that in terms of patient-centered care. You can't have a patient-centered care mission and model if you don't allow access for the patient to access those services. So that's my point.

It's three o'clock now. Two hours of assessment of what we are saying where we are at. I think you really need to look within our own resources here. It may end up being a great model, but I think we are

shortchanging the resources that we already have. That's just my voice.

SPEAKER: I think if you can get a good data from -- again, hopefully your data is showing a good --

SPEAKER: Actually, I have a link.

DR. HARRISON: Send it to me. I'll get it to the group.

SPEAKER: Sure. I'll be happy to.

SPEAKER: You are doing something that's really -- patients are able to come in and do -- because you need to engage them in some way. I think that's what -- you're showing less -- that's a model --

SPEAKER: I'm not going to oversell it.

SPEAKER: Maybe something more can be added to it, whatever you're missing. Maybe that's a model you want to strengthen up in the e-mail.

SPEAKER: The staff has that same degree of fluidity that the patients so they go around. The staff have

their assignments, but they also talk to each other and they know everybody. There's two or three active. Plus -- it's -- people can -- the patients can move throughout the system comfortably.

It's also very empowering. If you come to PROS once a week, that's okay. If you come to PROS five days a week, that's okay. We can build on whatever we got.

SPEAKER: You know the CCBHC Model has data shown. You said even the hospitalizations went down. So the thirteen providers in the State of New York, we are able to go on a portal and look at our data and see where we fall in that type of -- you know, with those outcomes.

So this model kind of mirrors it a little bit. Where you have the hub, which is the CCBHC and then you have all the players outside in the community that are doing all the

community-based servicers. Then they come, back once in a while, to the hub again. So clients are able to get their services either only out in the community or they come to the clinic if help is needed. The data does show that.

DR. HARRISON: There are three in the New York City?

SPEAKER: Yeah, thirteen in the state.

DR. HARRISON: I only care about New York City. Sorry.

SPEAKER: There's ACACIA.

SPEAKER: There's four. There's Samaritan. We're Samaritan. Acasia.

SPEAKER: Isn't ICL?

SPEAKER: No. SUS and then Horizon.

SPEAKER: What is limiting the more sort of rapid expansion of that?

SPEAKER: SAMHSA came out with a grant that's allowing for you to add on extensions of your -- not the city,

not the state CCBHC, but the SAMHSA one. Which is staffing pattern only. They gave you $200.00 each year for staffing only.

So like we have a program in Suffolk County that has that. And you can add on. We had to put that in recently, so we're doing that. They did an extension on the thirteen providers for the state. They're two separate grants, two separate CCBHC. Which is hysterical.

That was a cost rate. We had a cost rate that was put into that on a cost report. That's where you get your funding. Every service, that's a specific cost that you get for it. The other one is they give you whatever your OTPS or your staffing is. They do that. The data does show that it absolutely went down.

DR. HARRISON: Where is that data?

SPEAKER: We have the data. We have access to the data.

DR. HARRISON: The individual has it?

SPEAKER: And the state has it.

DR. HARRISON: OMH has it?

SPEAKER: OMH has it. Absolutely. They're the lead. Lauren is actually the lead liaison for the CCBHC.

DR. HARRISON: Lauren --

SPEAKER: I'll give you her e-mail. She actually has all the data and Bob Low. He's actually the head of the whole --

DR. HARRISON: Okay. Any other input from you guys?

(No response.)

DR. HARRISON: So appreciate hearing all out of you. Your thoughts and ideas and you know help us do a better job. Okay. So thank you for coming.

(TIME NOTED: 3:16 p.m.)

C E R T I F I C A T E

STATE OF NEW YORK)
:SS
COUNTY OF NASSAU)

I, Elbia Merino, a Notary Public within and for the State of New York, do hereby certify:

I reported the proceedings in the within-entitled matter, and that the within transcript is a true record of such proceedings to the best of my ability.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 28th day of January, 2020.