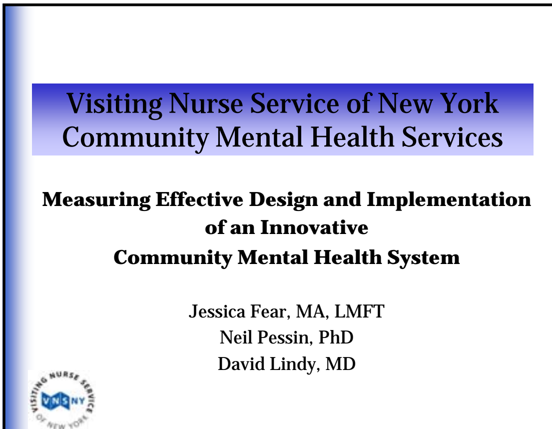
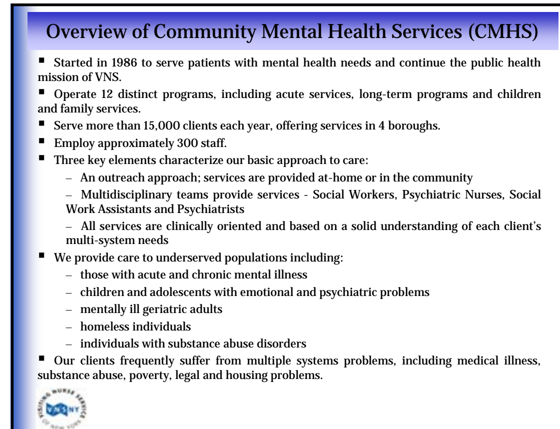
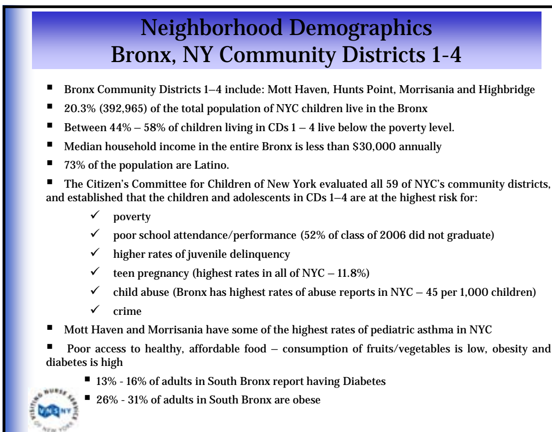
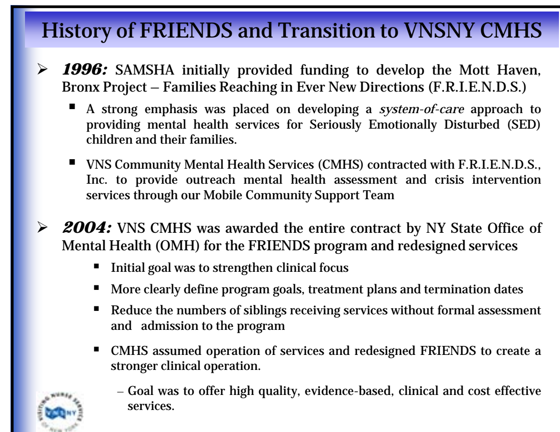
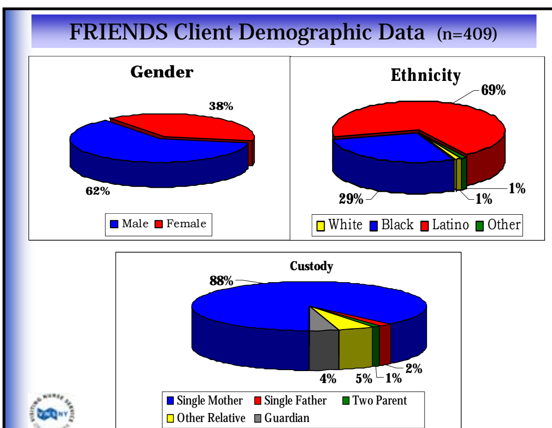
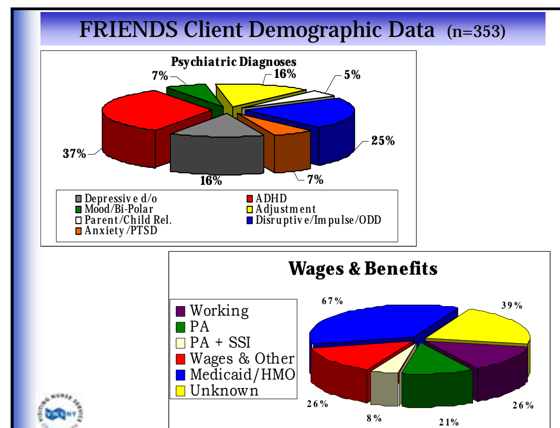

Visiting Nurse Service of New York
Community Mental Health Services
Measuring Effective Design and Implementation
of an Innovative
Community Mental Health System
Jessica Fear, MA, LMFT
Neil Pessin, PhD
David Lindy, MD
VNSNY


Overview of Community Mental Health Services (CMHS)
Started in 1986 to serve patients with mental health needs and continue the public health mission of VNS.
Operate 12 distinct programs, including acute services, long-term programs and children and family services.
Serve more than 15,000 clients each year, offering services in 4 boroughs.
Employ approximately 300 staff.
Three key elements characterize our basic approach to care:
– An outreach approach; services are provided at-home or in the community
– Multidisciplinary teams provide services - Social Workers, Psychiatric Nurses, Social Work Assistants and Psychiatrists
– All services are clinically oriented and based on a solid understanding of each client's multi-system needs
We provide care to underserved populations including:
– those with acute and chronic mental illness
– children and adolescents with emotional and psychiatric problems
– mentally ill geriatric adults
– homeless individuals
– individuals with substance abuse disorders
Our clients frequently suffer from multiple systems problems, including medical illness, substance abuse, poverty, legal and housing problems.


Neighborhood Demographics
Bronx, NY Community Districts 1-4
Bronx Community Districts 1–4 include: Mott Haven, Hunts Point, Morrisania and Highbridge
20.3% (392,965) of the total population of NYC children live in the Bronx
Between 44% – 58% of children living in CDs 1 – 4 live below the poverty level.
Median household income in the entire Bronx is less than $30,000 annually
73% of the population are Latino.
The Citizen's Committee for Children of New York evaluated all 59 of NYC's community districts, and established that the children and adolescents in CDs 1–4 are at the highest risk for:
poverty
poor school attendance/performance (52% of class of 2006 did not graduate)
higher rates of juvenile delinquency
teen pregnancy (highest rates in all of NYC – 11.8%)
child abuse (Bronx has highest rates of abuse reports in NYC – 45 per 1,000 children)
crime
Mott Haven and Morrisania have some of the highest rates of pediatric asthma in NYC
Poor access to healthy, affordable food – consumption of fruits/vegetables is low, obesity and diabetes is high
13% - 16% of adults in South Bronx report having Diabetes
26% - 31% of adults in South Bronx are obese


History of FRIENDS and Transition to VNSNY CMHS
1996: SAMSHA initially provided funding to develop the Mott Haven, Bronx Project – Families Reaching in Ever New Directions (F.R.I.E.N.D.S.)
A strong emphasis was placed on developing a system-of-care approach to providing mental health services for Seriously Emotionally Disturbed (SED) children and their families.
VNS Community Mental Health Services (CMHS) contracted with F.R.I.E.N.D.S., Inc. to provide outreach mental health assessment and crisis intervention services through our Mobile Community Support Team
2004: VNS CMHS was awarded the entire contract by NY State Office of Mental Health (OMH) for the FRIENDS program and redesigned services
Initial goal was to strengthen clinical focus
More clearly define program goals, treatment plans and termination dates
Reduce the numbers of siblings receiving services without formal assessment and admission to the program
CMHS assumed operation of services and redesigned FRIENDS to create a stronger clinical operation.
– Goal was to offer high quality, evidence-based, clinical and cost effective services.


FRIENDS Client Demographic Data (n=409)
Gender
38%
62%
Male
Female
Ethnicity
69%
29%
1%
1%
White
Black
Latino
Other
Custody
88%
4%
5%
1%
2%
Single Mother
Single Father
Two Parent
Other Relative
Guardian


FRIENDS Client Demographic Data (n=353)
Psychiatric Diagnoses
7%
16%
5%
25%
37%
16%
7%
Depressive d/o
Mood/Bi-Polar
Parent/Child Rel.
Anxiety/PTSD
ADHD
Adjustment
Disruptive/Impulse/ODD
Wages & Benefits
Working
PA
PA + SSI
Wages & Other
Medicaid/HMO
Unknown
67%
39%
26%
8%
21%
26%

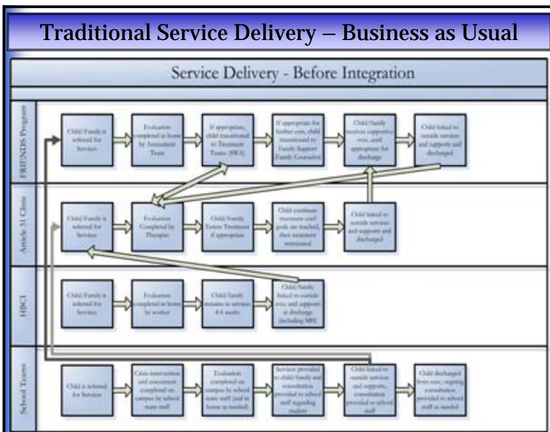
FRIENDS Program Integration
Creating a local "System of Care"

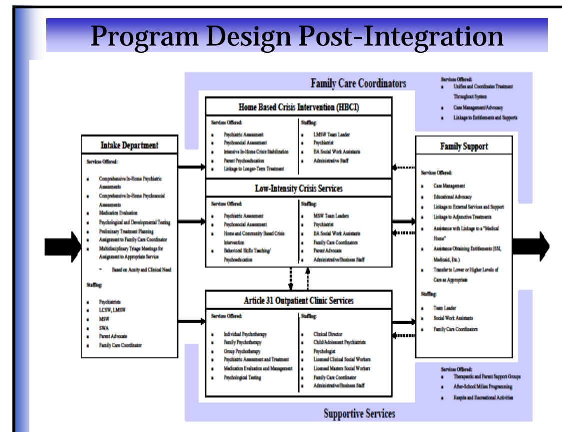
Identifying Need – Purpose of Integration

- ✓ High percentage of current shared cases between FRIENDS Crisis & FRIENDS Clinic – some role confusion for providers & families
- ✓ Need for more formalized care coordination for families already within care in multiple program components
- ✓ Reduction of the need for families to "tell their story" multiple times – one intake as opposed to 2 or 3
- ✓ Fluid continuum of care available to families – treatment tailored to their current level of need and regularly re-evaluated
- ✓ Ability to offer multi-disciplinary team approach to treatment with shared goals
- ✓ Create program efficiencies - combining staff resources and streamlining procedures will increase levels of service and reduce expenses for both programs
- ✓ Staff integration promotes common goals and purpose for staff and increased morale
- ✓ System will offer a comprehensive array of MH and supportive services in one location to families in the community that is unique to the South Bronx

FRIENDS Program Integration
Philosophy of Care

- ➢ To use the least invasive course of treatment, leading to the highest empowerment of parents and children to markedly improve their social, emotional and educational functioning
- ➢ To provide the most readily accessible, shortest-term treatment to achieve the family's goals
- ➢ To empower families with the tools to meet the needs of their children independent of care





FRIENDS Program Integration – New Service Delivery Overview

Integrated Intake Department

- ➢ Clients/referral sources call one phone number to access services
- ➢ Initial phone screening conducted to determine overall eligibility for services
- ➢ Thorough assessment conducted with child/family to determine immediate clinical need and appropriate level of care
- ➢ Psychiatric appointments scheduled once initial assessment is completed – based on acuity and need
- ➢ Multidisciplinary triage meetings held weekly to discuss new cases – staff "rotate" through intake
- ➢ Psychological testing available at assessment phase if needed to provide services or transition to OMRDD system
- ➢ Transition to appropriate level of care once assessment completed – either crisis services or clinic services
- ➢ Supportive services recommended through assessment, Family Care Coordinators assigned as appropriate
- ➢ Uniform paperwork and staff collaboration eliminates need for multiple intakes

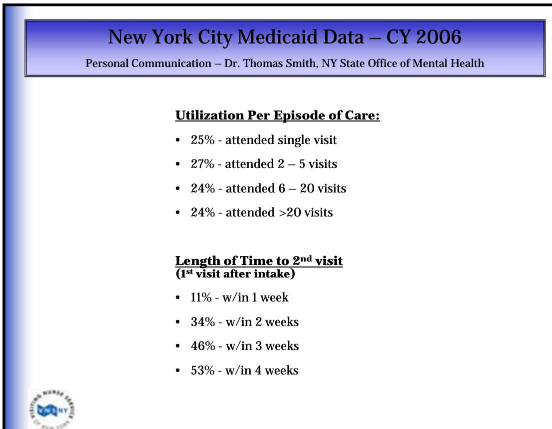
FRIENDS Program Integration – New Service Delivery Overview

Care Coordination

- ➢ Family Care Coordinators (FCC) assigned to cases as needed, usually after assessment completed
- ➢ Provide educational advocacy, benefits and concrete support assistance, linkage to external services/supports
- ➢ Coordinates overall care within the FRIENDS system – helps family/child transition between program components and is primary holder of family information for all staff involved in case

Supportive Services

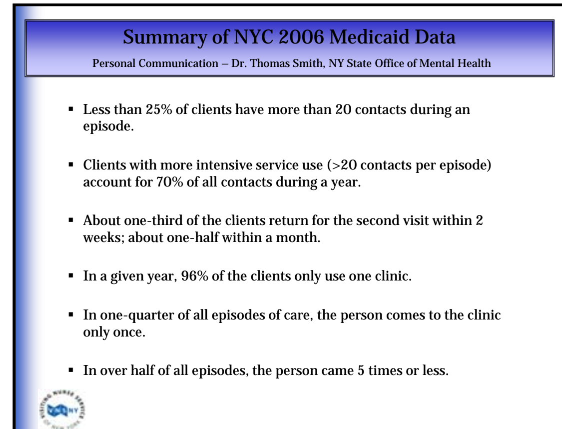
- ➢ All families within FRIENDS system eligible for supportive services at any point throughout care
- ➢ After school programming redesigned to offer milieu setting programming combined with therapeutic groups


New York City Medicaid Data – CY 2006

Personal Communication – Dr. Thomas Smith, NY State Office of Mental Health

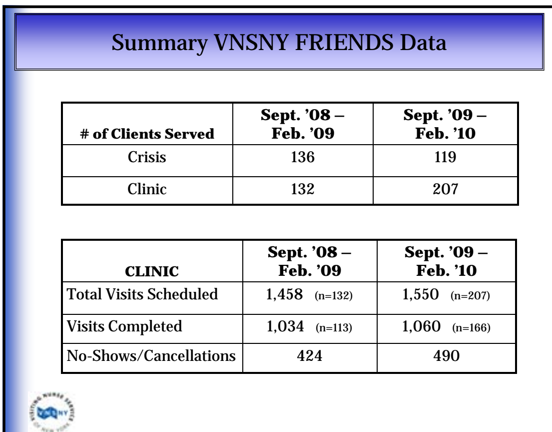
Utilization Per Episode of Care:
- 25% - attended single visit
- 27% - attended 2 – 5 visits
- 24% - attended 6 – 20 visits
- 24% - attended >20 visits

Length of Time to 2nd visit
(1st visit after intake)
- 11% - w/in 1 week
- 34% - w/in 2 weeks
- 46% - w/in 3 weeks
- 53% - w/in 4 weeks


Summary of NYC 2006 Medicaid Data

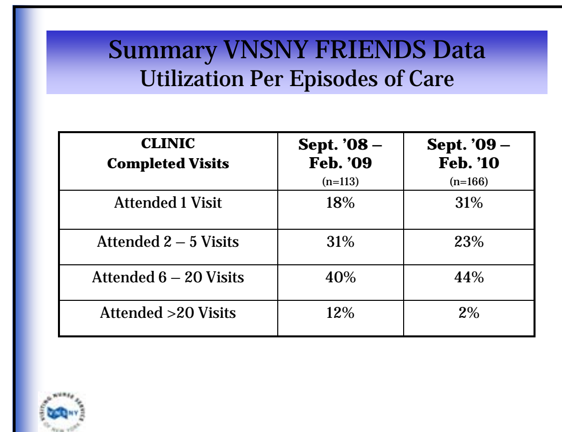
Personal Communication – Dr. Thomas Smith, NY State Office of Mental Health

- Less than 25% of clients have more than 20 contacts during an episode.
- Clients with more intensive service use (>20 contacts per episode) account for 70% of all contacts during a year.
- About one-third of the clients return for the second visit within 2 weeks; about one-half within a month.
- In a given year, 96% of the clients only use one clinic.
- In one-quarter of all episodes of care, the person comes to the clinic only once.
- In over half of all episodes, the person came 5 times or less.


Summary VNSNY FRIENDS Data

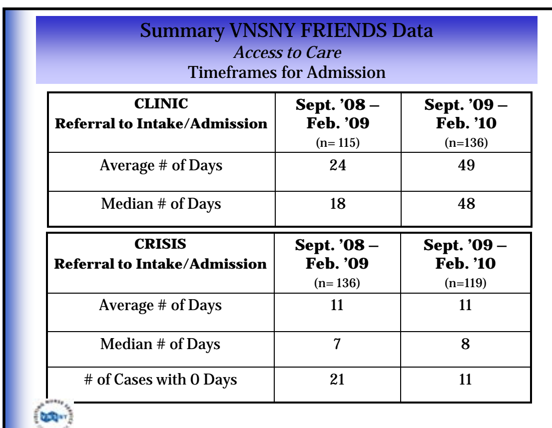
# of Clients Served	Sept. '08 – Feb. '09	Sept. '09 – Feb. '10
Crisis	136	119
Clinic	132	207

CLINIC	Sept. '08 – Feb. '09	Sept. '09 – Feb. '10
Total Visits Scheduled	1,458 (n=132)	1,550 (n=207)
Visits Completed	1,034 (n=113)	1,060 (n=166)
No-Shows/Cancellations	424	490


Summary VNSNY FRIENDS Data

Utilization Per Episodes of Care

CLINIC Completed Visits	Sept. '08 – Feb. '09 (n=113)	Sept. '09 – Feb. '10 (n=166)
Attended 1 Visit	18%	31%
Attended 2 – 5 Visits	31%	23%
Attended 6 – 20 Visits	40%	44%
Attended >20 Visits	12%	2%

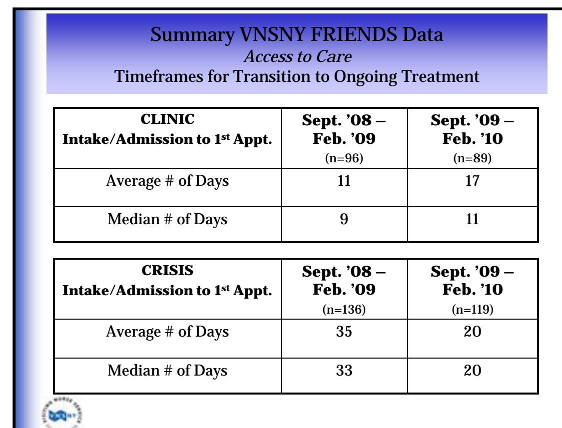

Summary VNSNY FRIENDS Data

Access to Care

Timeframes for Admission

CLINIC Referral to Intake/Admission	Sept. '08 – Feb. '09 (n= 115)	Sept. '09 – Feb. '10 (n=136)
Average # of Days	24	49
Median # of Days	18	48

CRISIS Referral to Intake/Admission	Sept. '08 – Feb. '09 (n= 136)	Sept. '09 – Feb. '10 (n=119)
Average # of Days	11	11
Median # of Days	7	8
# of Cases with 0 Days	21	11


Summary VNSNY FRIENDS Data

Access to Care

Timeframes for Transition to Ongoing Treatment

CLINIC Intake/Admission to 1st Appt.	Sept. '08 – Feb. '09 (n=96)	Sept. '09 – Feb. '10 (n=89)
Average # of Days	11	17
Median # of Days	9	11

CRISIS Intake/Admission to 1st Appt.	Sept. '08 – Feb. '09 (n=136)	Sept. '09 – Feb. '10 (n=119)
Average # of Days	35	20
Median # of Days	33	20

Summary VNSNY FRIENDS Data

Access to Care

Admission/Intake to 1st Appointment

CLINIC	W/in 1 Week	W/in 2 Weeks	W/in 3 Weeks	W/in 4 Weeks
'08 (n=113)	39%	78%	93%	95%
'09 (n=166)	35%	62%	69%	85%

CRISIS	W/in 1 Week	W/in 2 Weeks	W/in 3 Weeks	W/in 4 Weeks
'08 (n=66)	5%	24%	32%	43%
'09 (n= 67)	27%	39%	52%	67%

Summary of FRIENDS Data / Discussion Points

Pre Integration:

- Care was fragmented, not oriented toward specific need and acuity level of clients
- Families experienced several intakes
- Crisis cases had long timeframes between admission and 1st visit
- Clinic was in start-up phase with increasing numbers of clients and staff

Post Integration:

- Crisis cases are moving from intake to 1st visit on average 15 days sooner
- Access to care has increased – volume higher in '09 - '10
- Families need only to work with 1 intake person regardless of presenting problem – their care within our system is coordinated
  - Data suggests that new cases are more appropriately assigned to a level of care
- At 6 months into the integration of programming, it is too early to understand the full impact on client engagement and access to care
- Data analysis has illuminated areas within the intake process that need further attention
  - No-show rates for first visits and beyond remain high
  - Clients not moving from intake to 1st vistit more swiftly post-integration
  - Staffing not increasing at the same rate as client volume, leading to full caseloads
- Percent of clients attending >20 visits cannot yet be determined
- Need to focus on discharges to ensure adequate capacity to enroll new clients into the system

Contact Information

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