

Peer Run Respite Advisory Committee Meeting

November 19, 2013 Summary

Members Attending: Kathryn Ackley, Jill Chaffee, Philip Corona, Donna Christianson, Hannah Flannagan, Karen Iverson Riggers, Evonne Kundert, Michelle Larson, Lyn Malofsky, Jacklyn Mckay, William Parke-Sutherland, Alice Pauser, Sue Shemanski (phone), Joann Stephens, Paula Verrett

Staff Attending: Joyce Allen, Faith Boersma, Kenya Bright, Sue Cochran, Pat Cork, Sarah Coyle, Kay Cram, Caroline Ellerkamp, Linda Harris, Lalena Lampe, Kate McCoy, Sola Millard, Brad Munger

Guest: Dr. Richard Parker

Welcome: Faith Boersma welcomed everyone back. Advisory Committee members and staff introduced themselves. Copies of October 18th meeting summary were provided. No comments or feedback were noted by the Advisory Committee. A “Peer Run Respite Goals” document summarizing input at the October meeting was introduced. Committee members were asked to review these goals in preparation for further discussion at the December meeting.

Presentation on Current Crisis Services in Wisconsin: DMHSAS staff member Brad Munger presented a PowerPoint presentation providing an overview of current crisis services throughout the state. Brad explained the program components of crisis program certifications. He detailed the current system for crisis intervention, including service packages and definitions.

Committee input: Committee members were asked to give input on the presentation. Participants broke into small groups and were asked to discuss how they envision PRRs fitting in the current system. The groups reported out the following:

One group indicated that PRR would be on a different “plane” than crisis services such that thinking about the program linearly within the continuum of the current system of care is not appropriate. The PRR would be a pre-planned option for peer-supported recovery and respite rather than a service based on need in a crisis. However, this group also noted that a solid partnership with crisis services made sense. The PRR should also be a resource center with lots of information.

A second group stated that it would be important to have a clear understanding of the different roles of crisis services and PRR services. Community education would be important. It would also be necessary to dialogue with crisis networks, law enforcement, and first responders; and also to collaborate with other provider types, including peer-run organizations. If the PRR were to be a regional model, relationships between all the counties and communities would need to be established.

Peer Run Respite Advisory Committee Meeting

November 19, 2013 Summary

A third group emphasized community resource connection on all parts of the continuum of care. The group shared a model that focused on self-selection by providing individuals with information and education about all of the various options so that they could have the opportunity to direct their own care. They envisioned four levels: the first level (hospitalization) would be the most intensive, appropriate for individuals in acute need of a high level of care to ensure safety. The second would also be an intensive level of care, but in a less restrictive setting such as a crisis bed. The third level of care would be the PRR, and the fourth level would be peer support. The idea was that all parties would understand their roles, and that peers could choose to move between these levels in either direction according to their needs. One phone call or contact would afford an individual experiencing symptoms with adequate education and information to select an appropriate option, which would then be available to them at the right time and place. The group noted several items that would be highly important: education, self-selection based on understanding and collaboration, and connection with community resources.

The fourth group also highlighted the importance of collaboration as key to successful navigation of the system. They noted that creating collaboration would not only allow people to obtain the services that they want, but it would diminish the “us vs. them” mentality that sometimes occurs. This group also emphasized the importance of self-selection, based on the individual’s desires and needs rather than those of the provider. Warmlines, in collaboration with crisis lines, were also seen as critical. There should be no wrong door or wrong place to go.

The importance of collaboration was affirmed by the last group as well. They saw a working relationship between the PRR and crisis, including the opportunity for consultation. Also important would be collaborative relationship with law enforcement, a clear definition of what self-referral means, and clarity around the short-term length of stay at the PRR. This group noted that having a crisis plan on file is helpful, and that the PRR might help a person to develop this plan.

There was also discussion regarding HIPAA (Health Insurance Portability and Accountability Act) requirements at the PRR. Because the PRR would not be a medical facility or provide medical services, there would be less documentation and information protected by HIPAA. It was noted that many people at the statewide GEP listening sessions held earlier in the year expressed that they did not want notes taken by the PRR staff.

Quality Assurance and Outcome Measures: DMHSAS staff Kate McCoy, Mental Health Data and Evaluation Specialist, provided an overview of quality assurance and outcome measures. She explained the importance of demonstrating effectiveness and quality in order to support ongoing operation and sustainability. Establishing a means of measuring this is essential; however, these questions can only be answered with supporting data. She shared a template that delineated quality assurance (“Is the PRR successfully creating the sort of environment we

Peer Run Respite Advisory Committee Meeting November 19, 2013 Summary

hoped it would?”), output/utilization (“Who is the PRR serving?”), and outcome measures (“What difference is the PRR making in people’s lives?”). Kate also provided examples of several ways to collect this data, including surveys, questionnaires, etc.

Committee Input on Quality Assurance and Outcome Measures: Committee members were asked to give input regarding quality assurance, output/utilization, and outcome measures. Each group developed written comments and suggestions for these measures, which will be compiled into a survey and distributed to all committee members for feedback prior to the next meeting.

Wrap Up & Next Meeting: The next meeting will be held on December 18, 2013 at 1 W Wilson, Madison in room B370. Any questions or concerns, please contact

Faith.Boersma@wisconsin.gov