Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

Liberty Resources, Inc. (LRI) is a 501(c) (3) not-for-profit agency founded in Madison County in 1979 for the purpose of providing housing to chronically mentally ill individuals. Today, services have diversified and are provided throughout New York State and Texas. LRI currently employs nearly 1,400 professional staff who serve over 17,000 clients annually. Our mission is to assist individuals and families in need of achieving an improved quality of life by providing progressive services in the least restrictive, most community-based setting. LRI strives to achieve the highest level of independence for the populations we serve, which include: individuals with serious mental illness; those who are homeless or housing vulnerable; people with developmental disabilities; individuals who have sustained brain injuries; adults and children with psychiatric and addiction issues; people living with HIV/AIDS; survivors of sexual assault and domestic violence; youth in foster care; individuals requiring assistance or support to attain and maintain employment; and children in need of early intervention services. We are committed to excellence in all aspects of service delivery, staff development and business management. LRI is willing to take risks to meet the challenge of delivering the highest possible quality services to diverse populations. For over 39 years, LRI has been delivering effective services that utilize best and promising practices that are appropriate within the array of our various services. Our model of care ensures that behavioral health service delivery is trauma-informed, person-centered, strengths-based and recovery-oriented, incorporating peer, family and recovery support services, thereby supporting the goals of recovery and health while maximizing independence and increasing community integration. We have customized practices to meet the complex needs of our client population and have consistently expanded and developed new innovative models of care. We embrace evidence-based principles surrounding elements of participant-centered residential services consistent with the individual's assessed need, with a rehabilitation and recovery focus designed to promote skills linked to positive health and wellness outcomes.
Our vision is to be a center for excellence with demonstrated effectiveness in serving individuals and families with special needs. On a broad regional level, we will offer a comprehensive continuum of services through partnerships and internal integration of services. We believe that all people deserve the opportunity to make decisions regarding their lives and to achieve their highest potential. We also believe each person has the ability to change and that all people should be treated with dignity and respect. These beliefs are demonstrated in the value and support shown to those served as well as to the staff of LRI.
LRI's values drive its service provision, administrative practice, staff development and business management and include the following components:
Excellence: LRI demonstrates its commitment to excellence by striving to exceed established standards to achieve optimal outcomes.
Integrity: LRI strives to align daily practice with its mission and values.
Diversity: LRI is strengthened when it embraces a broad array of diverse talents and perspectives. LRI strives to maintain welcoming and inclusive environments that ensure that all people are treated with dignity and respect.
Self-Determination: All people deserve the opportunity to make decisions regarding their lives and to have the opportunity to achieve their highest potential. Service staff go above and beyond to meet the needs of individuals, families and communities through consistent, compassionate service.
Innovation: LRI is willing to take risks and engage in creative approaches to respond to the challenges of a constantly changing environment and society.
Fiscal Responsibility: Business management and financial stability enable the agency to achieve strategic goals, to be an employer of choice and to maintain a supportive environment so that employees can focus on high quality service delivery.

Q3 Please indicate which category your organization falls under.

Health Care Provider,

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

LRI provides a diverse array of programming contributing to decreasing unnecessary hospitalizations and promoting proactive, preventive service utilization to the most vulnerable patients. LRI has developed expertise in providing innovative treatment and community-based services to individuals with complex behavioral health disorders and chronic medical conditions, who are high-

frequency, high-cost Medicaid users or uninsured. Over the past four decades, LRI has established a customized approach to ensure individuals' successful transition to independence while addressing regional community health needs. We have a clear understanding of the complex needs unique to this target population to ensure positive engagement and have well-established relationships that foster cross-sector collaboration between the physical/behavioral health sector and CBOs and non-traditional partnerships. LRI embraces a person-centered, culturally and linguistically aware, trauma-informed approach to care, examining and responding to the influence and impact of the social determinants on health.

LRI has the capacity to provide direct access for needed primary care and behavioral health services within our integrated care clinic services. Our clinic provides customized services that have a direct impact on the social determinants of health with which our target population is often challenged. We utilize an integrated case consultative approach with LRI care team members comprised of clinicians, primary care providers, care managers, peer specialist, pharmacist and nutritionists that allows for improved patient engagement and positive health outcomes.

LRI's proposed program meets the complex needs of the behavioral health (BH) population identified by the JSI community needs assessment and current PPS data across Onondaga, Madison and Oswego counties. The social determinants of health related to homelessness and lack of a continuum of supportive housing compounds the problem as many of the people who are addicted end up on the streets, in the ED for shelter and food, admitted for short-term treatment, and then back on the streets. CNYCC partners cited a lack of detox facilities throughout the region. The DOH Expanded BRFSS shows that the rates of the leading chronic medical conditions are all generally higher in these counties than the rest of the state. HEIDIS Measures for this target population also fall well under the state average in relation to medication adherence, necessary follow up and monitoring. Furthermore, rates of obesity and risk factors associated with chronic disease and poor nutrition are higher within these counties for percentage of population with low-income and low access to a grocery store. Recent outcome measure data supplied by CNYCC has identified a need specific to individuals with BH, while identifying the west side of Onondaga County as the zip code with the highest utilizers.

Our targeted model provides an opportunity to engage a traditionally disconnected population through the delivery of peer-based behavioral strategies that improve chronic disease self-management and clinical outcomes while intersecting with community-based nurses following the Coleman model. An array of medical, BH and nutritional services will be embedded within the Rescue Mission and across the region. LRI has been closely working with the Rescue Mission and has received letters of support from both Onondaga County DSS and Adult and Long Term planning officials to support our collaborative approach with this population.

As we look regionally to our rural communities, our proposal meets the needs identified in Madison and Oswego counties as we focus on gaps in care transitions collaborating closely with healthcare and community-based organizations. The regional team that we are proposing would enhance meaningful access to preventive and community-based services that provide key functions for the social determinants of health to avoid hospital readmissions. Our proposed model has a direct impact on areas related to access to healthcare/primary care/trusted provider, health literacy, economic stability, food security and social cohesion. Service delivery will be comprised of an innovative array of evidence-based practices that create a collaborative team approach while weaving in peer-based models that enhance social and community cohesion comprised of the following:

Peer Specialist Support Services: Peer support would be the core of the delivery system assigned/embedded in hospitals, justice centers, the Rescue Mission and primary care settings, following the client well beyond discharge from those settings (actively for about six months). Elements of peer-based behavioral strategies to improve chronic conditions based on studies conducted by Martha Mitchell Funnel will be utilized through an array of evidence-based models. Intentional Peer Support (IPS) will be woven into the proposed program so that Peer Specialists are infused within service delivery to provide various levels of mentoring, guidance, health and wellness coaching. Additionally, in-home cooking; medication coordination including monitoring and training; socialization and community outreach; and crisis diversion will also be offered. Peer Specialists will also provide evidence-based practices known as Wellness Recovery Action Plan (WRAP) planning and Whole Health Action Management (WHAM). Innovative approaches to service delivery will include elements of skill building through the use of technology that includes wearable devices to track heart health and evidence-based health mobile applications, wellness coaching and disease self-management and home-based independent living skills and medication management. Peers would deliver access to a regional 24/7 peer-run warm line as an alternative to emergency department use and unnecessary hospitalization. Peer Specialists will follow the client well beyond discharge from those settings for up to six months.

LRI has extensive experience and expertise in successfully operating an array of peer delivered services woven into our residential services throughout the agency. We have developed a customized training track for peer employees that offers support, training and state certification. Our Peer Specialists provide various levels of mentoring, guidance, education and community outreach across OASAS, OMH and MRT programs. Our values and mission support roles for peer staff and have proven to foster client ongoing wellness and housing stability as evidenced by the fact that individuals who received peer support had improved wellness scores, were more

engaged in treatment adherence and were able to successfully maintain stable housing even after transitioning out of services.
Nutrition/Food Services: Nutrition Services would promote independent nutrition skills and would include nutrition classes, individual nutrition assessment and coaching, “Choose My Plate” portion tracker program, healthy eating recipes, food safety, grocery tours and Chronic Disease Self-Management. Peer-based services would work closely in unison with the nutritionists and provide some in-home cooking with the patient. Healthy nutrition strategies, based on practical application and evidence-based models, would be utilized that link directly to positive health outcomes and sustainable lifestyle improvements.
Evidence-Based Approach to Health and Wellness: Implementation of Nutrition and Exercise for Wellness & Recovery (NEW-R): The University of Illinois at Chicago, Department of Psychiatry, College of Medicine, Center on Psychiatric Disability and Co-Occurring Medical Conditions staff partnered with Dr. Catana Brown at the Midwestern University-Glendale and her colleagues to develop this modified version of the successful RENEW (Recovering Energy through Nutrition and Exercise for Weight Loss) Program that targets weight management and health needs of people with psychiatric disabilities. RENEW addressed weight loss through education and skill building to improve diet and physical activity. Results of a randomized control trial involving 89 individuals found that the intervention group lost an average of 5.4 pounds at the end of the three-month intensive phase. At six-month follow-up, they maintained this weight loss while the weight of the control group remained stable during this same time period. Dr. Brown and colleagues developed NEW-R, which is a free, downloadable curriculum for use in real-world community settings. The curriculum includes a facilitator’s manual, a participant’s manual, and a series of exercise videos designed collaboratively with occupational therapists and people in recovery.
Community Based Nursing Services: Nursing services based on the Coleman’s Care Transition Model would be implemented by using Nurse Care Coordinators specially trained to act as patients’ guides through the discharge process. Nursing staff would provide follow-up care that include home visits, medication management/education, patient-centered medical care and transportation assistance to critical follow up appointments. This model is effective with reducing all-cause readmission rates for heart failure and ensures patients are seen by a primary care physician within seven days of their transition from the hospital to home. A regional 24/7 nurse triage line will be established that includes community-based nursing support when appropriate serving as an additional alternative/diversion to unnecessary emergency department use. Comprehensive care management: The Nurse Care Coordinator will function as the hub for care management and work closely with clients and health providers to develop plans of care that incorporate both preventive and PC treatment goals. The NCC will help clients develop self-management for chronic health condition goals, learn skills and techniques to manage chronic conditions, and promote wellness by supporting tobacco cessation, nutrition, and exercise. As noted above, client need will be triaged based on acuity. LRI wants to ensure that gaps in treatment are closed and that clients receive services needed to address treatment goals. The NCC is responsible for ensuring that ongoing assessments of service needs are conducted, that regular team meetings occur, and that data from the EHR is used to identify gaps as well as ensure all needed services are provided.
Over the past 39 years, LRI has proven capability and experience in implementing and operating over 75 programs with 85 distinct funding sources. We have successfully administered government contracts and grants with a multitude of counties, and State and Federal agencies, including DOH, HUD, HHAP, OPW, OASAS, OMH, HOPWA, OSAH, SAMHSA, SED, and the VA. LRI demonstrates success at program implementation with the ability to effectively implement programs, fidelity to best practices while establishing, tracking and reporting outcomes. We possess an extremely competent administrative, property management, fiscal and program staff. Administratively the CFO, COO, Senior Director of Human Resources/IT/Data Analytics, and VPs of Behavioral Healthcare and Integrated Healthcare assist the CEO in the administrative/fiscal activity and facilities management associated with program. The operation and management of the proposed program will be the responsibility of a multi-disciplinary team who has extensive experience operating, developing and managing numerous federal, state and local grants and capital projects. Together, this leadership team brings a unique blend of expertise into providing effective service delivery and has developed effective partnerships and networks with the full range of health and human service entities to optimize client outcomes. We anticipate that the proposed Innovation activities would begin within three months of approval. LRI provides services in several counties in the CNYCC PPS region and believes that a regional approach would provide the greatest outcome to the PPS network.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	**No**

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Social and Community Context** , **Health and Health Care** , **Neighborhood and Environment** , **Economic Stability**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**