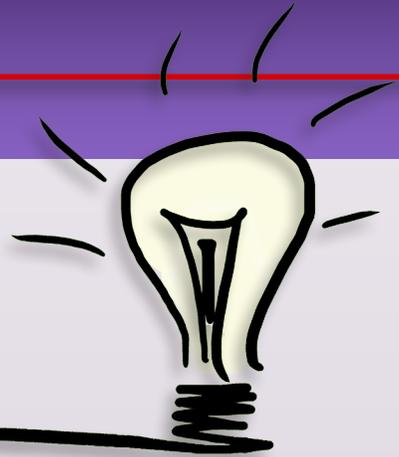




# INNOVATION:



## in Mental Health Care

*“Creating a better future requires creativity in the present.”*

– Matthew Goldfinger

*“Dreamers are mocked as impractical. The truth is, they are the most practical, as their innovations lead to progress and a better way of life for all of us.”*

– Robin S. Sharma

**I**nnovation requires thinking beyond the routine, taking risks, and learning from failure. It calls for collaboration, assessing obstacles, and persistence. In short, innovation is finding a way to do things better.

Throughout its history, New York State has been a leader in finding innovative ways to improve the lives of New Yorkers with mental illness. Some examples:

- New York opened the first state-funded and operated mental health facility in the United States in 1821, the first institution designed to treat alcoholism as a mental disorder in 1864, the first facility specifically for women in 1878, the first mental illness research institute in 1895, and the first clinics to address childhood mental health issues in the 1920s.
- New York was the first state to create a Department of Mental Hygiene in 1889 and enact the first State Care Act in the nation — which provided that all state institutions for the mentally ill were to be known as “state hospitals” instead of “asylums” and that all indigent patients with mental illness in county institutions were to be moved to state hospitals. New York was the first state to recognize the importance of collecting statistics and data on mental illness, starting the practice in 1907.
- Recognizing the power of collaboration, New York was one of the founding members of the Association of Medical Superintendents of American Institutions for the Insane, now called the American Psychiatric Association. The National Committee for Mental Hygiene in New York, now called Mental Health America, was founded here.

- Researchers in New York State were the first to describe childhood schizophrenia in 1933 and develop the nation’s first genetic research program in schizophrenia in 1946. They were pioneers in studying the use of medications for the treatment of mental illness and the role of nutrition in mental health treatment in the 1950s, the application of computers in psychiatry leading to the development of the first mental health information system in the 1960s, and the risk of depression for multiple generations within families in the 1980s.

- Today, mental health professionals, direct-care personnel, and researchers continue to find new ways to improve the lives of people with mental illness – not just through technology, but through new methods and approaches to treatment. Researchers are making discoveries in the role of genetic mutations and in using medications to possibly prevent mental illness.

- Understanding that former patients can help provide valuable services and supports to current patients, New York was the first state to establish a Civil Service title for Peer Support Specialists.

We invite you to read more about some of the innovative working be done in New York in this month’s edition of *OMH News*. We welcome your comments at [omhnews@omh.ny.gov](mailto:omhnews@omh.ny.gov).



# Crisis Diversion and Respite: Giving Clients Time and Space



“People don’t want to live cycling in and out of hospitals. But some just don’t yet know any other way,” said Melissa Wettengel, Assistant Director of Consumer Link in Nassau County. “This is what our crisis diversion program at Turquoise House is intended to address.”

Turquoise House in Uniondale is one of two crisis respite/diversion programs on Long Island. Crisis respite/diversion programs help to remove people from the environments that had been causing their crises – giving them the time and space to approach their life in a healthier manner.



Turquoise House is run by Consumer Link, the recipient-run arm of the Mental Health Association of Nassau County. The other program on Long Island, the Suffolk County Hospital Diversion Program in Centereach, includes clinical providers, as well as peer staff and is run by Family Residence and Essential Enterprises. Both programs provide supportive, recovery-focused environments that help clients develop the necessary strategies to cope with returning to their regular lives – including doctor appointments and medications, and work, school, and family responsibilities. Both projects are funded through OMH’s Community Reinvestment program.

## Easing the Transition

“Research shows us that, very frequently, a crisis is not always directly or severely clinical,” Wettengel said. “It has more to do with the situations that surround mental health challenges – such as isolation, relationship difficulty, financial problems, or symptom management. We wanted to create a place people could go – instead of our hospitals – to directly address the crisis in their lives while being treated with dignity and kindness. They can continue with outpatient treatment, work, and school. This is far less stigmatizing and disruptive to their lives.”

“In many cases, crisis respite/diversion programs can act as a step-down from inpatient units when clients return to previous living arrangements that are wrought with stressors that precipitated the crisis,” said Leon C. Marquis, Mental Health Program Specialist 2 and most recently Regional Advocacy Specialist for OMH’s Long Island Field Office. “Guests are given a chance to look at their crises differently – as an opportunity for change.” Clients are offered help in developing Wellness Recovery Action Plans, which are evidenced-based programs to help people in all situations deal with the difficulties in their lives.

This model has been successful elsewhere in the United States and in Europe – such as Rose House in Poughkeepsie, which is run by PEOPLE, Inc. It had not yet been implemented on Long Island, where psychiatric ERs and inpatient units are often overcrowded with patients in crisis.

Because of the experience of Consumer Link, the Mental Health Association already had in place an existing team of trained peers, many of whom had worked together in the Long Island community for 20 years. Turquoise House is run entirely by peers, who provide support from their own experiences in living with mental health challenges and receiving services in the system.



*Melissa Wettengel*



The key to the program is the involvement of peers. “Our guests tell us that hearing the recovery stories of our staff is both comforting and inspirational, and empowers them to believe that they, too, can reach their recovery goals,” Wettengel said. “We take our own recovery and share it with our guests, encouraging them to define a vision for their lives and take reasonable short-term steps toward it. Our guests leave with a new support team and with renewed hope.”

Development of the program wasn’t without its share of challenges. Turquoise House was initially slated to open in 2014 in a large house in an East Meadow cul-de-sac, but the project was initially blocked by residents. “This was a blessing in disguise,” Wettengel said. “At our current location in Uniondale, the community welcomed us with open arms. It’s far more convenient to local businesses, transportation, and our own agency offices.”

While searching for a new location, the team perfected its processes and its mobile-respite model – which it continues to use for the homeless population who are unable to stay at Turquoise House and for those needing additional engagement after their stay.

## Building on Success

“Reception for the program has been overwhelmingly positive,” said Dr. Martha A. Carlin, Director of OMH’s Long Island Field Office. “The greater mental health community has seen these programs as an additional resource.”

The biggest challenge for Turquoise House is now keeping up with demand. It remains full, with a waiting list. It’s helped guests who had previously used the hospital habitually to create coping mechanisms for crisis and instead use their relationships with Consumer Link for support. They often refer themselves, and can be welcomed back to Turquoise House, if need be. Its latest statistics show less than 2% of guests are visiting a hospital within 30 days after checking out.

It is part of Turquoise House’s vision to expand its services, including opening another house just for women.

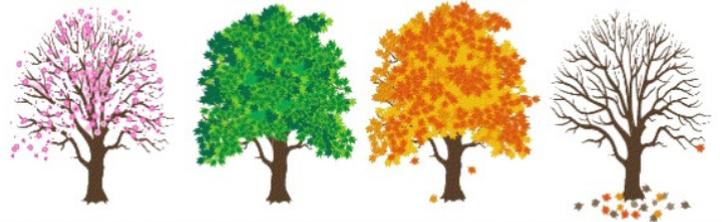
“We look forward to when peer-run crisis respite houses on Long Island are no longer an innovation, but the norm,” Wettengel said. “There’s a need for such programs in multiple neighborhoods, and with specialized focus – such as for bilingual communities and youth/first episodes. Not only does this provide a cost-effective means toward helping more people break the cycle of learned helplessness, it creates powerful employment opportunities for peers with inspiring recovery stories to share.”



Martha A. Carlin, PsyD



## MENTAL HEALTH ASSOCIATION OF NASSAU COUNTY, INC.



## OUR HELP KNOWS NO SEASON

For more information on Consumer Link and Turquoise House, visit the Mental Health Association of Nassau County website at: <http://www.mhanc.org/?PageID=908>.

# Information Technology: Getting OMH Facilities Online With VistA



Empire State VistA, a state-of-the-art electronic mental health records system, is now up and running at nine OMH facilities.

The system was first implemented at Buffalo Psychiatric Center, followed by South Beach, Mohawk Valley, and Capital District psychiatric centers. The four pilot sites have been instrumental in helping developers learn how the system functions in various environments and how to handle any complications as it's introduced throughout the state.

After the pilots, the team went on to Rockland Adult and Child Adolescent, Mid-Hudson Forensic, Creedmoor, and Kingsboro psychiatric centers. Implementation is currently underway at the Bronx Psychiatric Center.

VistA is replacing OMH's current electronic medical record (EMR) system, which is made up of separate parts. The goal is to help health care providers and other users efficiently coordinate and manage patient intake, scheduling, treatment planning, and medication management. Called "Track 1," it offers computerized provider order entry and barcode medication administration, which can be integrated with a facility's pharmacy system. Laboratory orders are electronically posted for the entire treatment team to review, which reduces the chance of medication errors.

## Software that Can Meet Future Needs

VistA was created in the 1970s and adopted by the United States Veteran Administration in 1994. Short for the "Veterans Health Information Systems and Technology Architecture," it was designed to support day-to-day operations at Veterans Affairs health care facilities. It has since been made available for public use as open-source software that can be integrated with other programs. It has been consistently rated among the top EMR systems in the nation.

In 2006, an analysis by OMH determined that its electronic clinical systems didn't meet current or future needs to comply with pending regulations and increased federal and state quality-of-care requirements. "OMH did have some components of an EMR – such as MHARS, MedsManager Pharmacy, and Cerner lab," said Gerald M. Engel, OMH Chief Medical Information Officer. "But the vast majority of the clinical record was still paper. EMR systems offer significant advantages over a paper record." (See sidebar on the next page.)

OMH had to decide whether to build on its current MHARS system or develop a vendor-based product. It researched numerous EMR vendors, assessing their ability meet all of OMH's needs. "Many vendors were very focused on hospital-based care environments," Engel said, "while other smaller systems specialized in clinic-based behavioral health settings. In addition proposed costs for all solutions were very high."

OMH then looked at VistA. VistA has a number of advantages over commercial based systems, having been successful in the sprawling VA system, which includes 152 hospitals and 804 outpatient clinics.

"VistA has been in existence for nearly 40 years, making it arguably the most mature EMR anywhere," he said, adding, "It's been accepted well by clinicians – many clinicians at OMH have already used it at the VA. It can be tailored by role. For example, a physician's screen may look slightly different than a nurse's view, based on needs. And because it's open source software, there are no licensing costs."

OMH has been working with the New York State Office of Information Technology Services for the past several years to customize VistA for the agency's needs. This approach has saved considerable time and money.

## Implementation in Buffalo and Albany

Preparation for introducing VistA in a facility generally takes several months, including developing facility implementation and training plans and meetings between facility representatives and VistA project teams. Actual implementation has taken between four to seven weeks, depending on a facil-



*Staff at Buffalo Psychiatric Center celebrating their accomplishment of being the first OMH facility to implement VistA. Holding the certificate of appreciation at center are Facility Executive Director Celia Spacone, PhD; and Gerald M. Engel, OMH Chief Medical Information Officer.*

ity's size. It includes training just before it goes live, to keep the information "fresh" in the mind of new users.

Buffalo Psychiatric Center (BPC) was the first OMH facility to implement VistA. BPC started out using the system only for laboratory and medication orders and medication administration. VistA electronically administers medication using a bar code scanner to identify patients and medication. It records the number of administrations during the day by unit or patient, timing, witnessing, pain assessment and re-assessment, and effectiveness of as-needed medication.

"From the most nervous to the most comfortable, it was wonderful to watch them learn and grow," said Susan K Fallis, BPC Chief Nursing Officer. "As with any new skill, there were frustrations. But once it was on the units, our staff were confident."

The majority of nurses are pleased with the system. "It's helped decrease the number of hand transcription orders, prevented errors, and eliminated a lot of clarifying of orders," Fallis added. "We used to print and Fax hundreds of sheets of paper every week. But the system has helped us eliminate paper medication administration records and Stop Order Renewal reports."

Medication events at Capital District Psychiatric Center have also gone down significantly. "Errors of omission had always been an issue. But with VistA, nurses can run reports to practically eliminate such mistakes," said Charlene Puerto, CDPC Chief Nursing Officer. "In 2015, prior to VistA, we were having about 14 events per quarter. In the first half of 2016, with VistA, we've had only 12. In the third quarter of 2016, we only had two events." Prescribers have also reported that notifications have saved time in tracking and processing renewals and in obtaining lab information.

Teresa M. Springsteen, Health Information Management Administrator at CDPC, said this success of implementation at her facility was due to their extensive preparation. Groundwork started 18 months prior to implementation and included completing an Enterprise Assessment, reviewing policies with "As-Is" and "To-Be" scenarios and preparing staff for upcoming changes.

"To help prepare the staff, we posted shots of the various screens related to physician order entry and bar code administration, published an initial guide to VistA language, put up 'coming soon' posters, and distributed a brochure of vital information prior to implementation," she said. "Our training and preparation went extremely well. As a result, our Command Center was very quiet after implementation."

## Rollout Continues

Since then, CDPC has hosted site visits with staff from other facilities there are preparing for implementation. "We advise staff that have not yet implemented VistA to: Prepare! Prepare! Prepare!," Springsteen said. "This is a big project to undertake. But in the long run, training, implementation, and use will be much easier."

"Implementing a solution that changes the workflow of thousands of OMH employees is always challenging," Engel said. "Overall, the reception to VistA has been excellent, even given the fact that there are still many issues that need to be resolved as OMH moves forward with this solution."

The next sites scheduled for VistA rollout are St. Lawrence, Central New York, and Hutchings psychiatric centers. OMH plans to complete the first track of VistA implementation for all OMH hospitals in 2017. It will start the second implementation track in late 2017. The second track will focus on the behavioral health components of the EMR, including hospitals and OMH state-operated clinics. Once fully implemented, the EMR will completely replace the paper chart.

"OMH plans to use VistA as the component for fully developing a health information exchange (HIE) process with outside healthcare providers," Engel added. "HIE will allow clinicians to share health information, with consumer consent, across multiple providers both within and outside of OMH. The goal is for each provider to have a full history of care provided by any provider and to allow for more collaborative and effective care."<sup>OMH</sup>



*Buffalo Psychiatric Center nurses (from top left) Katie Myers, Joselyn Roth, Bonney Cahalan, and Joan Keller-Clarke offering encouragement to staff at other OMH facilities who have yet to make the transition.*

## Advantages of an Electronic Medical Record System

- Helping clinicians work better and use technology to promote quality of care.
- Incorporating best practices and clinical-decision support for better outcome and patient safety.
- Improving completeness, format, and accuracy of documentation for effective communication with other providers.
- Providing immediate and managed accessibility to documentation for better care and communication.
- Decreasing duplicate orders and reducing costs.
- Increasing safety with clinical decision support.
- Eliminating handwriting interpretation.

# Telepsychiatry: New Regulations Provide Privacy Protection and Allow Use to Grow

In November, OMH announced the adoption of new regulations to accommodate the expansion of telepsychiatry services in New York State.

The new regulations expand the type of providers that can use telepsychiatry services. Previous regulations, enacted in February 2015, had limited the use of telepsychiatry between Mental Hygiene Law Article 31-licensed clinics. The new regulations now allow telepsychiatry appointments between any providers licensed under Article 31. This will add an estimated 250 mental health providers – including Comprehensive Psychiatric Emergency Programs, Inpatient Programs and Partial Hospitalization Programs.

Assertive Community Treatment and Personalized Recovery Oriented Services programs are excluded because these programs are based on face-to-face interactions between providers and individuals in care.

## Patient Consent and Confidentiality

The new regulations continue the safeguards that were the cornerstone of the original regulations to ensure quality of care and patient confidentiality. They add provisions to monitor the impact on the programmatic resources of OMH-licensed providers.

“Our concern from a privacy standpoint is that the individual may not be sitting in an area that is private,” said Dr. Christopher T. Tavella, OMH Deputy Commissioner, Division of Quality Management. “Without regulation ensuring that both the practitioner and the individual receiving care are in areas that assure privacy, personal protected health information could be overheard.”

To ensure that clients can make informed decisions, participating providers are required to give clients information on the use of telepsychiatry. “Some people do want to speak to a live person,” Tavella said. “So we ask for additional consent – specific to telepsychiatry – to protect the person’s right to choose whether or not they want to receive services face-to-face or through telepsychiatry.”

OMH has also issued guidance to its providers about technological standards. “We’re insisting that providers have the ability to pan, tilt, and zoom remotely, so that from their desks, they can move the camera to see the individual’s body language, and other aspects of their environment.”



*Dr. Tavella discusses the new telepsychiatry regulations online at: <https://www.youtube.com/watch?v=8kkOsY3A498>.*





# Triple Partnership Update: Eight Providers Awarded Partnership Innovation for Older Adults Grants



This past fall, OMH selected eight mental health providers to establish “triple partnerships” in their communities to help adults age 55 or older whose independence or survival is in jeopardy because of a mental health, substance use, or aging-related concern.

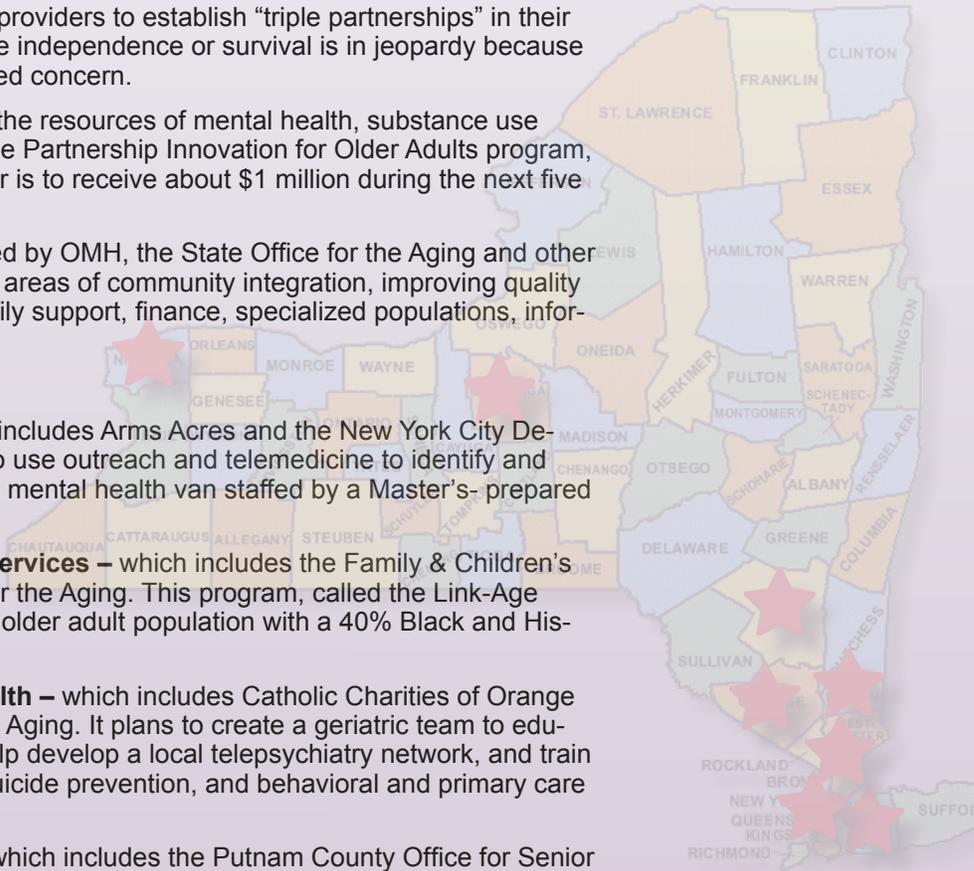
Triple partnerships are designed to pull together the resources of mental health, substance use disorder, and aging services. Awarded through the Partnership Innovation for Older Adults program, these grants will total \$7.96 million. Each provider is to receive about \$1 million during the next five years.

The Partnership Innovation program, administered by OMH, the State Office for the Aging and other state agencies, awards grants to providers in the areas of community integration, improving quality of treatment, integrating services, workforce, family support, finance, specialized populations, information, and staff training.

Recipients for 2016 are:

- **Flushing Hospital Medical Center** – which includes Arms Acres and the New York City Department for the Aging. This program plans to use outreach and telemedicine to identify and engage at-risk individuals, including a mobile mental health van staffed by a Master’s- prepared clinician.
- **Central Nassau Guidance & Counseling Services** – which includes the Family & Children’s Association and the Nassau County Office for the Aging. This program, called the Link-Age Project, will integrate needed services for an older adult population with a 40% Black and Hispanic rate.
- **Orange County Department of Mental Health** – which includes Catholic Charities of Orange County and the Orange County Office for the Aging. It plans to create a geriatric team to educate providers on engagement strategies, help develop a local telepsychiatry network, and train an outreach team on cultural competence, suicide prevention, and behavioral and primary care health screening.
- **Putnam Family & Community Services** – which includes the Putnam County Office for Senior Resources and the National Council on Alcoholism & Other Drug Dependencies/Putnam. This program calls for a licensed clinical social worker to assess, diagnose, and treat older adults; a care manager to identify and provide services; and a recovery coach to address substance use issues.
- **Institute for Family Health** – which includes the Ulster County Office for the Aging and Step One Child & Family Guidance Center Addiction Services. The partnership is to launch a mobile outreach, care navigation, and telehealth program.
- **Family Services of Westchester** – which includes the Westchester County Department of Senior Programs and Services and the Lexington Center for Recovery. The partnership intends to bring mobile outreach and off-site services, including telehealth interventions, to older adults.
- **Onondaga County Department of Adult & Long Term Care Services** – which includes the county’s Department for the Aging, Liberty Resources, and Syracuse Behavioral Health. This program, called the Senior Health and Resource Partnership Project, seeks to address barriers to accessibility, such as limited English language proficiency, cultural mores, cognitive and physical impairments, poverty, perceived shame, and isolation.
- **Niagara County Department of Mental Health** – which includes the Niagara County Office for the Aging and Northpointe Council. The program will use community-based case management staff and a mobile Older Adult Clinical Specialist to ensure the ability to reach isolated individuals and those reluctant to reach out because of cultural beliefs or stigma.

Under the Partnership Innovation program, providers will conduct mobile outreach to find individuals who are at-risk and not connected to the service delivery system or are having difficulty getting the services they need. Overall, the program is expected to reach 6,000 older New Yorkers during the next five years. <sup>OMH</sup>



Office of Mental Health

About OMH Consumers & Families Behavioral Health Providers Employment

### Partnership Innovation for Older Adults

The purpose of the RFP is to create a local “triple partnership” of mental health, substance use disorder, and aging services providers to innovatively address the unmet needs of older adults for such services. It constitutes the fourth round of geriatric service demonstration program grants made possible by New York State’s Geriatric Mental Health Act of 2005.

Request for Proposals

- Appendix A: Transmittal Form
- Appendix B: Operating Budget
- Appendix B1: Budget Narrative
- Appendix C: Old Master Contract Form and Instructions

Questions and Answers

**Attention**

A non-binding Letter of Intent is required. The letter must be postmarked or emailed by 5/12/16 (details in Section II, 2.1 of the RFP).

The deadline to submit a mandatory – but not binding – Letter of Intent to Bid has been extended to 5/20/16. Letters of Intent must be postmarked or emailed by 5/20/16 to the Issuing Office listed in the RFP.

Office of Mental Health

For information on the Partnership Innovation program, visit: <https://www.omh.ny.gov/omh-web/rfp/2016/partnership-innovation/>.

# Media: NPO Podcast Offers a Creative Outlet While Reaching Out to the Community

“It’s important for people working on recovery from mental illness to have a creative outlet by which to share their stories with others,” said Pete Shiffman, RN, Nurse Administrator 1 at South Beach Psychiatric Center. “It helps the individual storyteller focus their thoughts on the project – empowering them and providing hope for others who may face similar struggles.”

Shiffman and Peer Specialist Rachid Ottley recently started offering clients such an outlet through their NPO Media Podcast.

Audio editing has long been an area of interest for the two and the podcast came about after they had been facilitating recording sessions for many years in the media studio at South Beach as a component of the recovery and wellness program (see the August 2016 edition of *OMH News*).



*Podcast producers Ottley (left) and Shiffman at a recent NAMI educational conference.*

The two men are members of the Staten Island Board of the National Alliance on Mental Illness (NAMI). At the core of their work is the NAMI slogan “You Are Not Alone.”

“It’s hard to tell the world what you’re going through, but it’s also hard to keep it in,” Ottley said. “For some it may be cathartic. The podcast lets folks know that recovery is possible and there is a living, feeling person there fighting mental illness, with family and friends who hopefully are encouraged to educate themselves and have their back. As NAMI folks, the training and support networks that we are a part of show how much progress can be made, while accepting that we have a long way to go.”

## Specialized Programming for Specific Audiences

For more than a decade, podcasts have been a popular method of providing specialized information to specific groups of listeners. Because they’re distributed through websites, the potential audience for a podcast is as wide open as the Internet itself.

Prior to starting the podcast, the two spent many months researching the programming currently available, learning the technical skills, and obtaining the equipment needed to achieve quality voice recording and reliable audio feed hosting. “We already had home studio equipment,” Shiffman said, “so I purchased a broadcast quality microphone setup and built a portable recording rig to go to different locations.”

Several mental health-related podcasts currently feature single-person perspective and commentary or interviews with people discussing their experience. Others feature guests who answer call-in questions, often including a mix of clinicians and individuals with various diagnoses. The focus of the NPO Media Podcast is intended to be different.

“We’re not inventing anything new or trying to duplicate the work of others,” Ottley said. “We’re trying to create opportunities for the people we serve and advocate for. There is no political agenda or bias other than individual opinions. I make that disclaimer in the intro of the podcast.”



## In Production

The podcast involves the subject speaking into a microphone while the audio is recorded onto a computer. “Our first episode happened after I met an individual at a NAMI book signing event on Staten Island,” Shiffman said. “He’d written a book, and was early in his recovery. The recording involved me sitting at his kitchen table with my laptop, an interface, and a microphone on a stand in his living room.”

Today, they can record episodes via Skype, with a recent session arranged by the facilitator of a creative writing group from Fountain House in Norway.

“We give the interviewees the option of using their real name or being pseudo-anonymous,” Shiffman said. “Other times, we have someone recite another person’s writing. Recordings aren’t broadcast live – they’re edited if we need to reduce noise, and remove coughs or long pauses. I find this reduces stress as one needn’t worry about ‘saying the wrong thing’ and we’re also not going to ‘run out of tape’ on a digital system.”

Pending approval by the subject, the episode then published. They use two hosting companies to maintain a central list of the audio files on a server.

## Opportunities for Growth

So far, the podcast has received a great deal of positive feedback. “Although we are really just getting started, there’s a lot of interest in future projects by people who get what we’re trying to do,” Ottley said.

The podcast is evolving to be a totally peer-run project. “I believe that, as the podcast grows, it will have benefits for all involved, be it studio engineering trainees, screeners, interviewers, and social media marketers,” Ottley said. “We will continue to network and build relationships as we record more episodes in the community and remotely.”

The two are building another recording studio at South Beach, located in an outpatient area called the “Recovery Center.” Their goal is to train peers to record upcoming episodes featuring poetry and interview segments – building collaborative and vocational skills for technical trainees and artists alike, fostering teamwork in planning and problem-solving, as well as developing time-management skills.

To build its base of subscribers, the NPO Media Podcast team has to release frequent, engaging episodes. Then there’s the ongoing job of getting the word out. Promoting and networking on social media can be tedious, but necessary. Fortunately, they’ve found many people and groups who are willing to help.

“We all agree that we need to reach out to a diverse population, who need to know they don’t need to go it alone,” Shiffman said.

Showcasing creativity and resilience, the NPO Podcast is working to provide hope, reduce stigma, and let others know that there is more to a person than a diagnosis.<sup>OMH</sup>



*Ottley and Shiffman in their studio at South Beach.*



*The NPO Media podcast can be streamed or downloaded directly from its blog site at: [www.npomedia.org](http://www.npomedia.org), or through major podcast distributors.*