Reflections On The Inpatient Psychiatric Experience

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New York
CARE COORDINATION PROGRAM
Creating a person-centered, recovery-focused system of care

WESTERN REGION BEHAVIORAL HEALTH ORGANIZATION
WITH BEACON HEALTH STRATEGIES, LLC AND COORDINATED CARE SERVICES, INC.
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12 Hallmarks Of Person-Centered Practices For Acute Psychiatric Experience

1. Interactions with individuals, their families, and their supports demonstrate they are treated with dignity, respect, genuine concern, empathy, and staff truly listen to what individuals say.

2. Wait times are short, specifically emergency room wait times, as well as the time period between inpatient discharge and outpatient appointments.

3. The environment is welcoming, safe, and calming.

4. Individuals, their families, and their supports are included as integral team members alongside acute services staff.

5. Individuals, their families, and their supports are educated about mental health and informed about the community/outpatient service options available to them.

6. Individuals have access to Peer/Family and Youth support and advocacy.

7. Treatment plans reflect the needs and goals of the individual and family.

8. Medical staff educates individuals, their families and their supports about medication management and provides them with adequate supplies of medication to last up through outpatient provider appointments.

9. Individuals, their families, and their supports are informed about what to expect at each step along the way.

10. Discharge planning begins at the start of inpatient hospitalization.

11. Inpatient programming includes a variety of therapeutic options.

12. All aftercare services are coordinated and scheduled prior to discharge, and when able, aftercare service providers have talked and/or met with the individuals, their families and their supports.
Executive Summary

The State has asked the regional Behavioral Health Organizations (BHOs) to collect information to help understand the steps taking place to support effective discharge planning. The Western Region BHO also felt it to be important to hear from the individuals of inpatient psychiatric services to better understand what constitutes a positive experience as well as what opportunities exist for improvement. Therefore, during the summer of 2012, the WRBHO partners brought together various stakeholders from multiple regions to plan and host forums for youth and adult individuals with prior inpatient psychiatric experiences, along with their families, advocates, and clinicians to share their perspectives on individuals’ inpatient experiences. This report summarizes the themes from participants’ feedback gathered in the regional forums.

The degree of consistency of the feedback concerning what contributes to a successful inpatient admission and discharge led the WRBHO to develop a series of Hallmarks Of Person-Centered Practices For Acute Psychiatric Experience. These attributes reflect those values, practices and approaches identified by recipients of services that when embraced by providers would enhance the quality of the inpatient stay, improve the individual’s outcomes (increasing responsiveness to treatment as well as reducing the probability of a second admission within a short period of time).

12 Hallmarks Of Person-Centered Practices For Acute Psychiatric Experience

1. Interactions with individuals,* their families, and their supports demonstrate they are treated with dignity, respect, genuine concern, empathy, and staff truly listen to what individuals say.
2. Wait times are short, specifically emergency room wait times, as well as the time period between inpatient discharge and outpatient appointments.
3. The environment is welcoming, safe, and calming.
4. Individuals, their families, and their supports are included as integral team members alongside acute services staff.
5. Individuals, their families, and their supports are educated about mental health and informed about the community/outpatient service options available to them.
6. Individuals have access to Peer/Family and Youth support and advocacy.
7. Treatment plans reflect the needs and goals of the individual and family.
8. Medical staff educates individuals, their families and their supports about medication management and provides them with adequate supplies of medication to last up through outpatient provider appointments.
9. Individuals, their families, and their supports are informed about what to expect at each step along the way.

* Please note that “individuals” is defined as adults, youth and families receiving services.
10. Discharge planning begins at the start of inpatient hospitalization.
11. Inpatient programming includes a variety of therapeutic options.
12. All aftercare services are coordinated and scheduled prior to discharge, and when able, aftercare service providers have talked and/or met with the individuals, their families and their supports.

WRBHO Recommendations

- Encourage all stakeholders to review the information contained in this report.
  - All behavioral health Inpatient providers in our region
  - Western Region BHO Regional Oversight Team
  - County Office of Mental Health Directors and their teams
  - Stakeholders at upcoming WRBHO Evaluation and System Transformation (BEST) Meetings. Cross walk the hallmarks with the performance metrics being tracked.
  - HANYS behavioral health readmission team
  - Health Homes

- Use the information to have conversations with teams involved in serving these individuals.
  - Each behavioral health inpatient facility should discuss the hallmarks during an internal meeting where individuals who have received inpatient services are represented. The team should assess the facility’s work against the hallmarks and consider opportunities for additional training that might address any gaps in practice that may exist.
  - Encourage county officials to use hallmarks to hold conversations with providers about opportunities for improving the system of care for individuals of psychiatric services
  - Health Homes to consider using hallmarks to establish standards of performance for the inpatient providers in their network.

- Embed the Hallmarks into facilities’ policies and practices so that they become a part of the day-to-day work of the organization. Examples include:
  - Add the elements of the Hallmarks into job descriptions so they become a part of the work of each individual and can be evaluated during performance appraisals
  - Refine inpatient satisfaction surveys to ensure that elements important to recipients of inpatient services are measured.
  - Share feedback from inpatient satisfaction surveys with staff involved in providing services. Develop work plans for those areas of opportunity.
  - Build the Hallmark expectations into documented procedures.
  - Incorporate Hallmarks into the facility’s Quality Assurance Plan: Identify measures to be tracked that reflect the hallmarks and use continuous quality improvement to address identified challenges for the organization.
Introduction

“It is of compelling public importance that the State conducts a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure.”

Governor Andrew Cuomo, January 5, 2011

The perspective presented by Governor Cuomo in the statement above set forth a direction for Medicaid redesign that has been embraced by the New York State Office of Mental Health (OMH) and the Office for Alcohol and Substance Abuse Services (OASAS). Acting on this charge, these offices created regional Behavioral Health Organizations (BHOs) across the state. Very important in the focus of the State’s work, and the work of the BHOs, is the belief that we can improve health outcomes while at the same time controlling costs.

How can we both improve outcomes and reduce costs? New York’s Medicaid program serves almost 5 million beneficiaries at a cost of over $50 billion annually. Twenty percent (20%) of Medicaid beneficiaries (about one million individuals) account for 75% of the program’s expenditures, or about $31.1 billion. Further analysis of the program costs by the Department of Health has determined that approximately $800 million is spent in a given year on “avoidable Medicaid hospital readmissions” and that 70% of these involved beneficiaries with mental health, substance use and major medical conditions.

The regional BHOs were created in order to provide a period of up to two years for stakeholders to engage in planning for a redesigned Medicaid program in support of beneficiaries with Behavioral Health (Mental Health and Substance Use) needs. We are being given the opportunity to focus on what can be done to improve the quality of services and systems integration for Medicaid beneficiaries and to better understand critical success factors related to a restructured Medicaid delivery system, including those factors that will support a reduction in unnecessary readmissions. Specific goals of the WRBHO’s work include:

• Review behavioral health inpatient length of stay for all Medicaid Fee-For Service admissions
• Reduce behavioral health inpatient readmission rates
• Improve rates of engagement in outpatient treatment post discharge
• Better understand children diagnosed as SED
• Prepare performance reports for region and providers in the region
• Encourage cross systems linkages that will improve outcomes

As a component of our inpatient admission review process, the State has asked the BHOs to collect information to help understand the steps taking place to support effective discharge planning; work that will assure that the individual has the needed after care services in place at
Reflections On The Inpatient Psychiatric Experience

the time of discharge. The Western Region BHO also felt it to be important to hear from the individuals receiving inpatient psychiatric services to better understand what constitutes a positive experience as well as what opportunities exist for improvement.

Therefore, during the summer of 2012, the WRBHO partners brought together various stakeholders from multiple regions to plan and host forums for youth and adult individuals with prior inpatient experiences, along with their families, advocates, and clinicians to share their perspectives on individuals’ inpatient experiences. This report summarizes the themes from participants’ feedback gathered in the regional forums. It should be noted that while there are many differences between how Adult and Youth/Family services are provided, no significant themes from the forum data emerged to distinguish the two groups from each other.

The degree of consistency of the feedback concerning what contributes to a successful inpatient admission and discharge led the WRBHO to develop a series of Hallmarks of Person-Centered Practices For Acute Psychiatric Experience. These attributes reflect those values, practices, and approaches identified by recipients of services that when embraced by providers would enhance the quality of the inpatient stay and improve the individual’s outcomes (increasing responsiveness to treatment as well as reducing the probability of a second admission within a short period of time). The perspectives offered by the individuals also reinforce the importance of the discharge process information currently being collected by the BHOs. To the extent we can assure communication among providers supporting the individual and create solid connections to after care services, we are well positioned to improve outcomes for individuals, enhance quality of life, as well as reduce expenses by decreasing unnecessary readmissions.

12 Hallmarks Of Person-Centered Practices For Acute Psychiatric Experience

The WRBHO created 12 Hallmarks of Person-Centered Practice based upon the main themes that individuals identified as helpful and needing improvement in acute psychiatric settings. These Hallmarks operationalize and build upon Core Values of Person Centeredness (based on the work of Michael Kendrick), Hallmarks of Person Centeredness (OPWDD) and Guiding Principles for Person-Centered, Recovery-Oriented Services (NYCCP) (see Appendix A). Providers committing to these 12 Hallmarks will help better engage individuals in their treatment, as well as prevent acute setting experiences that can sometimes be traumatic, confusing, and fear-provoking for individuals. These 12 Hallmarks, along with examples of the Hallmarks in action follow:
1. **Interactions with individuals,** their families, and their supports demonstrate they are treated with dignity, respect, genuine concern, empathy, and staff truly listen to what individuals say.
   - Staff members take time to fully understand what the individual is communicating.
   - Staff members give the individual his or her full attention, and reflects back to the individual to ensure they are correctly hearing what the individual needs.
   - Staff members are validating and show patience, putting themselves in the individual’s shoes.
   - Staff members ask the individual for feedback on how well they heard him or her, whether or not his or her needs are being met, and if there is anything else they can do to be helpful.

2. **Wait times are short, specifically emergency room wait times, as well as the time period between inpatient discharge and outpatient appointments.**
   - When an individual arrives in the ER, the person is told how long to expect to wait and is updated if changes occur.
   - Individuals are connected to an outpatient or community provider within 7 days.

3. **The environment is welcoming, safe, and calming.**
   - ER waiting rooms are clean and organized with materials available for reading.
   - Individuals are introduced to security, explaining why security is present and that security is a resource to them.
   - Staff are trained in verbal de-escalation techniques, so as to avoid the use of physical restraints.
   - The inpatient unit is quiet with soothing colors and individuals respect each others’ boundaries.

4. **Individuals, their families, and their supports are included as integral team members alongside acute services staff.**
   - Inpatient staff and individuals invite family members and supports to participate in treatment team meetings so all are present in-person or by phone.
   - In the ER setting, supports can stay with the individual throughout the visit.
   - All individuals and supports participate in the collaborative partnership, and decisions are shared among all team members.
   - Staff ask the individual’s supports about their needs and concerns regarding the individual, and the team identifies how supports can be most helpful to the individual.

* Please note that “individuals” is defined as adults, youth and families receiving services.
5. **Individuals, their families, and their supports are educated about mental health and informed about the community/outpatient service options available to them.**
   - Staff members thoroughly explain how the individual’s specific symptoms relate to the diagnosis so all team members have an understanding of what the individual is experiencing and why.
   - Staff members help the individual and their supports recognize what may be triggering symptoms, and explain how coping skills and recommended treatment would be beneficial.
   - Supports are given the opportunity to learn about ways they can best support the individual.
   - Staff members take the time to educate the individual and his or her supports about the various services available in the community, explaining what the programs do and how each program could help that individual be more successful with controlling mental health symptoms.

6. **Individuals have access to Peer/Family and Youth support and advocacy.**
   - Facilities incorporate Peer/Family and Youth supports into the ER process. Upon arrival to the ER, a Peer meets with the individual and his or her supports and continues to check-in with him or her until the individual leaves the ER.
   - The Peer support helps answer questions, listen to concerns, and advocates for the individual as needed.

7. **Treatment plans reflect the needs and goals of the individual and family.**
   - Staff members ask individuals and families about their dreams, interests, preferences and strengths during the treatment planning process.
   - The individual feels satisfied with his or her activities, supports, and services.

8. **Medical staff educates individuals, their families and their supports about medication management and provides them with adequate supplies of medication to last up through outpatient provider appointments.**
   - Individuals meet one-to-one with the unit psychiatrist, and the psychiatrist explains what medication he or she recommends and why.
   - The individual has the opportunity to ask questions, and demonstrates to the psychiatrist that he or she has a clear understanding of why the medication was prescribed.
   - The individual understands the dosage, what side effects to look for, and what to do in case possible side effects occur.
   - The psychiatrist and medical staff makes sure the individual leaves the ER/inpatient unit with an adequate supply of medication, so the individual does not run out before he or she is connected with their outpatient psychiatrist.
9. **Individuals, their families, and their supports are informed about what to expect at each step along the way.**
   - Each ER staff member reviews what they did together with the individual and supports, and explains what the next steps are moving forward, including how much time each step should take.
   - Staff members encourage questions from the individual and his or her supports.
   - When an individual first comes onto the unit, inpatient staff members give him or her an anticipated timeline for the treatment visit.
   - The steps and timeline are reviewed daily up through the date and time of discharge.

10. **Discharge planning begins at the start of inpatient hospitalization.**
    - Upon entering an inpatient unit, individuals meet with staff to start creating a discharge plan together.
    - Time is devoted to determining the outpatient and community services and supports that would be a good fit for the individual.
    - The individual is connected to the supports and appointments are scheduled as soon as possible.

11. **Inpatient programming includes a variety of therapeutic options.**
    - An individual on an inpatient unit has access to activities and groups like yoga, tai chi, music therapy, art therapy, meditation/relaxation techniques, WRAP, psychoeducation, self-care, medication management, and wellness classes.

12. **All aftercare services are coordinated and scheduled prior to discharge, and when able, aftercare service providers have talked and/or met with the individuals, their families and their supports.**
    - Discharge planning begins at the start of the individual’s inpatient stay
    - Appointments are scheduled as soon as the individual identifies the outpatient provider he or she would prefer to work with. The individual may feel comfortable returning to work with their previous outpatient therapist. If not, a new outpatient provider is identified.
    - Assist the individual in making contact with the therapist before inpatient discharge and before they meet face-to-face. An in-person meeting with the therapist would be ideal.
Forum Planning

The WRBHO forums were based on a process created by a multi-stakeholder group consisting of representatives from Genesee, Livingston and Wyoming Counties. Members of this group shared their forum process with the WRBHO, giving them guidance and providing them with their materials including group topics and questions.

The WRBHO Peer and Family Advisory Group endorsed and oversaw the forum process. Four NYS regions were selected to ensure representation from the different areas of western New York: Buffalo, Ithaca, Olean and Rochester. Four corresponding multi-stakeholder planning groups were formed and included representatives from county mental health departments, Mental Health Associations (MHAs), inpatient providers, and other community providers.

The planning groups recruited forum participants mainly through word-of-mouth, but a couple of counties also used press releases. MHAs and various providers were contacted and flyers were posted on inpatient units and within different outpatient agencies and programs.

Forums

A total of four, five-hour forums were held in the following locations to reach all areas of the region: Buffalo, Ithaca, Olean, and Rochester.

<table>
<thead>
<tr>
<th>Forum Location</th>
<th>Forum Date</th>
<th>N</th>
<th>Counties Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffalo</td>
<td>8/15/12</td>
<td>110</td>
<td>Erie, Niagara</td>
</tr>
<tr>
<td>Ithaca</td>
<td>8/20/12</td>
<td>60</td>
<td>Chemung, Schuyler, Tioga, Tompkins, Seneca</td>
</tr>
<tr>
<td>Olean</td>
<td>7/27/12</td>
<td>50</td>
<td>Allegany, Chautauqua, Steuben, Cattaraugus</td>
</tr>
<tr>
<td>Rochester</td>
<td>7/11/12</td>
<td>62</td>
<td>Monroe, Ontario, Orleans, Wayne, Yates</td>
</tr>
</tbody>
</table>

Participants attended a half-hour presentation in the morning about changes to the behavioral health care system, and how these changes will affect them. They then had the opportunity to participate in three 50-minute small group discussions. At the start of each group session, participants were asked to first complete written forms that asked for their input regarding their emergency room and inpatient experiences with an eye towards identifying areas for improvement (see Appendix B for copies of blank forms). They were then asked to share their input at whatever level they felt comfortable in doing so, within some smaller group discussions. Scribes took notes at each small group discussion. Discussion topics included the following:
Group Discussion Topic 1:
Emergency Room and Inpatient Mental Health Experience

Pertaining to their emergency room experience, individuals were asked to discuss what was helpful, what needed improvement, any general suggestions/recommendations, and any recommendations for specific providers. The same was asked of individuals pertaining to their inpatient experiences. Participants were also asked to look back at the times they had their biggest crises, and report on what they wanted and needed at that time.

Group Discussion Topic 2:
Engagement and Transition Back Into the Community

Participants were asked “How could engagement and transition back into the community be improved for local folks and people returning to neighboring counties?” Participants were asked to think back to their discharge (or a family member’s discharge) from the hospital, referral, and transition to follow-up treatment and/or care coordination. Knowing what they know now, and looking back on that process, participants were asked what was helpful, what needed improvement, and what recommendations they had.

Group Discussion Topic 3:
Alternatives to Avoid an ER/Inpatient Hospitalization

Participants were asked to consider some possible alternatives that might have been helpful to them in avoiding an ER visit or inpatient stay and provide their feedback as to whether these resources might have been helpful.

Identified Themes

Forms completed by participants were collected and responses were combined with notes taken by scribes during the small group discussions. Content was subsequently evaluated for themes using theme identification, outlined by Ryan and Bernard (2003). Forum data were reviewed using methods such as: word repetition, key-words-in-context (identify key words and then systematically searching the text to find all instances of the word or phrase and then physically sorting the examples into piles of similar meaning), and compare and contrast (determining how each line of text is either similar or different from each other).
Group Discussion Topic 1: Emergency Room and Inpatient Mental Health Experience

Figure 2. Numbers of participants by forum location and participant type

<table>
<thead>
<tr>
<th>Participant Type*</th>
<th>Buffalo (N=33)</th>
<th>Ithaca (N=19)</th>
<th>Olean (N=22)</th>
<th>Rochester (N=34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>14</td>
<td>12</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Family Members</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Advocates or Clinicians</td>
<td>11</td>
<td>6</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>19</td>
<td>39</td>
<td>44</td>
</tr>
</tbody>
</table>

*Please note: participants had the opportunity to select more than one type

Emergency Room Experience

**Staff Interactions with Individuals Should Demonstrate Empathy, Respect, and Genuine Concern**

The manner in which staff interacted with individuals and their supports was the theme most often raised when asked what was helpful during their emergency room experience and what needed improvement. Participants thought it was helpful when staff were nice and courteous and showed empathy, kindness, compassion, understanding and respect for the individual. Participants explained that they were looking for staff to genuinely care for individuals and to clearly understand individuals’ situations, concerns and fears experienced in their time of crisis.

- One participant said staff with “a calm understanding voice” was helpful.
- “…there should be a team at the hospitals to assure that all people are treated with dignity and respect.”
- “The staff in the ambulance, the ER and in the patients room area made my family member feel at ease and protected. Individuals who suffer from mental illness need to have a feeling of safety around them and professionals who take the time and patience to figure out what is happening to them.”

While some participants reported positive interactions with ER staff, many shared that this was a significant area for improvement. It was often reported that staff used threats with individuals, and their treatment by staff directly affected their sense of dignity. They did not feel treated like people, and their concerns were not taken seriously.

- “Sometimes you are not feeling that the professional staff has empathy or care and concern regarding your situation or circumstance.”
- Many participants recommended training for the staff including: person-centered training, trauma-informed training, and training in appropriate bedside manner.
“More diversity training is needed about cultural norms within sub groups. People are not placed in some cookie cutter style of care. Each person should be respected and cared for genuinely and not as though they are just a number.”

Participants felt that one way staff could demonstrate these interactions would be to really listen to individuals and their family/supports.

“I just wanted them to listen, not just hear what I’m saying. Listening is harder for people with their own agenda. They are there to listen not only with their ears – use their minds for understanding – use heart to feel what I feel.”

“I wanted to be able to talk to someone that I could express my thoughts and feelings to.”

“Someone to listen, someone to let me know I wasn’t alone, someone who cared- genuinely cared.”

**Wait Times Need To Be Kept Short**
Participants reported that short wait times were helpful, and long wait times needed to be reduced. Many reported waiting hours in the emergency room to see someone, with some reporting specific wait times of up to 12 hours. Comments specifically identified wait time experiences with transportation, waiting to be seen by staff at the ER, waiting to meet with a psychiatrist, and hospital admission.

**ER Staff Must Communicate the Steps of the ER Process**
Participants found it very helpful when staff explained the ER process to individuals and their families so all were fully aware of what was happening during their stay and what to expect going forward. They felt that lack of communication was an opportunity for improvement.

“Families have told me that there is often little interaction with staff while they are waiting to be seen. They have no idea how long the wait will be, etc. and questions about that are not always welcome.”

Participants recommend increased communication throughout the entire ER visit.

“ERs need to communicate more to people coming in – clarify and re-clarify.”

One participant recommended “Inform people as to what, why, when- what are they doing/why are they doing it and how long will it take, define the purpose of the ED, what the next steps might be, involve the person/family in next steps, and all steps in process.”

**Individuals’ Supports Should Be Integral Team Members**
Individuals come to the ER with various friends, family or advocates as their supports, and participants said it was helpful when those supports were allowed to stay with individuals and to have staff fully involve them in the process. With the individual’s consent, staff should work with the supports to get more information about the individuals’ needs, as well as to educate the family about mental health and how to best support the individual.
Participants also recommended having a peer advocate or a “family support worker/advocate to explain, and be a go-between to offer hope and understanding.”

Another participant explained that the individual would “Need someone to go with the person to transport from doctor to hospital/someone at hospital to explain why they are there. To hear what is going on when the person in crisis cannot.”

**ER Environment Must Be Welcoming**
Many participants reported that a lot of improvements could be made to the physical environment in the ERs.

- One participant described the ER area as a “stuffy waiting room, cold, dirty, we were uncomfortable, tired, hungry, felt less dignified, not respected.”
- Another participant said the surroundings were “usually stark and bare” and others said they did not feel safe.

Many had concerns about the areas being loud and overcrowded, and worried about their privacy due to the close proximity of individuals to one another. Participants recommended better attention to privacy issues and “environmental changes – i.e. waiting room appearance, seating, available materials for reading” as well as separate areas for individuals to wait based on their needs or characteristics (e.g., youth vs. adult, medical vs. mental health). Participants appreciated that individuals were able to wear their clothes rather than being forced to change into hospital gowns.

**Staff Need To Provide Education About Mental Health and Available Community Services**
Participants valued receiving education from staff about their mental health diagnosis and treatment.

- “During my first experience, the assessment aided me greatly in understanding my initial experiences with mental illness.”
- Another individual reported he or she wanted the staff to “teach me about how to help myself stay out of hospital.”

Participants also found it helpful to learn about and, when applicable, get referrals to community services that would be helpful to them.
Inpatient Mental Health Experience

**Inpatient Services Should Include Linking Individuals To Community Services/Supports**

When asked for areas that need improvement, participants most often identified that discharges sometimes occur with minimal plans in place. They frequently identified the importance of getting referrals and linkages to community services (especially housing), and helping the individuals “establish a support system or network of people that can help them once they are released.” Participants felt that more time should be devoted to discharge planning, and it should start at admission. They reported that individuals and their supports, including outpatient providers, should all be involved in the discharge planning process. Participants shared that adding more supports in this planning would be helpful (e.g., peer/family and youth support advocates).

Participants thought it would be helpful for individuals and staff to have more information about services available to them after discharge, and one way to accomplish this would be to have community providers come in to educate individuals and staff about the services they offer.

- "Inpatient staff need to increase knowledge of community resources so they can help do a good plan for clients. Consider all areas and link to services ex: medical, CD issues, housing, clinical services/programming."

One participant summarized participants’ recommendations well:

- “Adequate support of medication 1-2 months, providing complete discharge information to outpatient providers and discharge summary records faxed to outpatient providers, completion of SPOA applications, ask and assess for all needs and arrange prior to discharge, ask about transportation to outpatient apt and if none set up for person, if need housing link and set up, don’t discharge to street or homeless.”

There were also recommendations for inpatient providers to follow-up with individuals up to two months after they are discharged from inpatient services.

**Individuals Must Have Medication Management and Psychiatrist Availability**

Participants stated that medication management and psychiatrist availability were areas for improvement. Participants had a lot of concerns about individuals struggling with side effects and being overmedicated.

- One participant explained “Staff say to you how you are feeling and that the medicine will help you if you take it. But if you know how it makes you feel and you don’t like how it makes you feel and they don’t want to work with you on coping. They would rather just dope you up.”
Participants would like psychiatrists to use more caution when prescribing medications to individuals who are also taking medication for medical conditions and individuals with chemical addictions. Participants want to know their options for medication and to learn more about the medications. Distributing learning materials was one recommendation.

Participants said they needed more time with psychiatrists treating them during their inpatient stays, and they wanted better communication from psychiatrists. One participant would recommend an “actual time to sit with the doctor for discussion” and include the individual’s support network. More time would allow for individuals to get additional information about the medication and have a discussion about side effects. Participants would like to hear more from the psychiatrist about what to expect regarding medication usage after discharge.

➢ One participant stated that the “doctor would not give my son meds, doctor lacked communication with us, doctor did not listen to my son’s psychiatrist.”

*Inpatient Programs Should Encourage Ongoing Visitation And Contact Between Individuals And Their Supports*

Participants identified the importance of maintaining ongoing contact between individuals and members of their support systems, and found it helpful when inpatient staff encouraged it.

➢ One participant explained that “the staff welcomed and encouraged my visits” and another participant recommended that staff “encourage family members/other providers (CM) to visit and be involved.”

Participants would like to see visitation hours extended and for hospital inpatient programs to be more inclusive in setting rules about who can visit (e.g., ages). It would be helpful to have larger areas for families to meet with children.

➢ Recommendations also included: “do not restrict phone hours and have multiple phones, skype availability, multiple spaces available for different locations for visitors to connect with individual and places to do family work towards recovery.”

*Staff Must Regularly Communicate With Individuals’ Family, Friends, And Other Supports Including Providers*

Participants stated that it is helpful to have direct lines of communication open among staff and the individual’s identified family, friends and other supports, including providers.

➢ “The staff in the unit were very understanding and provided me with clear explanations of what was happening to my loved one.”

Participants reported that it is important for the individual to identify who is a part of his or her support network. If family is not the main support system, identify who is, and obtain signed consent from the individual for those individuals. Participants recommend that staff talk to a wide range of service providers including those from school, mental health, and primary care settings.
One participant gave an example about her client’s admission. “I did not find out about her admission until several days after she entered- from a family member. Inpatient staff should work to find out about every aspect of an individual’s care and inform the appropriate parties as soon as it is possible.”

According to participants, staff should help educate supports about mental health and the inpatient process, including medications, mental status, hygiene, etc.

One participant explained “Help family understand and do not take it for granted that they are already aware or have a clue of what is going on.”

**Staff Interactions with Individuals Need To Demonstrate Empathy And That Staff Are Really Listening to Individuals**

Participants found it was helpful to have direct care staff who are very caring and empathetic to the individuals’ situations. Participants also reported that there were opportunities for improvement regarding staff’s ability to connect and engage with individuals.

One participant stated that “Staff stressed, not listening, not accommodating, not consistent.”

Participants agreed that all staff, including psychiatrists, need to listen to individuals better and more often.

One participant suggested “more training for workers and personnel to know who and how to hire the correct workers to fit the new person-centered planning.”

**Inpatient Environment Should Be Safe and Calming**

Participants liked that the environments of some hospital inpatient settings felt safe, calming and had structure. Other participants explained that the environments were not safe with individuals wandering into each other’s rooms at night, unnecessary restraint use, and loud televisions.

“The peace and tranquility was helpful for resting and reducing stress.”

**Therapeutic Programming Offered Must Include A Variety Of Options**

Participants had positive feedback about the types of programming options available while inpatient.

One participant identified that the following was helpful: “The classes in behavioral therapy. The physical exercise times. Classes and being allowed to do art work in my room.”

Another participant liked “taking advantage of the facilities like the swimming pool, courtyard. Grounds for exercise is great.”

Other participants felt that there were opportunities to provide more groups, workshops, activities, and classes. Participants offered many recommendations including: yoga, tai chi,
music therapy, art, guided meditation, any activity providing exercise, and outside time for fresh air.

- One participant explained “I have visited only one client on an inpatient unit. The only criticism I have is that there is a lot of TV watching and very little education going on. You have a ‘captive’ audience why not begin to teach them recovery techniques... WRAP, meditation, relaxation, self-discovery and self-care.”

**Individuals Need To Connect With Others Who Have Similar Experiences**

Participants reported it was helpful to connect with other individuals while inpatient. One participant stated “it is always helpful to talk to others that understand what you are going through.” There was a sense that some staff may not understand what individuals are experiencing as demonstrated by their lack of empathy/understanding mentioned above. Others recommended adding peer/family and youth support advocates, peer/family and youth support groups, and greater access to community social groups. Another participant stated that it is helpful to have a “peer buddy program or something to reduce sense of isolation. Better if it’s the same person.”
Group Discussion Topic 2:
Engagement And Transition Back Into The Community

Figure 3. Numbers of participants by forum location and participant type

<table>
<thead>
<tr>
<th>Participant Type*</th>
<th>Buffalo (N=39)</th>
<th>Ithaca (N=28)</th>
<th>Olean (N=23)</th>
<th>Rochester (N=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>22</td>
<td>15</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Family Members</td>
<td>9</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Advocates or Clinicians</td>
<td>11</td>
<td>13</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>31</td>
<td>36</td>
<td>40</td>
</tr>
</tbody>
</table>

*Please note: participants had the opportunity to select more than one type

All Services After Inpatient Care Should Be Coordinated And Scheduled Prior To Discharge
Participants talked about the importance of having all outpatient linkages coordinated and scheduled before the individual is discharged from inpatient services. Some participants stated they simply did not have any services or supports to follow-up with leaving inpatient. The summary below outlines what participants found helpful and recommendations for making seamless linkages.

Discharge Planning Must Be Completed By A Team
Participants consistently reported across forums that it is most helpful to have discharge planning completed by a team which includes: the individual, inpatient staff, individual’s family and friends, outpatient providers (behavioral health, PCP, case managers, etc.), peer/family and youth support advocates, and any other supports identified by the individual. According to participants, collaboration and communication among these groups in regards to discharge planning is an area for improvement for some hospitals.

Participants recommended that through attendance at meetings and/or telephone calls, the individual and all of his or her supports should contribute to the plan, know the plan details, and understand the roles for each person in the plan. Having a written plan that is distributed to all team members at discharge was another recommendation. Participants explained that the individual should be clear about who he or she will see after discharge and the reason(s) for the services.

- One participant stated that at “a few of my hospitalizations, I was misinformed of who I was to see afterwards. I thought I was seeing my counselor but I was in a group with peers and my counselor.”
Participants talked about how helpful it was to have supports during this transition period. When asked what was helpful, participants made statements like:

- “Knowing I wasn’t alone”
- “The establishment of a support system to ensure that people/resources are readily available for their needs.”

While the presence of any supports was positive, family and peer/family and youth supports were most often identified.

- “Educating my family about my illness and things they may expect or things (signs) to look for to indicate when I need help.”
- A family member explained “Knowing where to go, how to explain to staff what was happening to my loved one and understanding that you stay with the person until they get the treatment that they need...do not be tempted to just drop someone off and expect that they will get treatment.”

**Discharge Planning Needs to Begin At The Start Of Inpatient Hospitalization**

Consistent with the recommendations provided in group 1, participants were also clear in group 2 that discharge planning should begin at the start of inpatient treatment. Participants explained that some hospital providers waited too late in the individual’s stay to plan for their discharge, so there was not enough time, and the individual and family did not feel prepared.

- One participant recommended “Involvement (communication) at day #1 with family, significant other, and outpatient providers to understand what led up to hospitalization and to plan for follow-up care.”

**Staff Should Identify All Options For Outpatient And Community Services**

Participants reported it was most helpful to have staff knowledgeable about the variety of outpatient and community services and supports in order to better educate individuals and their families/supports about their options. Participants explained that individuals want to know what their choices are, and what services are available to them, so they can make the best possible decision regarding their aftercare. Participants would like the staff to have a discussion about their options and ask the individuals where they may have attended services previously, and what they think would help them be successful in their transitions.

- “It is helpful for patients to know that their outpatient options are and for referrals to be made before discharge. When choices for outpatient treatment are available-patients should be given their choice of treatment provider.”

According to participants, it was helpful for individuals to be linked not only to behavioral health outpatient services, but also to other necessary resources and supports. The resources/supports most often identified were: housing, social services benefits, transportation, physical health providers, and SPOA. Participants would like staff to consider the whole person, and to think about the individual’s needs beyond just behavioral health, including the individual’s family.
Participants also recommended the following:

- Inpatient staff could provide some type of “Community Resource Sheet” listing possible resources they could use once leaving inpatient care, including resources such as: employment services, subsidized housing, food pantries, peer/family and youth support services, support groups, family support groups, etc.
- Have community agencies come to the units to talk about the services they provide.

**Wait Time Between Inpatient And Outpatient Services Must Be Short**

Participants explained that the wait time between inpatient and outpatient services for individuals can often be too long, so they found it more helpful when individuals were connected to services quickly. Participants recommended connecting individuals to other supports while they wait for outpatient services, as well as having plans in place for the individuals to follow while they wait to meet with their outpatient providers.

- One participant explained “There’s so much structure/support in the hospital; then you get out and there’s nada. It helps to have a schedule and plan for the first few days, then meetings with support people soon (a couple days, not a couple of weeks) after. Having a social worker to help me negotiate the system really helped in the early days.”
- Another participant stated “Having a plan in place to assist a patient to have things to do, people to talk to and places to go- and an advocate to help carry this through. Otherwise, boredom and negative, repetitive ‘old’ thought patterns take over and land you right back in the hospital.”

Participants also felt it was helpful to have individuals make contact with the outpatient/community service provider by phone or in-person prior to discharge to help form that connection before their actual outpatient appointments.

**Individuals Need Education About Medication Management And An Adequate Medication Supply To Last Up Through To Their Outpatient Provider Appointments**

Participants stated it was helpful for the individual not only to know what medication he or she is taking, but also the purpose for the medication, what side effects are possible, how to cope with side effects, and to ensure that he or she has an adequate supply to get through until outpatient appointments.

- One participant shared his or her experience stating the following: “One of my psych doctors just said ‘here take this med.’ I felt I was just popping pills. He said you should feel better in 3 weeks. But he didn’t seem interested in taking the time to helping me understand my diagnosis. You feel like a number. Though he did say it had something to do with a chemical imbalance in the brain.”
Group Discussion Topic 3: Alternatives To Avoid An ER/Inpatient Hospitalization

Figure 4. Numbers of participants by forum location

<table>
<thead>
<tr>
<th>Forum Location</th>
<th>Buffalo</th>
<th>Ithaca</th>
<th>Olean</th>
<th>Rochester</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>39</td>
<td>23</td>
<td>22</td>
<td>31</td>
</tr>
</tbody>
</table>

Participants were asked to identify possible alternatives that they feel would have helped them avoid an ER visit or inpatient hospitalization. Individuals were given the following statement: **“If the following had been available, one or more of my inpatient admissions might have been avoided or shortened.”** Participants were provided with a list of options (see figure 5 below) and asked to select all that apply. Participants then discussed their feedback in small groups.

Figure 5. Numbers of participants selecting hospitalization alternatives (N=115)

<table>
<thead>
<tr>
<th>Alternatives*</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A peer to sit with me to help me through a rough time</td>
<td>81</td>
<td>70%</td>
</tr>
<tr>
<td>Respite or crisis service I could have gone to instead of ER/hospital for the a short time</td>
<td>79</td>
<td>69%</td>
</tr>
<tr>
<td>A more comprehensive person-centered treatment plan</td>
<td>72</td>
<td>63%</td>
</tr>
<tr>
<td>Better personal supports at the time to get me through hard times</td>
<td>69</td>
<td>60%</td>
</tr>
<tr>
<td>A crisis prevention/WRAP plan, etc.</td>
<td>68</td>
<td>59%</td>
</tr>
<tr>
<td>Better knowledge of my own mental illness, triggers, early warning signs</td>
<td>68</td>
<td>59%</td>
</tr>
<tr>
<td>Support and education for my family/support</td>
<td>67</td>
<td>58%</td>
</tr>
<tr>
<td>Knowledge of self-calming techniques</td>
<td>57</td>
<td>50%</td>
</tr>
<tr>
<td>Treatment or techniques to deal with past trauma in my life</td>
<td>54</td>
<td>47%</td>
</tr>
<tr>
<td>I wasn’t on the right medication at the time</td>
<td>41</td>
<td>36%</td>
</tr>
<tr>
<td>A more skilled outpatient therapist</td>
<td>41</td>
<td>36%</td>
</tr>
<tr>
<td>Medical issues that were not being taken care of</td>
<td>40</td>
<td>35%</td>
</tr>
<tr>
<td>More attention to the role drugs and alcohol were playing in my life</td>
<td>28</td>
<td>24%</td>
</tr>
<tr>
<td>I had stopped taking medications as prescribed</td>
<td>27</td>
<td>23%</td>
</tr>
<tr>
<td>I went to ER because that was the only way I could get prescriptions for meds</td>
<td>21</td>
<td>18%</td>
</tr>
</tbody>
</table>

*Please note: participants had the opportunity to select more than one alternative*
Participants Would Like Access to Peer/Family And Youth Supports
The alternative most often selected by participants was “a peer to sit with me and help me through a hard time” (70%). Participants have found it helpful to work with peers who share individuals’ experiences, and would like to see more peer/family and youth support advocates in the community and the ER, as well as peer-run programs.

➢ “Peers have been there and I believe most patients would relate better possibly and avoiding hospitalization.”

There were numerous other participant suggestions for different roles peers/family and youth supports could take to help prevent ER/inpatient hospitalizations including: a peer/family and youth hotline or “warm line,” peer/family and youth support advocacy training, access to peers/family and youth support online (e.g. Skype), have peers/family and youth support available to assist with questions prior to visit with the doctor, peer/family and youth support drop-in center, peer/family and youth support run recovery center, peer/family and youth support wellness center, peer/family and youth support groups, peer/family and youth support club, and peer/family and youth support -run respite center.

Individuals Feel Access to Respite and Crisis Services Would Be Helpful
Sixty-nine percent (69%) of group 3 forum participants felt that they could have gone to respite or crisis services for a short time to help avoid ER/hospital visits. Participants explained that it has been/would be helpful to have a safe place to go to talk to someone about their crises, and de-escalate. This “hospital diversion” facility could take different forms, and participants suggested various combinations of the following:

➢ Respite care -planned and unplanned, day or overnight, adults and youth, group home setting
➢ Urgent care centers only for behavioral health needs
➢ Drop-in/crisis center- open 24/7 with access to peer/family and youth support and/or therapists
➢ On-call psychiatric staff at the clinics- evenings and weekends
➢ Home visit crisis intervention services

Participants Think Having A More Comprehensive Person-Centered Treatment Plan Would Prevent ER Visits/Hospitalizations
Sixty-three percent (63%) of participants felt that having a more comprehensive person-centered treatment plan would have helped them avoid an ER/Inpatient hospitalization. Participants said they did not always feel that behavioral health providers were listening to them.

➢ One participant wanted the provider to be “listening to my needs not what they think I need or what my child needs.”
Other participants stated they would have liked “more active goal setting” and more inclusion of the individuals in their treatment plans prior to the hospitalization to better prevent it from occurring.

Participants said providers should “recognize and respect patients as people” and they would have liked “more understanding doctors with better bedside manners.”

Participants Would Have Liked Better Personal Supports At The Time Of Crisis
Participants reported that having better personal supports at the time would have helped prevent ER/inpatient hospitalization (60%). Participants emphasized the importance of individuals having relationships with supports that listen and understand them. Participants often stated that those supports are needed in the moment of the crisis, and crises can happen at any time, including nights and weekends.

Having A Crisis Prevention/WRAP Plan Would Be Helpful
Having a crisis prevention or wellness recovery action plan (WRAP) was identified by 59% of participants in group 3. They explained that these plans are empowering for individuals to “do what they can themselves to avoid the need to go to hospital.” WRAP plans need the necessary training and support to develop and implement. One participant stated that the treatment team needs to take time during formal sessions to set-up the WRAP plan together. Another individual reported that there should be some type of a plan that says “this is what I do when I am stressed- ie: my survival skills list.”

Participants Think Better Knowledge Of Their Own Mental Illness, Triggers, Early Warning Signs Would Prevent ER visits/Hospitalizations
Participants felt that having better knowledge of their mental illness, triggers, and early warning signs has helped keep them out of the ER/inpatient treatment (59% of participants). Participants stated there is “poor patient education” and individuals should know the signs and symptoms of mental health disorders. According to participants, when individuals learn about their illnesses, it allows them to be more proactive in finding out what helps them stay well.

One participant explained “My counselor of 6 years never told me my diagnosis, only the code. Never gave me information or input that may have helped. I learned no coping skills and was made to feel as if I were less than. After going without counseling and meds for several years I found a counselor who took interest in me and was not a textbook counselor. My life was turned around in 6 months. Knowledge of my diagnosis would have helped if known earlier.”

Another participant stated “I never understood my mental illness so I turned to drugs to take the pain away. If I would have had the hospital help me 20 years ago and talk to me and showed me, explained to me, made me understand about my illness instead of shoving pills in my face and showing me out the door, I think I would of turned out different. 20 years and I'm finally understanding... about my illness and I have been clean off drugs and going great.”
Participants Would Have Liked Support And Education For Their Family/Supports
Fifty-eight percent (58%) of participants thought that having support and education for their families and supports would have been helpful. Participants suggested teaching family members skills to assist the individual, as well as having family members on treatment teams. 

- One participant stated “I need my family to be more involved and to have more understanding not just think it is me. (My) son thinks he knows it all.”

Discontinuation of Outpatient Treatment
About a third of participants (30%) reported they discontinued outpatient treatment (figure 6). When asked why they discontinued, a little over a half (53%) discontinued due to cost and half (50%) felt their treatment was not person-centered.

Figure 6. Reasons for discontinuing outpatient treatment (N=34)

<table>
<thead>
<tr>
<th>Had discontinued outpatient treatment because of:</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>18</td>
<td>53%</td>
</tr>
<tr>
<td>Treatment wasn’t person-centered</td>
<td>17</td>
<td>50%</td>
</tr>
<tr>
<td>Thought I didn’t need it</td>
<td>15</td>
<td>44%</td>
</tr>
<tr>
<td>Not effective</td>
<td>12</td>
<td>35%</td>
</tr>
<tr>
<td>Turned off</td>
<td>10</td>
<td>29%</td>
</tr>
</tbody>
</table>
Forum Evaluation Results

Participants completed evaluations at the end of the forum, and overall results were very positive (figure 7). They felt the forums were successful for 1) sharing feedback that will improve the behavioral health system (4.42/5.00), and 2) creating an emotionally safe and respectful environment to share feedback (4.35/5.00).

**Figure 7. Evaluation Results**

<table>
<thead>
<tr>
<th>Question</th>
<th>Scale</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate the <em>usefulness</em> of today’s forum.</td>
<td>1=not useful – 5=extremely useful</td>
<td>4.27</td>
</tr>
<tr>
<td>Rate how <em>valuable</em> you found discussions and group activities.</td>
<td>1=not at all valuable – 5=extremely valuable</td>
<td>4.32</td>
</tr>
<tr>
<td>Rate how <em>successful</em> we were in accomplishing the following objectives:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing information about changes in health care and its impact on you.</td>
<td>1=not at all successful—5=extremely successful</td>
<td>3.93</td>
</tr>
<tr>
<td>Creating a forum to share feedback that will improve the behavioral health system.</td>
<td>1=not at all successful—5=extremely successful</td>
<td>4.42</td>
</tr>
<tr>
<td>Getting to know others in my region.</td>
<td>1=not at all successful—5=extremely successful</td>
<td>3.87</td>
</tr>
<tr>
<td>Creating an emotionally safe and respectful environment to share your feedback.</td>
<td>1=not at all successful—5=extremely successful</td>
<td>4.35</td>
</tr>
</tbody>
</table>

Participants felt the following were the most worthwhile aspects of the forum: discussions; listening to others’ feedback, ideas, and first hand experiences; ability to share thoughts, ideas and concerns; interacting with others; individuals learned about obtaining better mental health care; clinicians heard individuals’ perspectives with the goal to help improve mental health care; learning new things about the system.

Participants felt the following were the least worthwhile: the health home presentation; spending too much time on crisis stories and not enough time on ideas; hearing redundant information; groups could have kept on track better to allow everyone time to speak; some participants would “talk over” others.

Participants stated they will do things differently as a result of the forum, including the following: connect themselves and others with services/agencies they previously did not know about prior to the forum; bring information back to others (colleagues, other individuals, etc.);
focusing more on the role of peers/family and youth support in services; advocate more for self and others; listening more and asking individuals/family members more about what they need (e.g., services, their thoughts/feelings, etc.), and learn more about what services and programs are available.

Participants asked for a report summarizing findings from the forums. Some stated it was a well-organized event and asked that these forums be held on a continual basis.

**Conclusion and WRBHO Recommendations**

The WRBHO provided individual regional group feedback to their respective planning teams. Each team is using the forum feedback to identify opportunities for changes in ER/inpatient services for their region. Based upon the above identified themes, the WRBHO has the following recommendations for the 19 county system:

- **Encourage all stakeholders to review the information contained in this report.**
  - All behavioral health Inpatient providers in our region
  - Western Region BHO Regional Oversight Team
  - County Office of Mental Health Directors and their teams
  - Stakeholders at upcoming WRBHO Evaluation and System Transformation (BEST) Meetings. Cross walk the hallmarks with the performance metrics being tracked.
  - HANYS behavioral health readmission team
  - Health Homes

- **Use the information to have conversations with teams involved in serving these individuals.**
  - Each behavioral health inpatient facility should discuss the hallmarks during an internal meeting where individuals who have received inpatient services are represented. The team should assess the facility’s work against the hallmarks and consider opportunities for additional training that might address any gaps in practice that may exist.
  - Encourage county officials to use hallmarks to hold conversations with providers about opportunities for improving the system of care for individuals of psychiatric services
  - Health Homes to consider using hallmarks to establish standards of performance for the inpatient providers in their network.

- **Embed the Hallmarks into facilities’ policies and practices so that they become a part of the day-to-day work of the organization. Examples include:**
  - Add the elements of the Hallmarks into job descriptions so they become a part of the work of each individual and can be evaluated during performance appraisals
  - Refine inpatient satisfaction surveys to ensure that elements important to recipients of inpatient services are measured.
Share feedback from inpatient satisfaction surveys with staff involved in providing services. Develop work plans for those areas of opportunity.

Build the Hallmark expectations into documented procedures.

Incorporate Hallmarks into the facility’s Quality Assurance Plan: Identify measures to be tracked that reflect the hallmarks and use continuous quality improvement to address identified challenges for the organization.
References


Appendices

Appendix A:
- Hallmarks of Person Centered Practices (NYS OPWDD)
- Guiding Principles of Person-Centered, Recovery-Oriented Services (NYCCP)
- Core Values of Person-Centeredness (Adapted from Michael Kendrick)

Appendix B:
- Group 1 Forms Completed by Forum Participants
- Group 2 Forms Completed by Forum Participants
- Group 3 Forms Completed by Forum Participants

Appendix C:
- New York Care Coordination Program’s Directory of Peer and Family Supports During Inpatient Admission. This directory provides information on the types of services available for adults and youth during their inpatient admissions. Information is organized by County, provider organization, and service site, and includes the days/time services are provided, the types of services provided, and contacts for each organization.
Appendix A

Hallmarks of Person-Centered Practices

- The person’s activities, services and supports are based upon his or her dreams, interest, preferences and strengths.
- The person and people important to the person are included in lifestyle planning and have the opportunity to exercise control and make informed decisions.
- The person has meaningful choices, with decisions based on his or her experiences.
- The person uses, when possible, natural and community supports.
- Activities, supports and services foster skills to achieve personal relationships, community inclusion, dignity and respect.
- The person’s opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.
- Planning is collaborative, recurring and involves an ongoing commitment to the person.
- The person is satisfied with his or her activities, supports and services.

New York State Office of Mental Retardation and Developmental Disabilities

New York CARE COORDINATION PROGRAM
Creating a person-centered, recovery-focused system of care
Guiding Principles of Person-Centered, Recovery-Oriented Services

- The goal is recovery, not just stabilization and maintenance.
- Hope is necessary and recovery is possible for everyone.
- Every individual is unique; every recovery different.
- People have prompt access to compassionate care and services.
- The system is flexible, wherever possible, to support the person’s recovery.
- Every plan for recovery is centered on the person’s goals, strengths, and preferences -- not the availability of a particular program or service.
- Natural supports, outside the mental health system, are explored and encouraged.
- Family support is valued and included when appropriate.
- There is a partnership between individuals and their treatment team, care coordinators, service providers, and their peers and family members, when appropriate.
- Individuals are educated to make informed choices about their health care and recovery.
- Peers (people in recovery) are included and involved at all levels in the organization.
- Everyone is treated with dignity and respect; differences in culture, belief, or language are valued.
Core Values of Person-Centeredness

- A commitment to know and to deeply seek to understand an individual
- A conscious resolve to be of genuine service
- Openness to being guided by the person
- Willingness to struggle for difficult goals
- Willingness to stand by values that enhance the humanity and dignity of the person
- Flexibility, creativity, and openness to trying what might be possible; including innovation, experimentation, and unconventional solutions
- To look for the good in people and help to bring it out

Adapted from Michael Kendrick
Appendix B – Forms Completed By Forum Participants

**Group 1: What is important to individuals and how could the ER/inpatient experience be improved?**

**Check All that Apply:**  Client ___  Family Member ___  Advocate or Clinician___

*Please complete this form and share what you are comfortable with your group/table. A scribe will take notes in order to share responses with the Workshop Planning Committee after the workshop.*

The Emergency Room Experience (including transportation to, your experience in the ER, discharge processes, etc.):
A. These things were helpful:

B. These things needed improvement:

C. General Suggestions/Recommendations:

D. Specific Recommendations for ________ hospital (we will pass along):
The Inpatient Unit Experience:
A. These things were helpful:

B. These things needed improvement:

C. General Suggestions/Recommendations:

D. Specific Recommendations for ____________ hospital (we will pass along to them):
Looking back at when you were having your biggest crisis, what did you WANT at the time?

Looking back at when you were having your biggest crisis, what did you NEED at the time?

Turning in this form is completely voluntary; But we would be grateful if you would turn it in at the end of your group discussion so the Planning Committee can have the information to help improve services! THANK YOU!
Group 2: Engagement and reintegration back into the community at discharge: How could this be improved for local folks and people returning to neighboring counties?

Check All that Apply: Client ___ Family Member ___ Advocate or Clinician___

*Think back to your (or your family member’s) discharge from the hospital, referral, and transition to follow-up treatment and/or care coordination.

*(If your comments are from an experience in which you lived in a different county than where you were inpatient, please note:
County that I live in: ____________________ County that I was inpatient in: ______________

KNOWING WHAT YOU KNOW NOW AND LOOKING BACK on that process, what were:
A. Things that were helpful:

B. Things that needed improvement:

C. Suggestions/recommendations for improving the transition (not only what the hospital could do to improve, but what the receiving clinic or service could do to improve the transition too. Examples might include: making a connection with the outpatient provider prior to discharge, having peer support in place, having a family/discharge meeting, etc.):

Turning in this form is completely voluntary;
But we would be grateful if you would turn it in at the end of your group discussion so the Planning Committee can have the information to help improve services!
THANK YOU!
Group 3: ALTERNATIVES TO HOSPITALIZATION

Check All that Apply:
Client ___ Family Member ___ Advocate or Clinician___

Please complete this form and share what you are comfortable with your group/table. A scribe will take notes in order to share responses with the Workshop Planning Committee after the workshop.

Please check all that apply to the below question. If you had multiple admissions, we understand some checks might not apply for every admission.

“If the following had been available, one or more of my inpatient admissions might have been avoided or shortened”

__A more comprehensive person-centered treatment plan
__A crisis prevention plan/WRAP plan, etc.
__A peer to sit with me to help me through a rough time
__Respite or crisis service I could have gone to instead of ER/hospital for a short time
__I wasn’t on the right medications at the time
__I had stopped taking medications as prescribed
__Support and education for my family/support system
__Better knowledge of my own mental illness, triggers, early warning signs
__Better personal supports at the time to get me through hard times
__Knowledge of self calming techniques
__Treatment or techniques to deal with past trauma in my life
__More attention to the role drugs and alcohol were playing in my life
__Medical issues that were not being taken care of
__I went to the ER because that was the only way I could get prescriptions for meds
__A more skilled outpatient therapist: If checked, briefly note skills they needed but didn’t have

__Had discontinued outpatient treatment because of     Cost   Not effective   Turned Off
Thought I didn’t need it   Treatment wasn’t person-centered   (circle all that apply)

Comment:

Turning in this form is completely voluntary;
But we would be grateful if you would turn it in at the end of your group discussion so the Planning Committee can have the information to help improve services!
THANK YOU!
Directory of Peer and Family Supports During Inpatient Admission

June, 2012
## Inpatient Supports for Children (June, 2012)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Site of Service</th>
<th>Days/Times Services Provided</th>
<th>Services Provided</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monroe County Inpatient Support</strong></td>
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<tr>
<td>Mental Health Association of Rochester</td>
<td>Strong Memorial Hospital- Adolescent Unit</td>
<td>1st Tuesday, 3rd Thursday 5:30-7:00pm</td>
<td>*Family Mentors support parents of children with mental health challenges during hospitalization and after discharge, educate parents on community resources, advocate to ensures proper school placement and supports are in place after discharge, mentor families in regards to safety plans and transitions from inpatient to outpatient care, provide peer group for parents, provide peer group for teens.</td>
<td>Renee Jacobs 585-325-3145 x 133 <a href="mailto:rjacobs@mharochester.org">rjacobs@mharochester.org</a></td>
</tr>
<tr>
<td>Compeer Rochester</td>
<td>N/A</td>
<td>N/A</td>
<td>*Provide screened and trained adult volunteer mentors for long term individual support before, during, and after hospitalizations. Family mentors help families navigate systems and processes.</td>
<td>Sara Passamonte 585 546-8280 x106 <a href="mailto:spassamonte@compeer.org">spassamonte@compeer.org</a></td>
</tr>
<tr>
<td><strong>Erie County Inpatient Support</strong></td>
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<tr>
<td>Erie County SPOA</td>
<td>Erie County Medical Center</td>
<td>Varies</td>
<td>*If family is enrolled in the Family Voices Network (a community based service model for youth at risk of out of home placement), an advocate will work with the family to strengthen community plans for smooth and timely transition from the hospital.</td>
<td>Rachaelle Benz 716- 858-2618 <a href="mailto:Rachaelle.Benz@erie.gov">Rachaelle.Benz@erie.gov</a> or Elizabeth Benitez 716- 858-2192 <a href="mailto:Elizabeth.Benitez@erie.gov">Elizabeth.Benitez@erie.gov</a></td>
</tr>
<tr>
<td>Western New York Independent Living Center</td>
<td>Erie County Medical Center, Buffalo General</td>
<td>As needed</td>
<td>*Provide independent living skills instruction, peer counseling/support, advocacy and information/referral.</td>
<td>Crystal Jackson 716-836-0822 x 115 <a href="mailto:cjackson@wnyil.org">cjackson@wnyil.org</a></td>
</tr>
<tr>
<td>Mental Health Association of Erie County</td>
<td>BryLin Hospitals</td>
<td>2-3 days a week from 5:30pm – 7:00pm</td>
<td>*Family advocates visit the adolescent unit to talk with youth and families letting them know about peer and family support resources after discharge.</td>
<td>Jenny Laney 716- 886-1242 ext. 313 <a href="mailto:laney@eriemha.org">laney@eriemha.org</a></td>
</tr>
<tr>
<td>Services Provided</td>
<td>Contact Information</td>
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<tr>
<td>Families Child Advocacy Network/Compeer West Inc.</td>
<td>Erie County Hospitals</td>
<td>As needed</td>
<td>*If families are enrolled or referred to Families Child Advocacy Network, family advocates provide support on the CPEP Unit and during hospitalization. Services include advocacy, bridging between staff, family, youth and members of their care coordination team, linking to services outside of the hospital, assistance with development of safety plans.</td>
<td>Vicki McCarthy 716-884-2599 ext 302 <a href="mailto:Vicky@compeerbuffalo.org">Vicky@compeerbuffalo.org</a></td>
</tr>
<tr>
<td>Niagara County Inpatient Support</td>
<td>The Mental Health Association in Niagara County, Inc.</td>
<td>Niagara Falls Memorial Medical Center</td>
<td>Mon-Fri 8am-4pm</td>
<td>*Provide advocacy for individuals hospitalized at Niagara Falls Memorial Medical Center; provide information and referral for services within Niagara County.</td>
</tr>
<tr>
<td>Cattaraugus County Inpatient Support</td>
<td>Family Support and Youth Services</td>
<td>At the request of the family or from inpatient unit staff.</td>
<td>*Provide family support, advocacy and education during the hospitalization of a child under the age of 18.</td>
<td>Ginger Oyer 716-372-0208 or 716-790-0022 <a href="mailto:goyer@mhapatt.org">goyer@mhapatt.org</a></td>
</tr>
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| Cattaraugus County Inpatient Support     |                 |                              | *Peers help create WRAP plans, start working on SSI/SSDI applications, work with individuals to find out what their life goals are, work one on one to get the person back into the community, assist with referring them to services.  
This is a new program (Recovery Center-S.T.R.A.W.W.) in the Tri-County area (Cattaraugus, Allegany & Chautauqua) partnering with H.O.M.E. (the lead agency), Mental Health Association in Cattaraugus County, Mental Health Association in Chautauqua County, and Directions In Independent Living. | Rolita Wielkie (716) 372-0208 rwielkie@mhacatt.org |
| Mental Health Association of Cattaraugus County | Olean General Hospital |                              | *Recovery Skills Training groups conducted by peers.  
*Community Resources Information groups educate individuals about programs/services available after discharge (conducted by peers).  
*Peer Coaches work one-on-one with individuals beginning in inpatient settings and continuing after discharge.  
*Peer Coaches work with individuals on a variety of issues related to continuing recovery strategies, staying connected with supports and community resources, maintaining healthy routines.  
*Coaches also help individuals obtain housing and government benefits. | Cindi Licata 585-325-3145 ext. 113 clicata@mharochester.org |
| Mental Health Association of Rochester   | RGH- G-1 Unit    | Skills Grp: 2 Tues/mos. 2:00pm Resource Grp: 2 Thurs/mos. 2:30pm Peer Coaches: 2 Thurs/mos 2:30pm + as needed | *Recovery Skills Training groups conducted by peers.  
*Community Resources Information groups educate individuals about programs/services available after discharge (conducted by peers).  
*Peer Coaches work one-on-one with individuals beginning in inpatient settings and continuing after discharge.  
*Peer Coaches work with individuals on a variety of issues related to continuing recovery strategies, staying connected with supports and community resources, maintaining healthy routines.  
*Coaches also help individuals obtain housing and government benefits. | Cindi Licata 585-325-3145 ext. 113 clicata@mharochester.org |
### Mental Health Association of Rochester

**Strong/2-9200 Unit**

- **Resource Group and Peer Coaches**
  - Every Friday, 11:00am

- *Community Resources Information groups educate individuals about programs/services available after discharge (conducted by peers).*
- *Peer Coaches work one-on-one with individuals beginning in inpatient settings and continuing after discharge.*
- *Peer Coaches work with individuals on a variety of issues related to continuing recovery strategies, staying connected with supports and community resources, maintaining healthy routines. Coaches also help individuals obtain housing, government benefits.*

**Cindi Licata**
585-325-3145 ext. 113
clicata@mharochester.org

### Mental Health Association of Rochester

**Strong/3300 Unit**

- **Recovery Skills Training Groups**
  - 1st and 3rd Mondays at 10:30am

- *Recovery Skills Training groups conducted by peers.*

**Cindi Licata**
585-325-3145 ext. 113
clicata@mharochester.org

### Erie County Inpatient Support

**Mental Health Peer Connection:**
Member of the WNY Independent Living Inc. family of agencies

- Erie County Medical Center, Buffalo General
- As needed

- *Peers provide the following during hospitalization: independent living skills evaluation and instruction, WRAP planning, peer counseling/support, advocacy, and information/referral.*
- *Peers provide the following on an outpatient basis: life coaching, work support, and benefits advisement.*

**Crystal Jackson**
716-836-0822 x 115
cjackson@wnyil.org

### Wyoming County Inpatient Support

**Peers Helping Peers**

- Wyoming Community Hospital

- *Peers provide support during hospitalization.*

**Colleen Eccleston**
585-786-0992
Colleenec01@aol.com