

Pillars of Peer Support Services Summit III
Whole Health Peer Support Services
Atlanta, GA
The Carter Center
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BACKGROUND AND INFORMATION:

The third annual Pillars of Peer Support Services Summit was held September 26 and 27, 2011 in Atlanta, GA at the Carter Center. The focus for this summit was on Whole Health Peer Support Services. The goal was to bring together leaders from U.S. states and territories to examine the best practices in Medicaid and Peer Support Services for integrating healthcare across the full spectrum of behavioral and physical health.

This summit was again supported by stakeholders committed to fostering and developing the role of Peer Support Services in health care services and promotion. This group included: The Substance Abuse and Mental Health Services Administration; OptumHealth Behavioral Solutions; the National Association of State Mental Health Program Directors; the Carter Center; the National Council SAMHSA-HRSA Center for Integrated Health Solutions; Appalachian Consulting Group; and the Georgia Mental Health Consumer Network.

Building on the foundations established with the development in 2009 of the 25 Pillars of Peer Support Services and the subsequent Summit in 2010 to expand Medicaid billing of peer support services, this meeting was convened to expand the understanding of the role of Peer Support Services in the overall promotion of Whole Health and well being. The concept of Whole Health has been developed to describe health services that integrate both behavioral health (mental and substance use conditions) and general health. Leaders from the field presented keynote, plenary, and panel sessions aimed at addressing the rapidly evolving and transforming health systems, the roles of peers in Whole Health, innovative and exemplary programs, the role of Medicaid in funding Whole Health services, and the role of peers in the workforce. Additional work was done by the participating state representatives to outline next steps, challenges and possible action agendas to address Peer Support Whole Health Services in their states and territories. A workgroup also developed a consensus statement that was adopted by the Summit participants that outlines the roll of Peer Support Services in a health care essential benefits package.

For the purpose of these proceedings the keynote and panel presentations have been distilled into brief summary reports. The summaries in this report are intended to provide a key overview of the material presented. The section that outlines the work completed by states is again presented in summation, and describes the range of issues discussed and the common themes. The work on essential benefits provides the consensus statement adopted by the summit participants.

An additional feature of this summit was a film recording of the sessions. There was also a short promotional video made that included participants and other collaborators in the project. The films will be housed on the Georgia Mental Health Consumer Network website, and can be accessed at www.gmhcn.org.

PRESENTATIONS:

Opening Keynote

Bringing Peer Support and Recovery Values to National Health Reform

Ron Manderscheid, Ph.D. Executive Director

National Association of County Behavioral Health and Disability Directors

This opening keynote presentation began with a review of some of the milestones of Peer Support Services. This includes the creation of the Georgia Consumer Network in 1991, which helped lead to the recognition in 2007 by CMS that Peer Support Services is an evidence-based practice. And, while this is an important beginning, there are vast opportunities ahead.

The Peer Support movement has helped to move forward mental health recovery, which is “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (http://www.samhsa.gov/pubs/mhc/MHC_recovery.htm, accessed on the internet on 12/22/11). Peer Support services are also a way of delivering care. Peer Support is provided by specially trained individuals who have personally experienced a mental illness, and who are focused on providing services to individuals who can relate to the Peer Support provider in part based on the provider’s personal recovery experiences. The provider assists the participant using particular expertise that includes but is not limited to his/her life experiences in recovery.

Dr. Manderscheid also noted challenges people with mental illnesses face that must be addressed. These include the fact that more than 49 million people with mental illnesses are living in poverty in the United States, on average more than 25 years of life are lost prematurely, and more than 80% are unemployed. Several important developments are underway to help address some of these issues. This includes the World Health Organizations (WHO) Communicable Diseases Initiative that is addressing cardio-vascular, cancer, diabetes, and respiratory conditions. Mental illness is implicated in each of these categories. The US Department of Health and Human Services (USDHHS) has launched the Million Hearts Initiative that is focused on saving lives from cardiac disease. The Centers for Disease Control (CDC) is also focusing on public mental health initiatives, including strategic public health interventions to be implemented to promote positive mental health.

Considering these emerging challenges and opportunities, a new strategy is needed. In the past Peer Support has worked from the inside out focusing on mental health care with limited connection to the overall health systems. A new approach must be initiated that works from the outside in, building a base in health and community services and including mental health. National health reform also provides an opportunity for new strategies. The key features of the Affordable Care Act include: Insurance reform, coverage reform, quality reform, payment reform, and IT reform.

The key features of insurance reform include new insurance coverage for 32 million adults. This will include 10.5 million who already have mental health or substance use conditions. This will be achieved through State Health Insurance Exchanges and an expansion of Medicaid. Dr.

Manderscheid noted that this is a core feature of health reform and it is essential that the peer services community is involved.

Through insurance reform there are several key opportunities for Peer Support Services. These include *Insurance Navigators* helping the 10.5 million people with mental illness and substance use conditions enroll in either Medicaid or State Exchanges. Once that population is enrolled in health plans, they will need *Access Navigators* who can teach those with behavioral health conditions how to access care in these systems. *Care Navigators* will be needed to help peers use care appropriately and move towards recovery. And *Advocators* will be needed to advocate for the well being of those in these plans and help foster the role of peer support.

Coverage reform supports the expanded populations that will now have coverage in these plans. This includes youth coverage and that no person under 19 years of age can be excluded from insurance because of pre-existing conditions. This will be expanded in 2014 to cover all ages. In addition young adults can remain on their family's policy until the age of 26. There will also be no annual or lifetime financial limits on insurance, and no deductibles or co-payments for prevention services. Under coverage reform Dr. Manderscheid speculated that there will be a role for *Education Navigators* who can help provide information and guidance to people with behavioral health conditions and their families. Additionally, there will be a role for *Advocators* to inform insurers about key population and personal prevention opportunities that must be a part of quality healthcare services.

Quality Reform will feature new delivery mechanisms for health care including Health Homes and Accountable Care Organizations (ACOs). Quality measures will help drive improvement through the systems with the use of performance measurements. There will be key opportunities for *Navigators* in both ACO's and Health Homes. These roles will include assisting in the development of these resources and the enrollment of behavioral health consumers. It will also be important to identify the role of peer support in these organizations. *Advocators* will be able to provide input, guidance, and follow up on the implementation of performance measures that reflect recovery objectives.

Payment Reform features changes in the way services are billed and reimbursed. There will be a movement away from encounters or events as units of service, and a trend towards case, episodic, or capitation models for reimbursement. Additionally the goal is to have performance-adjusted payments that are linked to outcomes of care and quality measurement. The role for peer support in this process is for *Navigators* and *Advocators* who can promote recovery based reimbursements and peer-directed capitation systems.

Health Reform will also promote new opportunities for information technology (IT). This will include expanded use of Electronic Health Records (EHRs) and quality management systems. Peers can serve in *Navigator* and *Advocator* roles to help those with behavioral health conditions understand the appropriate use of EHRs to coordinate care and monitor quality. They can also promote the development and use of consumer controlled Personal Health Records (PHR) that promote self directed care and recovery.

Dr. Manderscheid concluded his talk with a focus on the important role of Peer Support Services in the evolving health systems and by thanking peers for their services. Healthcare transformation requires better integration of general and behavioral health services, the promotion of recovery goals, and an expanded role for Peer Support Services in all health care.

Panel One: The Role of Peers in Enhancing Whole Health

1) Peers as Health/Wellness Coaches

Peggy Swarbrick, Ph.D.

Institute for Wellness Initiatives, CSPNJ

University of Medicine and Dentistry New Jersey

As a part of the morning panel, Dr. Swarbrick presented *Peers as Health and Wellness Coaches* to the Summit. She noted that there is an increased morbidity and mortality associated with mental illness. This is largely due to preventable medical conditions that include Metabolic Disorders, Cardiovascular Disease, and Diabetes Mellitus. In addition there is a high prevalence of modifiable risk factors that include obesity and tobacco use. These conditions are further complicated by psychiatric medications that contribute to the risks, and by limited monitoring and adherence to treatment guidelines.

Dr. Swarbrick presented screening data from the Collaborative Support Programs of New Jersey (CSPNJ) Institute for Wellness and Recovery Initiatives. These findings note that 67% of those screened reported that their physical activities are affected by physical health problems during the course of the month, and 35% reported that they have sought medical care from the emergency room one to four times in the past year. Health literacy is also a significant problem. The screened participants had difficulty differentiating between the terminology of hypertension, high cholesterol, and heart disease. They also had difficulty identifying if they had a history of specific chronic diseases.

These findings support an opportunity for leadership in the support of peers in their pursuit of health and wellness. Dr. Swarbrick noted that wellness is not the absence of disease, illness and stress. Rather, it is the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness (as cited by Halbert, Dunn, 1961). It is a conscious and deliberate process where a person becomes aware of choices, and then makes those choices that support a more satisfying lifestyle (Swarbrick, 1997). Eight dimensions of wellness were presented, including: Emotional; financial; social; spiritual; occupational; physical; intellectual; and environmental dimensions.

Wellness coaching can help an individual identify ways to promote their own health and wellness. By asking facilitative questions, a wellness coach can help individuals gain insight into their personal situations. This supports finding solutions for health problems and concerns that the person may be facing. The result is that individuals can be motivated to face the health problems and concerns they may be facing as defined by themselves. CSPNJ and UMDNJ-SHRP through a 2009 SAMHSA Transformation Transfer Initiative (TTI) grant were able to organize a training curriculum to prepare a new role for peers called *Wellness Coaching*. This training focuses on: Wellness; coaching methods; the role of the wellness coach; lifestyle factors

for health and wellness; metabolic syndrome, smoking cessation, nutrition, sleep, rest, and health habits; health literacy; and wellness narratives. Coaching activities promote successful outcomes through attention to strengths, needs, and goals. This is a new role designed to prepare the peer workforce to further recovery by a strengths-based focus on whole health and wellness.

Dunn, H.L. (1961). *High-Level Wellness*. Arlington, VA: Beatty Press; Dunn, H.L. (1977). What High Level Wellness Means. *Health Values*, 1(1), 9-16.

Swarbrick, M. (1997, March). A wellness model for clients. *Mental Health Special Interest Section Quarterly*, 20, 1-4.

2) Peers in Health Homes

Richard Dougherty, Ph.D.

CEO, DMA Health Strategies

Dr. Dougherty presented the challenges of reforming the health delivery system through a systematic approach. The current system involves a diverse range of components including the funding, workforce, suppliers, and providers. These resources form delivery systems that include processes of enrollment, care, and payment. Health reform provides expanded coverage options and new models of care. Expanded coverage will be available through healthcare exchanges and will increase enrollment. Covered health services will be determined through the essential health benefits, and new models of care including *Accountable Care Organizations* and *Patient Centered Medical Homes* will be available.

The role of behavioral health services will be a central focus as the healthcare system develops new approaches to care. Patients with high behavioral and high physical healthcare costs as a result of chronic conditions account for the bulk of spending for healthcare services. New systems of care will likely become involved in the care of people with high health costs. Accountable Care Organizations are being designed with a strategy for the potential of shared risk for health outcomes. Health homes and health teams will likely become cornerstones of new health systems. With expanded services including care management, coordinated health promotion, family and other supports, and enhanced IT resources, health homes will be in a better position to manage patients with chronic illnesses, including mental and substance use conditions. Health homes will also likely receive enhanced reimbursements to provide this range of services, and it is anticipated that this will include better coordinated care for behavioral health services. Three models of emerging health home services and administration were presented by Dr. Dougherty. These include: Health home network administration, provider driven health homes, and health plan driven health homes.

The role of peer support in health homes is emerging with significant potential for growth. While peer support services are becoming common in behavioral health there is an emerging opportunity in primary care. Peer-driven health teams were discussed and core functions of enrollment, engagement, and care coordination are possible roles that peers might have. For people with two or more chronic illnesses and people with serious and persistent mental illnesses, a new model of health home services is possible. It will be necessary to link together primary and behavioral health care services. Certified Peer Support Specialists can serve as recovery coaches and provide a vital function in helping to coordinate and integrate services.

National models of health homes are based upon Person-Centered Care and other evidence-based practices. These include shared decision making, which will involve a cultural change for most health care organizations. Treatment guidelines are needed to convert evidence-based knowledge into useful interventions with an emphasis on skill building and home-based practice. Screening, brief intervention in primary care, referral to specialists, and peer and family support should become essential elements of integrated primary care and behavioral health services.

Health homes for people with serious and persistent mental illness and addiction disorders need to support recovery and to employ peers. Traditional health home services include: Care management; coordination and health promotion; transitional care; person and family support; and referrals. These and the use of IT need to expand to develop recovery-oriented health home services. The components of recovery-oriented home services should include: Wellness Recovery Action Planning (WRAP) and other Person Centered Planning; the assistance of peer engagement; peer health education and motivational interventions; transitional care between levels of care including peer bridger services; individual and family support; peer coordination and follow up on referrals; and the use of IT systems.

Dr. Dougherty presented a series of requirements for the implementation of peer driven health homes/teams. There will be a need to develop and implement certified training for peer recovery coaches into state plans. A framework for collaborating with other health professionals on the team will also need to be developed, and a feasibility and financial review with operating budgets and capital costs should be conducted. The impact of caseload size should be assessed, as productivity will be an important issue for sustainability. Furthermore, operational procedures including enrollment, assessment, tracking and billing strategies will need to be created, and technology and documentation needs will also be important.

There are enormous financial pressures to achieve results quickly in reformed health systems. At the state level officials are facing pressure to develop their state plan amendments for health reform. The integration of delivery systems meanwhile is being led by health homes and Accountable Care Organizations. All of these developments can support the care of people with serious mental illnesses. There is a unique opportunity for people with lived experiences of mental illnesses and addictions to strengthen and drive the policy and practice for the implementation of health homes in state systems.

3) Peer Support Services – FQHC Perspective

Karen Williams, MS

Associate VP Programs

West End Medical Centers, Inc.

Karen Williams presented successes and challenges of the peer support services provided within the West End Medical Centers (WEMC) in Decatur, Ga. She noted that the WEMC is a Federally Qualified Health Center (FQHC) that was established in 1976 which has five primary locations, and provides services for dental, medical, health education, behavioral health, and outreach services. Peer Support Services connect patients and the community and the peer providers participate as team members in individuals' care. They support and provide evidence-

based strategies that bridge the care continuum, including the basics of evaluation and data collection.

Peer Support Specialists provide services as community health workers and as agents of change. Some of these services include health education and screening, outreach, care management, patient navigation, community referrals, and other services. In this work Karen Williams reported that it is important for peer support staff to know the culture and understand the intricacies of the settings in which they work. They frequently become involved in developing healthy living strategies, health care plan follow up, coaching, community liaisons and monthly meetings for support.

For peer support services it is important to create models that work. This includes short and long term goals, and the steps to implement these services in the FQHC settings. Integration of these services within the overall scope of services is a key to success, and evaluating outcomes is essential. Ms. Williams concluded her presentation with a quote from Shirley Chisholm that characterizes the work done in the peer support and healthcare fields: “Service to others is the rent you pay for your room here on earth.”

4) Peer Recovery Coaches Promote Long-term Recovery from Addiction

Tom Hill, Director of Programs

Faces and Voices of Recovery (FAVOR)

Tom Hill’s presentation *Peer Recovery Coaches Promote Long-term Recovery from Addiction* focused on the challenges people face in dealing with addictions. This includes individuals in or seeking recovery who are returning to their families and communities following an active addiction, treatment, time spent in jails and/or prisons, military duty, and a range of other complicating life experiences. Individuals in addiction follow many pathways to recovery. This can be achieved through mutual aid, faith-based supports, medication, treatment assisted care, on their own and/or any combination of these approaches. Recovery-supportive environments are vital to helping people get back on their feet. Some of these elements include safe and affordable places to live, sober support networks, health and wellness, and a sense of belonging and purpose. Education and vocational skills support employment and job readiness. He also noted that people in recovery from addictions commonly face a variety of other health issues as a result of their addictions.

Recovery support services in the addictions field are viewed as non-professional and non-clinical, and help individuals and families initiate, stabilize, and sustain recovery. They provide links to professional treatment and indigenous communities of support including mutual aid support. Peer recovery support services include four types of support. These are emotional, informational, instrumental, and affiliation. Examples of peer recovery support services were presented, and include peer recovery coaching, resource connectors, and peer-operated recovery centers.

Peer recovery coaches are personal guides and mentors for individuals seeking to achieve or sustain long term recovery from addiction, regardless of their pathways to recovery. They serve as connectors to recovery support services, such as for housing, employment, and other

professional and nonprofessional services. They also provide liaisons to formal and informal community supports, resources and recovery supporting activities.

Mr. Hill's presentation stressed that "recovery capital" informs recovery planning. Peer recovery coaches assess an individual's recovery capital and then address challenges and build on the individual's strengths and capacities to overcome "low" recovery capital. Recovery goals are determined cooperatively by the coach and peer, and achievement strategies and milestones are identified. Coaches promote the responsibility for recovery and help identify locations of recovery supportive services and strategies to address each individual's hierarchy of needs.

Peer recovery services are provided by individuals with lived experiences of addiction and recovery. They can be paid or volunteer and some states reimburse these services when provided by a certified peer addiction recovery support professional. Peer services are designed and delivered to be responsive and appropriate to the different stages of recovery. These services are currently delivered in recovery community centers, in faith and community-based organizations, recovery and sober housing, addiction and mental health service agencies, justice settings, family services agencies, and emergency and other health facilities. There is also great potential for expansion of services into newly evolving health settings, including patient centered medical homes and Accountable Care Organizations. These settings will help support vulnerable populations that are newly insured and they will help address workforce shortages.

Mr. Hill also presented alternative models of peer recovery support services. He noted that recovery community organizations have great potential to be valuable resources. This approach to care would center on reimbursements for organizations rather than individuals providing recovery support services. The accreditation of these organizations would promote quality standards and support the emerging workforce. FAVOR is moving forward in this direction to create accreditation test standards in 2012 and they have a goal of finalizing them in 2013.

SAMHSA's Recovery Community Services Program (RCSP) has developed organizational and practice guidelines for grantees and stakeholders. These include the categories of organizational capacity, peer leader development, ethical frameworks, workforce management, and organizational governance. There are three domains, including standards, practices, and indicators.

Mr. Hill reported that the evaluation of peer recovery support services has insufficient research on these services provided in peer run organizations. The research that does exist supports that these services are moving from being promising to evidence-based practices. Plus the 2011 Government Performance and Results Act (GPRA) data demonstrates positive outcomes at six-month follow-up. Some of the promising future considerations presented include the development of secure funding streams for recovery community organizations, and peer recovery coaches and services. This will ensure the respect of peer recovery coaches in the workplace across professional, clinical, primary care, and criminal justice settings.

Panel 2 – Innovative and Exemplary Programs:

1) Whole-Health Peer Specialist Program

Peter Ashenden

*Director of Consumer Affairs
OptumHealth Behavioral Solutions*

Peter Ashenden presented an innovative program that Optum piloted in Texas. This Whole-Health Peer Specialist (WHPS) program admitted people who are 60 years of age or older and had at least two hospitalizations in the prior year. They also needed to have been diagnosed with a mental health issue and a general health issue. The participants agreed to develop a relationship with a Whole-Health Peer Specialist (WHPS). Optum contracted with an elder care provider to administer the program, and referrals were offered to the provider by Optum. The program was launched in September, 2010.

Both in-person and phone contact was established with the program participants. Some of the participants were easy to engage and quickly willing to participate. Others were more reserved and required additional conversations to get them engaged in the program. A common finding among all participants was the need for the WHPS to share their experiences with both mental health and physical health issues.

Four case studies were presented that examined the challenges and opportunities faced by the participants. The common theme among participants was the engagement with a WHPS, and that this contact helped them connect with both service providers and support systems to address their health conditions.

The outcomes of the program demonstrated a decrease in hospitalization rates by 70%. Prior to the initiation of the pilot program, the average length of hospital stay was 6 days. After entry into the program the average length of stay declined to 2.3 days. Participants were better engaged in their local communities, and were willing to call their WHPS as needed.

This pilot program utilizing Whole-Health Peer Specialists indicates that there is a role for consumer delivered services in an elderly population. Additionally, the outcomes of the pilot suggest that there is an improvement in health outcomes for participants, and that this type of program can be extended to other locations.

2) Peer Support and Whole Health Resiliency

Judith Cook, Ph.D.

Professor and Director

Center on Mental Health Services Research

University of Illinois Chicago Medical Center

Judith Cook, Ph.D., Professor and Director of the Center on Mental Health Services Research and Policy at the University of Illinois at Chicago Medical Center presented work on Peer Support and Whole Health Recovery (PSWHR). It was noted that PSWHR needs to be voluntary because people cannot be forced or coerced to change unhealthy life-style habits. In order to initiate change, a participant needs to first acknowledge having health issues they wish to address. This approach recognizes that people are more likely to create a healthier life-style when they focus on their interests, strengths, supports, and they are able to envision the possibility of being healthier. PSWHR training helps people identify and focus on what they

want to create in their lives, not what they need to change. Participants focus on creating new habits and disciplines on a weekly basis, and are monitored for how they are progressing with these goals. This is accomplished through accepting support from their peers and focusing on new habits rather than trying to change old ones.

The PSWHR program has two main components. These include weekly education and goal setting in one-on-one sessions with a Certified Peer Specialist (CPS). Participants also attend weekly support groups led by a CPS. This process is focused on the IMPACT model which helps peers identify goals that:

- Improve health quality
- Measurable
- Positively stated
- Achievable
- Calls forth action
- Time limited

Weekly action plans break goals into small steps that are achievable in a seven day period, and include a confidence scale that ranges from 0 = none, to 10 = total confidence that they can complete the step in a week. The program has also identified 10 wellness and resiliency domains for Person-Centered Planning. These include: 1) Stress Management; 2) Healthy Eating; 3) Physical Activity; 4) Restful Sleep; 5) Service to Others; 6) Support Networks; 7) Optimism Based on Positive Expectations; 8) Cognitive Skills to Avoid Negative Thinking; 9) Spiritual Beliefs and Practices; 10) Sense of Meaning and Purpose.

Dr. Cook presented information on optimism based on positive expectations and resiliency research. She noted that patients with positive expectations about recovery were 27% less likely to die from heart disease over the next 15 years when confounding factors including severity of disease and depression were controlled for. The relaxation response (Benson et. al., 1974, Lancet) was presented as an essential resiliency tool. This can help attenuate the stress-induced, flight or fight response. It also helps counter the unremitting stress that can negatively impact genetically vulnerable areas of the body that promote mind/body illnesses and premature death.

Five overall keys to the success of PSWHR were noted. These include: The establishment of a person centered goal; a weekly action plan; a daily/weekly log being maintained; the inclusion of one on one peer support; and participation in peer support groups. In states where Peer Support services are billable under Medicaid, PSWHR might be billed through Person-Centered Planning and weekly action plan monitoring.

Dr. Cook presented recent research on PSWHR. One study found that all participants reported progress towards achieving their whole health goals and 20% fully achieved their goals. Positive improvement towards overall health was reported by 67% of participants. A second study found that 93% of participants reported progress towards achieving health goals, but none of the participants fully reached those goals. Thirty five percent reported positive improvements in overall health. In both studies participants rated their Certified Peer Specialist as very helpful in assisting them to achieve their whole health goals. This leads to the conclusions that taken together, these studies suggest that PSWHR may help people in recovery to identify and make significant progress towards achieving their self-determined whole health goals.

A current study is underway to evaluate PSWHR through a randomly controlled trial. Primary wellness outcomes include self reported improvements in physical/mental health symptoms as measured by the BSI and Duke Health profile. Secondary outcomes include: Health related quality of life outcomes as measured by the MOS and SF-36; decreased stress levels measured by the Health Locus of Control Scale; awareness and use of positive eating, hydration, and exercise measured by the Self Rated Abilities for Health Practices Scale; and psychosocial improvement measured by the Hope Scale and RAS. Dr. Cook noted that this will be one of the first randomly controlled trials for Peer Support Services and that it will help answer questions about the effectiveness of this model of care.

3) Improving Health and Healthcare: By and For Mental Health Consumers

Benjamin Druss, MD, MPH

Rosalynn Carter Chair in Mental Health

Department of Health Policy and Management

Rollins School of Public Health

Emory University

Dr. Druss began his presentation on improving healthcare with some historical perspectives. He noted the findings that in 1928 – 1931 Malzberg (Malzberg, B. *Journal of the American Statistical Association*. Mar 1932, 27 [177A]: 160 – 174.) found that in NY State’s Psychiatric Hospitals patients die on average 15 years earlier than other NY residents. This increased mortality was due to natural causes including heart disease (33%), pneumonia (10.1%), tuberculosis (9.5%), and peripheral artery disease (8.9%). Furthermore, despite ongoing victories in public health and improvements in the life expectancy of the general population, persons with severe mental illness have lagged behind in these improvements, and health disparities have widened (Saha, S, et, al, *Arch Gen Psychiatry*. Oct 2007, 64(10):1123-1131).

The Health and Recovery Peer Program (HARP) was presented as a model of a peer-led disease management program. The Chronic Disease Self-Management Program (CDSMP) is the most widely developed peer-led self-management intervention used in general healthcare settings (Lorig, K. et. al. *Med Care*. Nov 2001, 39(11):1217-23.). A pilot study from 2006 – 2009 worked with the developer of the CDSMP and with consumer leaders in Georgia to adapt it to be delivered by and for mental health consumers. The structure of HARP is based on 6 group sessions that include diet and exercise training combined with meetings in-between each session with a peer leader.

Action planning is a core “active ingredient” developed for use in the CDSMP. This includes setting achievable and specific goals for improved health. Confidence rankings for the likelihood of achieving the established goals and monitoring success towards those goals are also tracked. An example would be a plan to walk for 20 minutes three times over the next week. A written action plan includes: 1) what you are going to do; 2) how much you are going to do it; 3) when you are going to do it; and 4) how many days a week you are going to do it. Confidence ranking is based on a scale of 0 (not at all confident) to 10 (totally confident).

The results of the pilot study show improved outcomes for the HARP program versus usual care. Improvements were seen in the areas of physical wellbeing (SF-36), patient activation, increased primary care visits, and medication adherence. A full, randomized trial of HARP was recently funded by the National Institute of Mental Health (NIMH) and will be conducted across four community mental health centers in the Greater Atlanta area. The hypothesis is that learning to manage illness is a key step on the road to health, well-being, and recovery.

Although there has been evidence of the excess mortality in mental health consumers for over a century, it has only recently become a focus of concern. It is now being addressed in clinical, research, and policy venues. Peers can play an important role in helping address this public health crisis.

4) Establishing the Framework for Peer and Family Run Organizations

Teresita Oaks

Arizona Department of Health Services

Teresita Oaks presented a model for how to build peer and family run programs based on experience from work done in Arizona. Current events in the state support this approach and include initiatives for integrated care, health home implementation, and new models for behavioral health services. Their goal in the state is to establish peer and family run organizations as an integral and permanent element of the publically funded behavioral health system. A brief overview of Arizona's behavioral health system was presented with the structure of funding sources, managed care entities, and peer and family run organizations.

Peer and family run organizations provide significant outreach in the community. They provide system navigators, advocacy, and wellness and prevention programs. These services have been well received, and they use community based participatory research to examine collaborative approaches and shared decision making. Sharing data and results are the goal. A system transformation committee oversees this work and includes 26 focus groups and 371 peer and family members. Facilitators have been trained and data collected and analyzed for public reporting.

The plan is to incorporate peer and family organizations within the integrated care system. Current work includes the development of health home educational videos, conducting focus groups and other interviews, and mapping peer/family services. The next steps for this project include feedback on the design of health homes, including the role of peer and family members in the health home service delivery, developing contractual language that supports the role of peer and family services, and continuing to include peer and family members in the planning, organization and mentoring of the behavioral health systems.

General Session Presentation:

Medicaid Funding for Peers in Whole Health:

A Roadmap to Peer Support Whole Health and Resiliency

Wendy White Tiegreen, MSW

Georgia Department of Behavioral Health and Developmental Disabilities

Special project Consultant - NASMHPD

Wendy White Tiegreen presented on the opportunities for peer practitioners related to promoting whole health and resiliency. She began by noting rapid progress in the field in the 12 months since the Pillars of Peer Support Services Summit II. Healthcare reform had just passed and a panel focused on the emerging roles for Peer Specialists. The emerging theme of the integration of primary and behavioral health care has continued, and the role of peer practitioners within a behavioral health environment has expanded to consider both the role of peer practitioners as a bridge between primary and behavioral health systems, and the potential roles of peer practitioners within primary health settings.

With a whole health focus, person centered goals support an informed and “activated” patient (Mauer, Druss, 2011). Self-management is described as the ability to understand one’s health and medical problems. “Activation” is the ability to act effectively in managing one’s own healthcare. However, for those who strive to achieve and maintain recovery with a mental illness or addiction, historical barriers have made engaging in traditional health care systems difficult. Therefore, self-management and activation have not been well achieved (NASMHPD, 2006).

A health-trained peer practitioner was described as a natural ally, and someone who has walked “in the same shoes” as the individual seeking help. Peer perspectives can provide momentum to an individual toward his/her self-management and health activation. Sharing lived experiences and a strengths-based approach can foster support and motivate an individual towards health, wellness, and resiliency.

The SAMHSA-HRSA Center for Integrated Health has defined relapse prevention and wellness recovery support:

(http://www.samhsa.gov/grants/blockgrant/Relapse_Prevention_Wellness_Recovery_Support_Definition_05-12-2011.pdf) The presentation shared the following detail from that site:

Relapse Prevention and Wellness Recovery Support Services are designed to address the further needs of people who are working to develop or who have developed a Recovery Plan. Includes activities to develop and implement strategies or treatments applied in advance to:

- *Prevent future symptoms of and promote recovery strategies for addressing mental illness and/or substance use disorders*
- *Reduce the adverse health impacts related to mental illness, substance abuse, and related traumatic experiences*
- *Build on, and /or maintain wellness skills learned in medical, behavioral health, and related trauma treatment and allied recovery support services*
- *Link to other services that promote recovery and wellness, which are considered relapse prevention and wellness recovery support activities*
- *Relapse Prevention and Wellness Recovery Support can be built into the responsibilities of a Peer Recovery Coach or a separate service role that can be filled by a Peer Recovery Coach, among others*
- *Relapse and Prevention and wellness recovery support services:*

- *Provide or reinforce the individual's education, and understanding of factors that threaten recovery from mental and substance use disorders, including violence, abuse, neglect, and other environmental, interpersonal dynamics*
- *Include recovery planning, recovery management, and adaptive skill training to promote wellness*
- *Deliver skills for reinforcing abstinence from substances where necessary, engagement in health behaviors, and recovery maintenance*
- *Utilize community resources, including natural and peer supports to maintain recovery and wellness patterns of thinking, and behaviors to mitigate relapse-provoking crises*

Expected Outcomes:

- *Continued length of abstinence from substances*
- *Improved bio- psychosocial health*
- *Increased ability to identify and manage high- risk situations that could lead to relapse*
- *Increased ability to be proactive regarding relapse prevention and wellness recovery planning including the ability to identify warning signs and triggers and to adhere to self-defined goals and strategies to maintain abstinence and wellness achievements*
- *A reduction in mental illness and/or substance use disorder services as individuals assume responsibility for their own wellness and recovery stability, manage and reduce their symptoms through varied self help techniques and initiate the support of a network of peer, indigenous community and professional supports*
- *Increase in stable housing and employment*
- *Increased linkages made to other recovery and wellness support services*
- *Increased overall quality of life*

A roadmap for how to develop a Peer Support Whole Health and Resiliency project was presented (see Appendix 2). The roadmap begins with the identification of experts who can help in considering peer-supported opportunities, including engaging individuals with lived experiences along with traditional mental health partners. New partners in program development must also be engaged, and may include individuals with experience in health, policy, and financing who represent emerging health homes, Federally Qualified Health Centers (FQHCs), medical centers/hospitals, and health policy centers.

Secondly, a Target Population must be identified. Functional and/or diagnostic criteria are necessary so that payers, provider agencies, and clinicians understand the expectations. Leadership must consider diagnostic categories that include for co-occurrence with chronic health conditions. A target population may also naturally emerge through defining a target site such as a hospital or FQHC setting. Then it will be important to further develop a peer workforce that can be specially trained to address both the physical and behavioral health needs of the targeted individuals.

A crucial next step is considering the possible scope of your health/wellness program. You may have broad opportunities or may be limited to a pilot program, specific geographic area, certain sites, provider types, and/or functional/diagnostic criteria.

Once these elements are determined, it is then possible to define the goals of the service and a description of the programmatic efforts and work that the Whole Health Peer Specialists will do. Staffing must support the program work and must include peer practitioners. There may be specific personnel considerations or requirements in sites where the program operates, such as credentialing.

Defining a model of service delivery is the next critical step. The model definition should consider several means of structuring services. Some examples include that: Support may be delivered in a group setting or one-on-one; peer practitioners may operate independently or as part of multidisciplinary/multi-agency teams; and peer practitioners might support individuals in person or via electronic/telemedicine communications. Program elements should include referral processes and collaboration/communication with supporting partners. Functional definitions need to be developed, and the scope and duration of contacts defined as indicated by assessments and Person-Centered Planning with individual clients to identify needs.

Reimbursement strategies must also be considered and requirements for Medicaid and other funding sources built-in to the program components. Alternative reimbursement strategies should also be considered based upon the partnerships that are developed and available funding sources specific to the organizations that will be served. Funding opportunities may include State Medicaid Plans, Medicaid Waivers/Managed Care Plans, Health Home grants, FQHCs, Accountable Care Organizations (ACOs), insurance exchanges, and/or disease management/health coaching programs. Reimbursement strategies can differ and may include fee for service, pay for performance/outcomes, and other creative solutions. Documentation and other administrative standards will follow reimbursement strategies. Documentation standards typically include a review of a person's basic status, goals worked on during the intervention (recovery plan oriented), the types and results of interventions provided, and plans for next steps.

Finally demonstrating outcomes is a fundamental component of any program. A plan for measuring success should be crafted at the onset of the project implementation, but be prepared to modify and improve your program model as you go. Document these modifications so that they will be replicable. The presentation concluded with the recognition that these types of programs address some of “the most challenging engagement issues in healthcare, so be bold in your innovation, modify when necessary, and be successful.”

Day Two Keynote:

The Imperative for the Inclusion of Peers in the Health Workforce

Kathleen Reynolds, LISW

SAMHSA – HRSA Center for Integrated Health Solutions

Kathy Reynolds presented the day two keynote on work that is currently underway at the SAMHSA-HRSA Center for Integrated Health Solutions. Her presentation provided: A review of what is actually meant by “integration”; the consumer role in health behavior changes; Peer Support and Recovery Support in mental health and substance use disorders; and how to migrate peer and recovery supports to primary care settings.

Bi-directional integration involves providing mental health and substance abuse services in primary care, and providing primary care at mental health and substance abuse sites. It is a model of care that is distinctly different from the traditional medical model. Table 1 below describes the key functions and levels of collaboration/integration for health care services:

Table 1.

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4; one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management, cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

The World Health Organization (WHO) describes the biomedical aspect of health as including physical and mental health that are developed within the human body as influenced by genetic make-up. Environmental factors are all matters related to health that are external to the human body, and include the physical and social environment. Lifestyle influences are the aggregation of personal decisions that can be said to contribute to or cause illness or death. Health care organizations include medical practices, nursing, hospitals, nursing homes, medications, public health services, dental treatment, and other health services organizations. The determinants of health generally include income and social status support networks, education and literacy, gender, biology and genetics, and culture. Physical and social environments, personal health practices, coping skills, and development also impact an individual's health.

Changing health behaviors in real life is difficult. Generating habits is hard work, and denying ourselves unhealthy behaviors/habits is also hard to do. The sustainability of change is improved with the engagement of peers and persons with lived experiences. People tend to have an easier time changing habits or behaviors when they have someone to support them who is also going through the same thing, or who has made changes and can empathize with them through the challenges. And there are ample examples of successful peer support programs in mental health. The Georgia program was cited as a model program for the country.

The Faces And Voices of Recovery definition of Peer Recovery Coaches describes this role as a personal guide and mentor for individuals/families seeking to initiate, achieve and sustain long-term recovery from addiction, including medication assisted, faith based, 12 step and other pathways to recovery. A peer Recovery Coach serves as a connector and navigator in recovery support systems, and as a resource for problems associated with housing, employment, and other professional and non-professional services. This includes liaisons to formal and informal community supports, resources, and recovery support activities.

The impact of Peer Recovery Coaches is progressing from being considered a “promising” to an evidence-based practice. The 2011 GPRA data for the Recovery Community Support Program (RCSP) demonstrates positive six month follow-up outcomes. Improvement and favorable results are seen in abstinence, legal problems, employment, housing, and mental health symptoms. Important next steps for Peer Support Services will be for them to become billable in all 50 states plus the US Territories, for peers to be hired in all agencies, to develop competencies and training to be completed and certified for all peer providers across all states/territories, and to integrate language and terms among all peer and other professional providers.

Ms. Reynolds presented opportunities and challenges for migrating peer supports to primary care. She used Wagner’s Chronic Care Model as a framework to describe how health systems and the organization of care fit within the community of resources, and how they can include peer support. In general healthcare there are several models of how community based services support self care and health improvement. The role of community health workers has been reported by HRSA as:

“Community health workers are key members of communities who work for pay or are volunteers in association with the location health care system in both urban and rural environments and usually share ethnicity, language, and socioeconomic status and life experiences with the community members they serve... Community health workers assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for community and individual health needs, and provide direct services such as first aid and blood pressure screening.”

The role of community health workers has been demonstrated as an important part of care delivery teams, as navigators helping to negotiate complex service systems providing screening and health education, and as agents of outreach and engagement.

Another example of the role of peer services in general healthcare is that of the Promotoras. These are Hispanic community health workers who work within their community to help educate target audiences about the key health issues that affect those communities. Promotoras are members of the communities in which they work and have an understanding of the culture of the community and the unmet health and social needs. In this role they serve as liaisons between their community and health and social service organizations. They serve an important function as advocates, educators, mentors, coaches, role models and translators. Promotoras may be volunteer or paid, and provide basic health education linkages for health and human services resources.

There has been a demonstrated role for peer support and peer support services in mental health, substance abuse care, and recovery. The concept of staff having lived experiences of behavioral health conditions is similar to how community health workers in general health settings often have lived experiences of that with which they are trying to help. This role can be expanded to include a whole health focus and promote the integration of care across systems of care. The question was posed as to whether these currently distinct consumer movements could be integrated in some way to expand the impact of consumers across the whole continuum of care. There is a potential role for peer support staff in mental health services as Recovery Coaches in substance abuse systems and as Community Health Workers in primary care settings. One closing suggestion was that these efforts might be combined into a single movement that advocated for payment across peer support movements and across systems.

State Breakout Groups Summary:

States and territories that participated in the Summit had the opportunity to work together in small groups to explore opportunities and challenges for building and expanding Whole Health Peer Support Services in their communities. Each of the states/territories was assigned the task of reviewing the presentations and discussing what some possible next steps might be for their state/territory. This included possible challenges and possible action plans. For the purposes of these proceedings, a synthesis of the next steps, possible challenges, and possible actions are presented. In many cases there was consensus between the possible next steps and possible actions. Generally the issues that arose included issues of funding and sustainability, training and workforce development, evaluation and outcomes, and policy and politics.

Possible Next Steps:

- Include contractual requirements that support peer service delivery
- Funding new training programs
- Marginalization of peer services
- Build state and national partnerships to support Peer Support Specialists (PSS)
- Participate in health home development and peer support roles
- Involve local academic centers in the promotion and development of PSS roles
- Build new partnerships across state government divisions to support whole health
- Inventory state organizations for what might be being done in this area already
- Develop and implement a data tracking system to track outcomes of peer services
- Establish a peer workforce development group
- Establish career and educational pathways
- Launch a statewide initiative for wellness and whole health
- Ask for state support for expanded whole health training
- Explore training curriculums for Peer Support Whole Health
- Train supervisors to understand whole health issues
- Partnership with hospital services (e.g. dietary) to support a whole health agenda
- Expand the training for Peer Support Specialists to include whole health
- Supporting existing peer specialists on their own whole health strategies
- Include veterans in training and services

- Expand youth and adolescent peer support services

Possible Challenges:

- Addressing State leadership changes
- Funding and sustainability
- Lack of understanding of PSS benefits
- Measuring outcomes and demonstrating good work
- Building and maintaining buy-in from providers
- Stakeholder competition
- Establishing common language across health and behavioral health for whole health concepts
- Different agendas for stakeholders, agencies, and partners for a whole health approach
- Peers versus other professionals and established silos
- Fear that wellness will overtake other peer support services
- Lack of respect/value for peer specialist roles
- Rural/frontier challenges
- Lack of a whole health vision for decision makers and leaders
- Lack of job descriptions for whole health focused peer support
- Need for evaluation tools to document outcomes
- Bridging the gap between mental health and substance abuse – breaking down barriers
- Working with managed care organizations

Possible Actions:

- Whole health integration training for MH/SA
- Sharing the findings of the Pillars Summits with leadership
- Advocacy for the role of PSS
- Develop a new core competency grid
- Establish pilot programs with managed care programs
- Build new linkages to medical associations and others
- Build collaborative partnerships and develop champions
- Meet with commissioners and other leaders
- Develop values, goals, and strategies to implement wellness and whole health initiatives
- Draft competencies, craft job descriptions for civil service approval, conduct training
- Establish funding opportunities
- Develop webinars on whole health
- Expand trauma informed services training

Essential Benefits Consensus Statement:

A working sub group also met at the Summit and discussed possible language to support a consensus statement for what aspects of peer support services should be included in an essential benefits package for health insurance coverage. This group developed a statement, presented it to the larger group of participants, and then based upon feedback, modified it for consensus ratification. This statement is:

Peer Recovery Support Services are evidence based (SMDL No. 07-011) and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer Recovery Support Services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation.

This consensus statement was presented to the Summit participants, and is included here as a technical assistance resource for those working on the role of peer support services as covered benefits for health plans and payers. This includes both commercial and Federal payers.

Summary and Conclusions:

The Pillars of Peer Support Summits have been an evolving project to understand, define, and promote the role of peer services within Medicaid and other funded healthcare services. This work includes the development of the 25 Pillars of Peer Support, survey research to better understand the billing and reimbursement for these services across states and territories, a review of the evidence base for peer support and peer support services, and the expanding role for Whole Health Peer Support services. The most recent Pillars of Peer Support Services Summit III focused on the evolving health system reform and transformation, and the role of peer support services in the integration of behavioral and physical health care.

Presentation summaries and video links have been provided as a resource for those that are working to advance the role of Whole health Peer Support services. They provide examples and explanations of the current work that is being done to build the role of peer support services in the evolving health reform movement. Additionally, a statement of the role of these services as a part of an essential healthcare benefit was developed.

The rapidly evolving peer support workforce and service implementation models emphasize the importance of peer involvement in the continuum of healthcare services. The Pillars of Peer Support Services Summit workgroup is committed to continuing to provide resources to support these initiatives. We are indebted to our sponsors and partners and endorse the findings of the evaluations from this Summit that call for continuing work in this area and the ongoing need for the next Pillars of Peer Support Services Summit.

APPENDIXES:

Appendix 1- Video Links:

An additional feature of this summit was a film recording of the sessions. There was also a short video made that included participants and other collaborators in the project. The films are being housed on the Georgia Mental Health Consumer Network website, and can be accessed at: www.gmhcn.org.

Appendix 2:



Wendy White Tiegreen, 2011

The SAMHSA has released innovative Recovery Support Definitions which further the unique roles of Peer Specialists with the vision of their role in the integration of behavioral health and primary healthcare. Specifically, its **Relapse Prevention/Wellness Recovery Support** definition builds upon the foundation of a professional peer workforce with lived experience and furthers their scope to create thoughtful new opportunities for Peer Support in healthcare. Peer Support Whole Health and Resiliency (PSWHR) promotes developing whole health and wellness behaviors through the development of whole health and resiliency goals (SAMHSA-HRSA CIHS, 2011).

One of the greatest challenges in healthcare is engaging the individual in his/her own healthcare management. Mauer and Druss (2011) define the need for developing an “Informed, Activated Patient” including:

- **Self-management:** ability to understand and manage one’s health and medical problems
- **Activation:** ability to act effectively in managing one’s own healthcare

For individuals who are striving to achieve and maintain recovery with a mental illness or addiction, there may have been historical barriers to engaging in traditional healthcare systems. Therefore self-management and activation are not outcomes which have been achieved (NASMHPD, 2006). A natural ally for engagement in health is a professional who has walked in the same shoes: a health-trained peer practitioner. The peer perspective may be the key, as it models this “self-management,” while encouraging health activation.

Additionally, because of their lived experience including challenges accessing health as a person with a behavioral health issue, peer practitioners have a niche role in supporting and motivating the individual toward health, wellness, and resiliency. Their strengths-based approaches are essential to health teams including but not limited to those in a health home model (which currently has 90/10 match opportunities for initial 2 years of implementation), Federally Qualified Health Centers (FQHCs), and emergency rooms. Trained Peer Specialists can also be a tremendous aid in health workforce shortage areas and be key partner in rural health centers.

Peer Support Whole Health and Resiliency can be utilized in many settings. Once you have some ideas on your broad approach, the following definition and roadmap will provide checkpoints to you and your health partners as you consider the role of peer professionals in the changing landscape of health and wellness.

Relapse Prevention/Wellness Recovery Support Definition

Relapse Prevention and Wellness Recovery Support Services are designed to address the further needs of people who are working to develop or who have developed a Recovery Plan. Relapse Prevention and Wellness Recovery Support Services include activities to develop and implement strategies or treatments applied in advance to:

- Prevent future symptoms of and promote recovery strategies for addressing mental illness and/or substance use disorders
- Reduce the adverse health impacts related to mental illness, substance abuse, and related traumatic experiences
- Build on, and /or maintain wellness skills learned in medical, behavioral health, and related trauma treatment and allied recovery support services
- Link to other services that promote recovery and wellness, which are considered relapse prevention and wellness recovery support activities
- Relapse Prevention and Wellness Recovery Support can be built into the responsibilities of a Peer Recovery Coach or a separate service role that can be filled by a Peer Recovery Coach, among others.
- Relapse and Prevention and wellness recovery support services:
- Provide or reinforce the individual's education, and understanding of factors that threaten recovery from mental and substance use disorders, including violence, abuse, neglect, and other environmental, interpersonal dynamics.
- Include recovery planning, recovery management, and adaptive skill training to promote wellness.
- Deliver skills for reinforcing abstinence from substances where necessary, engagement in health behaviors, and recovery maintenance.
- Utilize community resources, including natural and peer supports to maintain recovery and wellness patterns of thinking, and behaviors to mitigate relapse-provoking crises.

EXPECTED OUTCOMES:

Expected outcomes should be consistent with those indicated in the individual's recovery/and wellness plan. These may include the following:

- ✓ Continued length of abstinence from substances
- ✓ Improved bio-psychosocial health
- ✓ Increased ability to identify and manage high-risk situations that could lead to relapse
- ✓ Increased ability to be proactive regarding relapse prevention and wellness recovery planning including the ability to identify warning signs and triggers and to adhere to self-defined goals and strategies to maintain abstinence and wellness achievements
- ✓ A reduction in mental illness and/or substance use disorder services as individuals assume responsibility for their own wellness and recovery stability, manage and reduce their symptoms through varied self-help techniques and initiate the support of a network of peer, indigenous community and professional supports
- ✓ Increase in stable housing and employment
- ✓ Increased linkages made to other recovery and wellness support services
- ✓ Increased overall quality of life

Additional detail @

http://www.samhsa.gov/grants/blockgrant/Relapse_Prevention_Wellness_Recovery_Support_Definition_05-12-2011.pdf

Checklist Items:

Identify your experts: Consider those who can work with you in the development of your ideas and plans. The work must include individuals with lived experience! Other experts in policy, health, or financing should also be strategically considered as guides, since they will eventually be potential owners. Think of traditional mental health partners, but also consider health policy centers, FQHC partners, emerging health homes, medical universities, hospital associations. These expert partners will help you build the rest of the work to follow.

Identify your target population: Conceptually, who do you desire to be served with Peer Support Whole Health and Resiliency (PSWHR)? Targeting may be person-centric or may target a health delivery site, such as an emergency room or public health hub.

- Diagnostic/Functional:** The individuals who will be targeted to receive the service must be identified in a way that payers, provider agencies and practitioners alike can understand expectations. As you target health, you may want to take into account the co-occurrence of diabetes, high blood pressure, obesity, or other chronic health conditions. If you are considering Medicaid or HRSA reimbursement, you will need to consider how your local programs typically define these elements (for instance, DSM diagnosis or CPT diagnosis) and conform with that standard.
- Target Population Scope:** After defining the diagnostic and/or functional elements above, consider the potential volume estimates to provide support to those persons. Remember you should come back to this item when you finalize available funds. Your expert team may need to narrow your scope if there are limited funds available (e.g. limit to a pilot, to a specific geographic area, to a certain provider type, to a certain health site, OR narrow your diagnostic/functional criteria, etc.)
- Site Targeting:** Given your local opportunities, you may choose to focus on a facility first which may narrow your population to those who will frequent that site. You may consider partnering with a hospital association to hire a trained peer workforce in a high-use emergency room (for instance using SBIRT: web citation) or partnering with an FQHC to use the peer workforce as guides for individuals who present at those sites with a health condition and a behavioral health issue. In these scenarios, the presenting site population is defining your target group and the peer workforce can be trained/oriented to work in that environment.
- Create a definition:** No matter your proposed framework, consider the structure of the existing policy so that your products are ultimately culturally acceptable (e.g. if most of the state agency definitions are 1-3 paragraphs in length, then limit your definition to this length). This should define the goals of the service and then define what will happen within the context of the service delivery. The provided SAMHSA definition is a solid base from which to begin.
- Define Programmatic Requirements:** The definition above has to be operationalized in a way that purchasers and providers can “see” how it will work. With sensitivity to the local selected practice, consider these following elements:
 - Staffing requirements:** Who can provide this service? Of course, individuals who self identify as having lived experience with a mental illness and/or an addiction are the practitioners, but other considerations such as credentialing and required training should be addressed. The peer staff must feel confident in their role supporting individuals in navigating health systems and creating and achieving health goals.
 - Models of Service Delivery:** Will the service be done one-on-one or provided to

groups? Will telephonic support or telemedicine be allowed? Will the peer professional work as an independent practitioner or be paired with a nurse or physician? Perhaps the peer will be a member of a multi-agency team which will span MH, SA, medical, and social services (Mauer, Druss, 2011).

Interconnectivity: The service ideally works with the identified person to build strong partnerships with those who will support wellness and recovery goals. Programmatic considerations should define expectations related to building trust with the person so that trusted consent is garnered. The following aspects should be considered programmatic elements:

Formal Supports: How the service receives referrals, refers to other services, and collaborates and communicates with other formal supporting partners, especially considering physicians, nurses, health homes, FQHCs, etc.

Informal Supports: How the service engages friends, family, and other informal networks in order to create a circle of support to accomplish wellness and recovery goals.

Service Scope and Duration: Your target population having been decided, what is the frequency of service contact and length of time you believe these individuals will need service? If Medicaid financing is being considered, generally a “Licensed Practitioner of the Healing Arts” (LPHA) must be utilized to determine how much and how often a service can be provided. LPHA is defined differently in different states, sometimes in law, but most often in policy. Be sure to know your local Medicaid expectations in defining this element. The best tools in determining service scope and duration with be:

Clear assessment

Person-Centered Planning

Good Relationship with LPHA

Documentation: How will you guide practitioners of this service to document the interventions provided? Consider minimizing administrative burden while maximizing the elements needed for the notes to be effective to health and behavioral health professionals. Most states/agencies have documentation standards which can be a framework for your decisions; however, the peer practitioner should be prepared to document:

Person’s basic status

Goals worked on during intervention (recovery plan-oriented)

Type of intervention

Results of intervention

Plans for next steps

Define Agency Requirements: If you haven’t already identified a specific environment in which to provide this service, you now must consider this: where are the natural provider hubs in which this service can thrive? If your state has Consumer-Operated organizations, will they be the best provider agencies? Also consider traditional behavioral health providers and other health hubs such as FQHCs, Health Homes, Case Management/Disease Management agencies, hospitals, etc.

Cost Analysis: The state will have to consider its peer workforce qualifications and those associated costs (certification, additional health coaching training), local salaries, staff-to-person-served ratios, benefits, productive hours, and administrative costs in determining its estimates.

❑ **Funding Mechanisms:** Your team must consider the current or potential mechanisms used for funding and financing behavioral health and/or health and wellness services. State Medicaid Plans, Waivers, Health Homes grants, and FQHCs are the most obvious mechanisms for supporting PSWHR. Additionally, there are broader health arrangements in which to embed the concepts or services. Accountable Care Organizations (ACOs), insurance exchanges, and managed care vendors will all be seeking solutions to supporting individuals with behavioral health issues and to address their overall health outcomes. Many state Medicaid authorities are challenged with how to engage individuals living with a mental illness or addiction in their disease management/health coaching programs and this service may create an opportunity outside of the traditional behavioral health service system. Depending on your local funding mechanisms and related opportunities, you may be considering a stand-alone service with a fee-for-service-unit rate, you may be selling the benefits of cost-efficacy in supporting pay-for-performance/outcomes, or you may be promoting a peer professional as a health coach. No matter the fund source, track your success, and then use your demonstrable evidence to leverage Medicaid in the future.

❑ **Demonstrate Outcomes:** Plan for outcomes monitoring from the onset of the service implementation. Consider this: When you provide a service to an individual, you always work from a recovery plan with goals and objectives, then you work with the individual to continually adapt and modify the plan. Craft similar goals for your implementation and be prepared to modify and improve your program model as you go. Document these modifications so that they may be replicable. Your initial approach does not have to be sophisticated, but you should be prepared to provide interested parties with some evidence of success.

Finally, know the detail of these checklist elements. The completion of the work above will make you and your team experts in your plan. From this knowledge base, you can decide your advocacy positions and identify the partners who are your allies in supporting the implementation of the approach. As you begin your persuasive conversations around the implementation, continuously refine your pitch and share your outcomes. You are providing solutions to some of the most challenging engagement issues in healthcare, so be bold in your innovation, modify when necessary, and be successful!