

Expediting successful transition to the community...



Healthy Mind. Healthy Body. Healthy Community.



We know already how to establish successful lives after a stay in the State Hospital.

The pathways to use include a combination of elements from three best practices.

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Three keys to success:

- Trauma-informed care
- Peer Bridger Services
- Step-down to intensive supported-living services



Trauma- Informed Care



Trauma informed care recognizes the neurological impact of trauma on the brain and acknowledges the role that trauma plays at the individual, group, organizational and global levels.

It is creating a culture that is grounded in physical, psychological, social and moral safety; trustworthiness and transparency; collaboration and mutuality; empowerment with consumer voice and choice.

Trauma- Informed Care



Trauma informed care is a process that is transformational for both consumers and those who serve them. It builds on the principles of Recovery, and creates healing and hopeful relationships.

Trauma- Informed Care

Some outcomes a trauma informed organization can expect are:

- A reduction in staff and consumer injury,
- A reduction in staff turnover,
- A reduction in patient/consumer recidivism rates,



Trauma- Informed Care



- A reduction in seclusion and restraints,
- A reduction in the use of multiple psychotropic medications
- A reduction in no-show rate
- An increase in consumer satisfaction scores.

Peer Bridger Services



Harborview and Navos collaborate to offer a Peer Bridger Program. It has been proven to improve quality of life after discharge from psychiatric hospitals. Program staff are state Certified Peer Support Specialists.

Peer Bridgers are sited within the hospital setting, working collaboratively on discharge planning and follow the participants into the community, engaging them in community-based services and supports.

Peer Bridger Services

The program has statistically proven to:

- increase enrollment in outpatient services
- shorten length of stay
- reduce number of hospital episodes/days
- increase enrollment in Medicaid



Peer Bridger Services



Participants in the Peer Bridger program reduced hospital use to a greater degree than nonparticipants.

Participants reduced hospital use by 1 full episode from 1.8 to .7. Hospital days were reduced an average of 23.4 days for participants and 5.0 days for nonparticipants.

Peer Bridger Services



- Participants reduced cost at a greater degree than nonparticipants. Hospital days were reduced an average of 23 days for participants or \$25,875 and 5.0 days for nonparticipants or \$5,625.
- Participants had a lower rate of re-hospitalization within 30 and 90 days of discharge from their hospitalization that included the Peer Bridger intervention.

Peer Bridger Services

Once discharge takes place, the range of services provided by Peer Bridgers is customized to the individualized need of the participant.

Peer Bridgers often provide temporary case management until the participant is successfully connected with outpatient services.

- Participants had a significantly higher rate of involvement in outpatient mental health services than nonparticipants within 90 days of hospital discharge, indicating a much greater rate of work to connect individuals to services.
- 72% of the Navos participant group remain engaged in outpatient mental health services 90 days post discharge from the hospital.



Peer Bridger Services

In the community, Peer Bridgers help people:

- Connect with natural supports & recovery communities
- Learn to manage a multitude of appointments while also prioritizing fun
- Talk about medications
- Navigate complex social service systems
- Cope with life changes (everything from diagnosis to challenging living situations)
- Obtain housing
- Follow-up with obtaining and understand benefits
- Connect with Recovery communities (12-step, CD treatment, etc.)
- Practice skills learned while in the hospital (DBT, CBT, WRAP, etc.)
- Learn self-advocacy



Intensive supported-living services



Step-down to a combination of elements of PACT and ECS models:

- Provide the homes and necessary staff and services daily to assure clients' success living in the community.
- Intensive case management uses recovery-oriented practices of care which emphasize independent living and normalizing social relationships, employment, education, cultural beliefs, religion or spirituality and wellness-thinking as the keys to our program success.
- Each individual receives support based on what the individual's goals and needs are.

Intensive supported-living services



A multi-disciplinary team of psychiatrists, nurses, counselors, case managers, vocational rehabilitation and chemical dependency professionals work with clients in their homes and communities tailoring services to the particular needs and capacities of the clients, however resistant or dysfunctional.

Intensive supported-living services



To be successful, step-down beds must have:

- Dedicated skilled staff.
- Affordable safe housing.
- A trans-disciplinary team of professionals.
- Integrated dual diagnosis/co-occurring disorder treatment model.

Intensive supported-living services



Step-down intensive supported-living services save tax payers a lot of money by keeping the clients out of the hospital, out of jail, and out of long-term psychiatric settings. The usage of 911 police and fire calls go down as a result of this population being housed and off the street.

Intensive supported-living services



Clients benefit from group classes:

- Illness management recovery group,
- Wellness recovery action plan group,
- Substance use disorder group,
- Computer skills,
- Gardening,
- Fitness,
- Sports club,
- Alcoholics Anonymous,
- Knitting, and
- Cooking

Intensive supported-living services



A culturally relevant focus (our team has staff who are Laotian, Chinese, West African, African American, Filipino, Caucasian, and Samoan). We provide a culturally diverse work environment with potlucks for staff (each cooking from their culture) and we also reflect the clients' needs either from origin or choice for cultural and spiritual/religious needs to be met in the community.

Intensive supported-living services



- The staff to client ratio provides that each client can have up to several hours per day of help to get back on their feet to independent living.
- The evidence based Harm Reduction Model allows for flexibility and tailored services.

Intensive supported-living services

Expanding Community Services 2016



(Including housing)

	Annual per client	Per bed day
• Revenue:	\$34,847	\$95.47
• Expense:	\$35,299	\$96.71

Intensive supported- living services

Program for Assertive Community Treatment (PACT) 2016



Excluding housing expense:

Annual per client	Per bed day
• Revenue: \$18,495	\$50.67
• Expense: \$21,545	\$59.03

Intensive supported-living services



Employment services provide quality, comprehensive, recovery-oriented vocational supports and services to provide opportunity for the individual to be successful in both acquiring and maintaining employment.

The evidence-based Supported Employment Services model uses individual placement and support that allow clients to choose, get and keep jobs.